Autistan
Studies and Suggestions

ISLE OF MAN | 2026
Isle of Man Government
National ASC Strategy 2024-2034
Autism Acceptance & Strategy Impact Survey

2026 Autism Acceptance and Strategy Impact Survey

Independent institutional analysis and practical proposals for the National ASC Strategy 2024-2034, Autism Acceptance Month 2027 and Phase 3



Autistan *The Autistic World*
Autistan Diplomatic Organization
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Isle of Man
ASC Strategy 2024-2034
Institutional Study | 2026

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This document was prepared as a complementary institutional contribution for the Isle of Man ASC Strategy team. It does not purport to be a resident survey response or a first-hand assessment of Island services.

Purpose	Practical value
Campaign 2026 and 2027	Assess what the campaign communicates, whom it reaches, and whether it leads to tangible accessibility improvements.
National Strategy 2024-2034	Connect 2022 concerns, 41 original actions, Phase 1 evidence, Phase 2 commitments and 18 Phase 3 actions.
Distinctive contribution	Distinguish autism from disorders and socially generated impingements; prioritise accessible environments, autonomy, direct experience and outcomes.

Executive Summary

The Isle of Man has already established meaningful foundations: a ten-year ASC Strategy, engagement processes, training, community initiatives, reasonable-adjustment activity, the 2026 Health Passport and a Phase 3 plan. The central proposal here is not to restart this work but to connect each measure to evidence that access, choice and everyday conditions have actually improved. [4][5][10][14][18]

For the 2027 Autism Acceptance Month campaign, we propose three practical priorities. First, publicise tested sensory, communication and procedural adjustments in ordinary settings. Second, improve the accuracy of public understanding, including the distinction between autistic functioning, co-occurring health conditions, avoidable environmental pressures, and actual safety risk. Third, reach people who are not identified, diagnosed, willing to disclose or able to participate in conventional meetings and surveys. These priorities should generate a feedback-to-action record rather than awareness figures alone. [3][22][23][29]

A separate, longer-term recommendation is a public evidence trail from each of the 41 original Strategy commitments to the actions, resources and outcomes of subsequent phases. The official First Annual Report and Phase 2 Action Plan (GD 2025/0069) is not a report on the completion of Phase 2. The Phase 3 Plan itself says that Phase 2 will be reported to Tynwald in early 2027; that subsequent report should be identified and evaluated separately when available. [4][10]

The methodology proposed below distinguishes policy commitments, services actually provided, ability to use those services, environmental changes and outcomes experienced by autistic people. It recognises improvements while keeping unanswered questions visible; it makes no claim of a representative field survey of residents. [3][4][10]

The concept of acceptance should be tested at its most demanding point: whether harmless autistic movements, clothing, forms of expression and choices of social distance can be unremarkable parts of ordinary life. In some settings, people of the same sex can hold hands without attracting a comment or glance; the pertinent comparison is not between autism and

sexual orientation as identical phenomena, but between a visible difference treated as a social problem and a difference that ceases to require commentary. Non-attention to harmless difference is compatible with attention to the person's actual words, requests and needs. [81]

The proposed assessment also guards against an apparent success achieved through concealment. If autistic people experience fewer hostile reactions only because they mask, avoid public spaces, suppress harmless self-regulation or abandon requests, that cannot demonstrate an accessible society. The evaluation must identify what changed in the institution as well as what the individual had to do to remain safe or be accepted. The same causal distinction applies when distress generated by social rejection is incorrectly attributed to autistic nature itself. [81][82]

Autistan's descending pyramid of autistic freedom supplies a complementary policy architecture. Its base is systemic measures for accessibility for autistic people; further levels concern subsidiary adjustments, autism-specialist assistance accessible to all concerned, chosen learning and real-life experiences, and personalised support where required. The person is symbolically situated above the barriers and moves DOWN towards ordinary society and greater freedom. The entire pyramid serves accessibility; the base must not simply be labelled 'autistic accessibility'. [82][46]

Consequently, an 'autism-friendly' claim, certificate, quiet session or awareness event should be treated as a starting point for verification, not proof of broad accessibility. Tests should include ordinary opening times, unscripted requests, staff responses to unfamiliar communication, available alternatives, voluntary disclosure and direct evidence that barriers disappeared or could be corrected. None of these proposals implies that individual support or specialist services become unnecessary. [82][83]

The central conceptual premise of this contribution is the Fundamental Distinction proposed by Autistan: autism as an autistic human nature should not be conflated with autism-specific disorders or difficulties, co-occurring medical conditions, or disabling situations arising when systems are not accessible. From that perspective, a substantial preventable source of autistic suffering lies in socio-generated sensory, mental and other impingements: avoidable disturbances of coherence, balance and what the organisation calls natural harmony. The 2023 explanation prepared for WHO specialist Chiara Servili includes eleven illustrative characteristics (A-K) that can be read very differently depending on the observer's assumptions and the real-world context. This is an attributed Autistan conceptual and policy position, not a revised WHO diagnostic definition. [44][82]

Correct consideration of autism throughout ordinary systems should therefore lead to systemic measures for accessibility for autistic people, supplemented as needed by reasonable adjustments, general assistance, chosen learning opportunities and individual support. Potential wider benefits include less unnecessary sensory exposure and energy consumption, fewer failed transactions or avoidable disputes, improved mental wellbeing and life opportunities, and better use of autistic competences in work and public life. These are plausible pathways requiring specific evidence, not promised savings or a demonstrated reduction in suicide deaths from the proposed measures. [44][46][82][86][87][88]

Consultation question-by-question: twelve institutional observations (Q1–Q12)

This section retains the analytical coverage of the twelve-question 2026 instrument. It does not select survey answers on behalf of an external organisation. This topical analysis uses the twelve questions and their displayed answer choices in the Government's online questionnaire as viewed on 2 November 2026. It does not purport to have tested every possible dynamic branch or to represent a response submitted to the form. [13][22]

Reading note: The Q1–Q12 headings are concise analytical labels, not verbatim quotations from the questionnaire. The observations address its topics without selecting personal survey answers on behalf of Island residents.

Q1 — Prior campaign awareness

Additional observation: institutional awareness of a campaign is not the same as the campaign reaching the intended population. The Government should publish the number of survey respondents who were previously aware of the campaign, broken down by respondent category where sample sizes allow, while avoiding any implication that an opt-in survey is representative of all residents.

Q2 — Source of awareness

The distinction matters because documentary awareness is different from being reached organically by a campaign. The survey results should therefore report channels separately and avoid treating all forms of “awareness” as evidence of equivalent reach or impact.

Question 2 allows several channels to be selected and also displays "Not applicable". This is not necessarily an error, but if that option can be selected together with named channels, the resulting records need a documented rule for handling logically inconsistent selections. Reports should distinguish respondents with no channel, those with one or several channels, and missing answers; the number selecting each channel is not necessarily the number of distinct people reached. [13]

Q3 — Respondent category

This distinction should remain explicit throughout the contribution. Our role is to provide complementary information, analysis, ideas and possible solutions for the improvement of autism-related public policies, particularly systemic accessibility. It is not to replace the voices of autistic people living on the Island.

Future reporting of Question 3 should preserve the distinction between respondent roles. Because the form allows multiple selections, categories will overlap. Where sample sizes permit, results should show autistic respondents separately from family members or carers, professionals or volunteers, employers and other roles, while explaining overlaps rather than merging them into a single “autism community” figure. Direct autistic responses should remain visible even where proxy or professional responses are numerically larger. [13]

The response category "Isle of Man resident" is displayed alongside descriptions such as autistic person, family member/carer, professional or volunteer, employer/business owner

and student/pupil, with multiple selections allowed. Residence is an attribute that can overlap any of these roles; it should not be treated as another exclusive population group. A useful analysis would show the overlap and the direct-autistic/proxy distinction while protecting small categories from identification. [13]

Q4 — Understanding

An external organisation cannot legitimately report a personal change in understanding caused by the campaign. Documentary review can nevertheless assess what kinds of information were disseminated and whether the campaign was connected to concrete measures.

The strongest potential value of an acceptance campaign is not only that people hear the word “autism”, but that the campaign improves how people interpret autistic behaviour and how institutions change their ordinary practices. Awareness should therefore be linked to practical subjects: sensory conditions, communication, waiting, unpredictability, remote options, written alternatives, reasonable adjustments, and professional attitudes.

A self-report that understanding has increased does not by itself show that the resulting understanding is accurate. Future campaign evaluation could therefore test a small number of concrete misconceptions and practical responses: for example, whether respondents distinguish overload or irritation from aggression, understand that accessibility is different from specialised support, recognise that autistic people may have very different support needs, and know at least one appropriate adjustment they could make in their own setting.

Q5 — Positive effects

From a documentary perspective, the campaign sits within a broader strategy that has generated several concrete initiatives: public information and training, Quiet Hours, the Hidden Disabilities Sunflower scheme, the Health Passport, education initiatives, public meetings, employment work and activity on reasonable adjustments. These are positive developments when they create usable changes rather than remaining symbolic. [4][5][9][23]

However, impact should not be inferred from the existence of an activity. A campaign can be positive and still coexist with serious unresolved barriers. This is why campaign evaluation and strategy evaluation should remain analytically distinct.

Q6 — Forms of effects

For future evaluation, the listed outcomes could be strengthened by adding a category such as “It helped me obtain or request a practical adjustment” and another such as “It changed how a service, employer, school or organisation responded to autistic needs”. These would move the survey from awareness toward observable changes in accessibility.

Question 6 begins "If yes, how did it help?", referring to the positive-impact question immediately before it. The percentage selecting each answer should therefore be reported with the correct conditional denominator, and any response entered by someone who did not answer "Yes" to Question 5 should be handled transparently. The displayed text establishes the intended follow-up, but the inspection did not verify the behaviour of every possible branch or submission state. [13]

Q7 — Communications

A useful evaluation would distinguish reach, comprehension, perceived usefulness and behavioural effect. “Aware of” and “helpful” are not interchangeable, and neither by itself proves a change in public behaviour.

The Question 7 matrix presents "Aware of", "Helpful", "Not helpful" and "Was not aware of it" as alternatives for each communication channel. It thus places awareness and appraisal on the same response scale. If the grid permits only one selection per row, someone cannot separately record both awareness and helpfulness; in that case, neither an awareness rate nor a helpfulness rate conditional on exposure can be inferred without additional rules. Future surveys should first ask whether the person encountered each channel, then ask exposed respondents separately whether it was useful, with a genuine "cannot judge" option. [13]

Q8 — Activities

The public-meeting records are particularly useful because they reveal concrete concerns that cannot be reduced to campaign awareness: education support, employment, police interactions, private diagnosis, shared-care agreements, health checks, the Child and Adolescent Mental Health Service (CAMHS), respite and adult support. The existence of these concerns is a reminder that public engagement should feed directly into implementation and follow-up, not remain a separate communications exercise. [1][2]

The Question 8 activity grid similarly offers "Aware and did not attend", "Attended", "Helpful" and "Not Aware" as answers to the same row. Attendance, knowledge of an event and usefulness are distinct facts and can coexist. If one response is allowed per row, these labels do not independently measure all three. In a later instrument, ask awareness first, attendance or participation second, and perceived benefit only where there was sufficient experience to judge. The present grid may still provide descriptive responses, but those answers should not be reported as separate participation and satisfaction rates without examining how the form encoded them. [13]

Apply the assessment to the activities actually named in the Government’s 22 October 2026 invitation. For the launch at Douglas City Hall, distinguish the existence of the event from the people reached, the information communicated, any questions or commitments recorded and subsequent follow-up. For public meetings, preserve who participated, the substantive issues raised and what decisions or changes followed. For buildings illuminated green and yellow, measure recognition, message comprehension and any resulting action without equating symbolic visibility with accessible services. For the Quiet Hours initiative, record which businesses offered it, when and for how long, who could use it, the specific sensory changes tested, direct feedback, and whether useful adjustments also became available in ordinary opening hours. None of those later outcomes is established merely by the Government announcement. [22][23]

Q9 — Memorable or useful aspects

What is most important is not the visibility of any single initiative but the principle behind it: autistic people should not have to rely on exceptional goodwill each time they enter a shop,

school, workplace, health service or public office. Accessibility should become an ordinary property of systems.

Q10 — Priorities for 2027

Show concrete, tested adjustments that ordinary organisations can reproduce in everyday practice — for example quieter sensory conditions, predictable information, written alternatives to telephone-only contact, and flexible participation. Emphasise measured practical effects rather than awareness alone, and identify where measures are demonstrably low-cost or low-resource and also benefit other users.

Explain that autism itself should not automatically be equated with suffering, dangerousness, incapacity or a collection of disorders. Distinguish the autistic nature from autistic-specific disorders, co-occurring conditions and socially generated impingements. Explain that irritation or visible distress is not the same as aggression, and perceived aggression is not the same as actual dangerousness. These distinctions can materially affect decisions in health, education, employment, policing and public services.

Explain that some autistic people are not yet identified and may not know that they are autistic. Promote routes to self-understanding, competent detection and, when appropriate, diagnosis, while avoiding a medical label as the default gateway to ordinary accessibility. This theme should also explain that diagnostic processes are not infallible: error or uncertainty can occur in either direction, which is why diagnosis, support, accessibility and eligibility for reserved representative roles need proportionate but different safeguards.

Q11 — Broad strategy statements

The seven statements are useful as a high-level pulse check, but they combine very different policy domains. Future surveys would be stronger if they separated experience of specific services from general impressions and allowed respondents to identify the mechanism of a problem: sensory environment, communication, eligibility, waiting time, attitude, procedure, cost, location, lack of information or refusal of adjustment.

Future versions should also consider an option such as “I do not have enough experience to judge”, distinct from both a neutral opinion and “Not applicable”. This would reduce the risk of treating lack of information as either satisfaction or dissatisfaction.

The seven domains considered should be reported separately: public understanding, information/support, health and public services, education/employment, community opportunities, environments/adjustments and overall change. The documentary assessment is not a personal rating.

Domain	Documentary assessment / caveat
Understanding and acceptance	Partial response: The 2022 consultation found substantial concern about limited public acceptance and negative attitudes. Repeated campaigns and training are documented, but no representative island-wide evidence yet demonstrates that respectful understanding has become the norm. [3]

Domain	Documentary assessment / caveat
Access to information and support	Progress demonstrated / partial response: The ASC directory and public updates improve signposting; the Health Passport can improve communication with healthcare; and MCALS provides an advice and liaison route within Manx Care. Fragmentation and adult-service gaps remain important, and navigation itself can become a barrier. [4][5][16]
Autism-friendly health, education and public services	Partial response: Training, Health Passport, education initiatives and reasonable-adjustment work are documented. The public record still contains unresolved concerns about access, communication, waiting, adult pathways and the lived effect of training. [1][2][5][6][26]
Education, training and employment	Progress demonstrated / partial response: Autism Education Trust (AET; now the Neuroinclusive Education Network) training, whole-school training, an employment subgroup and employer work are documented. Outcome evidence on inclusion, transitions, recruitment, retention and adjustments is still insufficient for a strong global conclusion. [4][7]
Community participation	Partial response: Groups, activities and engagement opportunities exist, including Autistic Bright Minds and work with community organisations. The evidence does not establish that opportunities are sufficient across ages, needs and locations. [4][8]
Autism-friendly environments	Progress demonstrated / problem not closed: Quiet Hours, Sunflower and transport/accessibility measures show concrete progress, but there is no island-wide audit demonstrating that sensory and communication barriers are now exceptional rather than common. [9][23]
Overall: becoming more autism-friendly	Documented progress with unresolved systemic issues: The documentary record supports a conclusion that substantial work has occurred and several practical measures have been introduced. It does not yet support a definitive external conclusion that autistic residents' overall lived experience has improved across all major domains.

Q12 — Change over twelve months

External documentary assessment: there is clear evidence of activity and some concrete progress during the period, including the Health Passport, Quiet Hours, education and employment work, public engagement and the launch of Phase 3. The first annual report and Phase 2 Action Plan are publicly available. However, the adult ASC/ADHD pathway remains

prospective and subject to a separate implementation and funding process, and several long-standing issues remain only partially resolved or are not yet supported by longitudinal outcome evidence. [4][5][10][11][19][23]

A useful health-access baseline predates the 2026 campaign. In a 2025 Manx Care consultation on healthcare access for people with learning disabilities and neurodivergent people, 151 individuals and families responded; 63% said they had avoided seeking healthcare because of previous negative experiences and 62% were unaware of their right to request reasonable adjustments. Respondents also called for alternative appointment-booking methods, quieter waiting areas and more time during consultations. These figures are not autism-specific and the opt-in sample should not be treated as representative of all Island residents, but they provide a concrete baseline against which later health-access measures can be tested. [26]

Using the longitudinal 2022–2026 review, the most accurate institutional description is not a single “improved/worse” choice but a combination of: PROGRESS DEMONSTRATED in several concrete initiatives and service capacities; PARTIAL RESPONSE where measures exist but the original problem remains; COMMITMENT IN PROGRESS for measures such as the adult pathway; and PROBLEM NOT CLOSED where the public record still documents persistent barriers or lacks outcome evidence. [3][4][10]

The Government should therefore publish Question 12 as a lived-experience indicator rather than using it as the sole measure of strategy performance. A perception of improvement is important evidence, but it should be triangulated with service and accessibility data.

The precise wording of Question 12 concerns change in "my experience as an autistic person, parent, carer or family member" over the preceding twelve months, whereas the invitation and Question 3 admit the wider public, including employers, professionals, students and people without an autism connection. "Not applicable" is consequently an important response, not a negative or neutral assessment of change. Any progress percentage should identify the eligible interpretive group, the number who could judge, and differences between autistic people speaking directly and proxies. The result should not be presented as the response of all Island residents or a direct like-for-like change from the different 2022 sample. [13][22]

Alignment with the official ASC Strategy: six goals and six principles

The Isle of Man’s 2024–2034 national strategy defines six goals and six decision-making principles. The tables below reproduce their official headings and show how the existing Autistan recommendations can be applied within that framework. These are proposed links and tests, not evidence that the Manx Government has adopted Autistan’s distinct theoretical framework. The strategy’s own structure remains primary, with supplementary Autistan analysis. Source: [14]; campaign consultation: [22]. Official strategy: An ASC-Friendly Island (2024–2034)

Six official goals: proposals and verifiable results

Official strategy heading	Autistan application and evidence to test
Goal 1 — Increase community awareness and acceptance of ASC	**Application:** Apply the four 2026 activity tests and the Q1–Q12 analysis. Link the 2027 campaign to accessible, routinely available practices; assess harmless autistic differences without requiring normalisation (Recommendations 12, 17, 20, 22). **Test:** Record reach, accurate understanding, ordinary-service reactions, actual adjustments and whether follow-up persisted outside April.
Goal 2 — Reduce health and social care inequalities for people with ASC	**Application:** Assess the full appointment journey, alternative booking, sensory conditions, Health Passport use by choice, and accountability across providers (Recommendations 07, 16, 20, 21, 25). **Test:** Track care avoided before contact, written access, adjustment receipt, user experience, remedies and the 2025 baseline; do not treat training attendance as an outcome.
Goal 3 — Provide high quality, safe and clear all-age pathways for diagnosis and support	**Application:** Separate self-understanding, competent assessment, reliable diagnostic review, accessible pathways and support without inappropriate gatekeeping (Recommendations 03, 04, 05, 24). **Test:** Identify financed service capacity, actual opening dates, waiting and refusal rates, quality review, useful follow-through and access pending assessment.
Goal 4 — Improve professional awareness and capability across public service providers	**Application:** Test staff decisions about atypical communication, irritation versus evidenced danger, written access and non-defensive resolution (Recommendations 02, 06, 17). **Test:** Use scored realistic scenarios, observation after training, correction records, actual transaction completion and autistic user feedback.

Official strategy heading	Autistan application and evidence to test
Goal 5 — Improve access, support and transitions to education at all levels	**Application:** Review chosen participation, sensory and procedural barriers, accessible learning options, transitions and education impact assessment (Recommendations 08, 16, 18). **Test:** Assess real access to lessons and transitions, adjustments delivered, exclusion and withdrawal, quality of learning and voluntary student accounts.
Goal 6 — Improve everyday experiences of people with ASC, their carers and families	**Application:** Prioritise systemic accessibility, accessible complaints, direct participation and the needs of people not reached by conventional consultation (Recommendations 02, 03, 10, 13, 15, 19, 20, 26). **Test:** Measure completion of ordinary activities, choice, uncorrected barriers, abandoned attempts, repeat complaints, support quality and changes in daily freedom.

Six official decision-making principles: practical application

These six principles are the Isle of Man Government's own decision-making principles. The examples below show where the existing contribution supports their practical application, without substituting the separate Principles of Autistan for the Government's definitions. [14]

Official strategy heading	Autistan application and evidence to test
Person Centred	**Application:** Ask the autistic person which outcome and form of interaction they choose; do not substitute a social-conformity target. Distinguish their own account from family/proxy accounts (Recommendations 13, 21). **Test:** Document the requested change, consent or refusal, option offered, experience and observed ability to pursue the person's purpose.
Equality of Opportunity	**Application:** Build anticipatory accessibility into ordinary services; permit written/asynchronous routes and reasonable adjustments without irrelevant diagnostic proof (Recommendations 02, 03, 16, 18). **Test:** Test whether the same legitimate task can be completed with fewer avoidable obstacles; record denial and remedy where applicable.

Official strategy heading	Autistan application and evidence to test
Early Intervention and Preventing Problems	**Application:** Detect an unnecessary noise, contradictory rule or misinterpretation early; protect the person and correct the source before escalation (Recommendations 17, 20, 25). **Test:** Trace time to clarification, prompt correction, recurrence, escalations, reported suffering and any unintended consequences.
Integration	**Application:** Connect policy commitments, commissioned services, staff responsibilities and complaint pathways so users need not repeat information unnecessarily (Recommendations 01, 07, 10, 19). **Test:** Track referral continuity, clarity of the responsible service, repeated contacts and demonstrated resolution across organisations.
Evidence-based	**Application:** Differentiate policy promises, implementation, usable availability, voluntary lived experience and measured results (Recommendations 01, 06, 14, 18). **Test:** Publish baselines, meaningful denominators, direct/proxy distinctions, uncertainty, corrective changes and follow-up, including adverse or null results.
Partnerships	**Application:** Engage autistic residents directly alongside relatives, community groups, professionals, employers and services; do not treat absent voices as represented by those present (Recommendations 13, 20, 26). **Test:** Record accessible participation routes, reach gaps, decisions influenced, shared responsibilities and publicly documented follow-through.

These correspondences make the contribution accountable to the Island's strategy. The further Autistan analyses of the Fundamental Distinction, socially generated sensory, mental and other impingements, the descending pyramid and acceptance beyond mere tolerance remain additional explanatory tools; the 26 proposals below should be judged by the real barriers they may remove, not by adoption of a theory or a label. The tables do not constitute findings of local non-compliance. [14][44][46][82]

1. Purpose, legitimacy and evidential method

The 22 October 2026 survey announcement asks Island residents about the reach and effect of Autism Acceptance Month in April 2026, with a wider opportunity to inform future work under the ASC Strategy. An organisation outside the Island cannot truthfully provide a personal rating of local experience. Our contribution therefore analyses the documentary evidence and offers operational proposals alongside, but not instead of, residents' responses. [22]

We use "Autism Spectrum Condition" (ASC) when describing the terminology of Isle of Man official documents. In our own analytical framework, "autism" refers to the autistic nature; we distinguish autism itself from clinical disorders or co-occurring conditions, and from difficulties or impingements that may be generated or aggravated by the environment. This is an Autistan policy framework, not a claim that international medical classifications have been replaced or that every difficulty is socially caused. [14][30][31]

Our evidence categories, which serve different purposes rather than forming a ranking of sources, are: (A) a legal, policy or budgetary commitment; (B) a reported administrative action; (C) verified availability to intended users; (D) direct voluntary experience, properly attributed; and (E) a measured outcome with explicit populations, methods and uncertainties. A government report, an individual testimony, a survey percentage and a causal impact assessment are different kinds of evidence and cannot be silently substituted for one another.

No recommendations below should be read as a finding that an unexamined measure has failed or that a legal violation has occurred. Where documents record a positive measure, we acknowledge it. Where the result is not documented, we identify the precise evidence needed to determine its effect.

2. What should the 2026 survey actually establish?

2.1 Campaign reach and understanding

The 2026 campaign addressed four themes chosen following public meetings and online consultation: health and wellbeing, reasonable adjustments, employment and education. The reported preparatory engagement included two meetings attended by more than 70 people, over 100 online responses and a separate exercise involving children and young people. These are meaningful engagement activities, but the number of events or responses is not itself evidence of behavioural change. [11][22]

The official consultation invitation identifies four forms of 2026 activity: the Douglas City Hall launch, public meetings, green-and-yellow landmark illumination, and Quiet Hours for retailers. Their evaluation should distinguish a visible campaign event from understanding, changes in behaviour, and accessibility delivered in ordinary situations. Question 8 of the institutional response above gives activity-specific tests. [22][23]

Questions about prior awareness, information channels and memorable activities can reveal self-reported campaign reach among respondents. They cannot establish the share of all Island residents reached unless sampling is designed for that purpose. Exposure, accurate comprehension, personal usefulness and subsequent behaviour should be reported

separately. Options to indicate no prior awareness, no direct experience, uncertainty and no change should be treated as legitimate data, not as poor engagement.

Campaign material can test concrete understanding: whether respondents know that written contact may be an appropriate alternative to a telephone call; that sensory conditions, temperature or waiting rules can create avoidable barriers; that irritation or overload does not automatically imply aggression; and that an adjustment can be relevant even without an autism diagnosis in hand. The objective is not assent to a slogan but the ability to respond appropriately in a realistic situation. [23][25]

The Canadian federal autism framework (2024) makes an explicit policy distinction: awareness educates the public about autism, whereas acceptance recognises autistic ways of being, thinking and doing as valid and seeks changes in public attitudes and behaviour. This useful distinction should not be mistaken for official Canadian endorsement of every element of the separate Autistan theory of autistic nature. The Irish National Disability Authority (2025) likewise found that wider autism awareness can coexist with incomplete knowledge and variable attitudes in education, healthcare, social care and justice. These comparative findings support a more demanding evaluation of the Island campaign: not just how many people heard a message, but what they understood, how they responded, and what barriers were removed. [35][36]

A future acceptance questionnaire could therefore include carefully drafted factual scenarios alongside experience-based questions. Ask what a staff member would do when an autistic customer requests written contact, when a direct communication style is misread as disrespect, when a waiting room produces avoidable overload, or when someone declines a group activity but still needs a service. Record the proposed response rather than relying only on agreement with a positive slogan. To test real change, repeat comparable questions before and after the campaign and, where feasible, corroborate them with anonymous service-user accounts or anonymised service audits. These are suggested evaluation methods, not claims that the current survey already contains them. [35][36][41]

2.2 Three practical themes for Autism Acceptance Month 2027

A. Everyday accessibility

Invite a modest range of services, employers, schools and businesses to demonstrate actual adjustments and explain their costs, trade-offs, availability and user-reported effects. Include alternatives to telephone-only access, clear advance information, quiet options, moderating unnecessary noise and temperature, flexible timing and remote options where suitable.

B. Understanding autism without stereotypes

Offer scenarios that distinguish autistic functioning, disorders, co-occurring conditions and socially generated impingements. Explain the differences between irritation, aggression perceived by others and evidenced danger. Avoid teaching that looking or behaving less autistic is a successful outcome.

C. People currently missed by standard systems

Provide trustworthy information on self-understanding, detection and access to competent diagnostic assessment when appropriate; explain that identification, diagnosis, accessibility

and individual support are different issues. Create ways to contribute in writing, asynchronously or without group participation, including for people who do not recognise themselves in public autism imagery.

For every 2027 campaign theme, record: the intended behaviour or environmental change; the organisation responsible; what was done; the number and kinds of people reached, with denominator where possible; a test of understanding; whether an actual adjustment occurred; user-reported positive, neutral and negative effects; and changes that persisted beyond April. Without these elements the campaign remains primarily an exposure exercise.

3. Use the Island's own 2022 and 2025 evidence as baselines

3.1 The 2022 consultation: direct and proxy evidence are not interchangeable

The 2022 consultation received 392 responses, including 120 autistic people or people who thought they might be autistic, 188 relatives, partners or friends, six carers speaking for someone else and several professional categories. It collected 195 pages of open responses. In the analysis, questions about lived experience distinguished direct autistic contributions and proxy contributions. These differences should be preserved in future reporting, without presenting a voluntary consultation as representative population prevalence. [3][17]

The composition of the 2022 first-part consultation responses also matters for comparisons over time. Figure 2 reports that 154 of the 314 direct and proxy responses concerned autistic people aged 5–24. This describes the ages of people represented in those responses, not an age distribution of all 392 consultation respondents or an estimate of the Island's autistic population. Evaluation of adult pathways and future acceptance campaigns should therefore keep the age of the person concerned, direct/proxy status and respondent role distinct where reporting is lawful and sufficiently confidential; these mixed-age responses must not be treated as an adult-only evidence base. [3]

The consultation identified ten recurring domains: support resources, mental-health needs, public understanding and adjustments, professional knowledge, social support and safety, education, information, employment, family support and reliance on medicines relative to other options. In each case, a newer survey should seek the same lived problem where an adequately comparable question can be constructed, not merely ask whether respondents liked the latest campaign. [3]

A particularly relevant difference concerns priorities: autistic respondents emphasised professional expertise, public understanding and waiting times; people answering indirectly emphasised funding, waiting times and expertise; professionals also emphasised funding and staffing or retention. These perspectives are all informative, but their rank orders are not identical. Present numbers, denominators and overlaps when publishing 2026 responses, and distinguish who is expressing a view from whose experience is being described. [3]

The 2022 report asked a separate question about priorities for action under the Strategy, not simply the barriers respondents encountered. For that priority question, 63% selected professional training and education as a leading priority. Autistic and proxy respondents each prioritised professional training, early diagnosis and support for families, while professionals prioritised early intervention, professional specialists and family support. These were preferences expressed in a voluntary consultation, not evidence that the corresponding measures were subsequently delivered or effective. A phase-to-phase evaluation should distinguish the reported obstacle, the intervention requested, what was actually implemented and whether the obstacle diminished. [3]

The same 2022 report also records positive local experiences: respondents named 90 organisations as examples of good practice and repeatedly mentioned patience, clear communication and willingness to adapt. These are mentions in a voluntary consultation, not independently verified counts of consistently accessible providers. The 2027 campaign could identify which concrete practices made these experiences positive, check whether they remain available, and test whether they can be reproduced in ordinary services rather than assuming that no effective practice already exists. [3]

That positive evidence also has limits recorded by the same source. More than 30 respondents said they had not encountered any good practice in supporting autistic people on the Island, and nearly 20% of the organisations receiving favourable mentions also received negative ones. These figures are not representative provider ratings or evidence that each mentioned organisation performs consistently. A 2027 follow-up should investigate which encounter, member of staff, setting or procedure worked well or poorly, ask both favourable and critical respondents where feasible, and test consistency over time rather than publishing an unqualified list of "autism-friendly" providers. [3]

Another 2022 finding exposes a separate gap between having a formal diagnosis and actually receiving assistance: nearly half of respondents with a formal diagnosis reported receiving no support services, while the majority without a formal diagnosis also reported no support. These findings concern the voluntary consultation respondents, not the population prevalence of unmet need. They strengthen the case for reporting diagnosis, eligibility, receipt and adequacy of individual assistance, and general accessibility as distinct measures rather than treating diagnosis alone as a service outcome. [3][17]

There is a separate definition problem in the 2022 data which should not be mistaken for a measured eligibility gap. The report distinguishes 'additional learning needs' (giving dyslexia, dyspraxia and attention-deficit/hyperactivity disorder (ADHD) as examples) from a later question asking whether the person had a 'learning disability'. For the latter, respondents were not given the IQ-below-70 definition cited elsewhere in the same report as relevant to certain support-service decisions. The resulting 35% 'yes', 47% 'no', 16% 'unsure' and 2% non-response cannot therefore be used to estimate how many respondents actually met that particular eligibility threshold. Future surveys should state the operative definition, keep additional learning needs distinct from any specific learning-disability eligibility category, and never treat self-description as verified clinical or administrative status. [3]

The report also offers a small but practical indicator of whether assistance is coordinated. Among 80 respondents receiving support from more than one team or organisation, 34% said the teams worked well together, 20% said they did not, and 46% were not sure. These are

percentages within that voluntary subgroup, not a population-wide service performance measure; uncertainty must not be recoded as failure. A follow-up could ask whether users know who coordinates multiple services, how conflicting instructions are resolved, whether necessary information is shared with appropriate safeguards, and whether the person experiences continuity and control rather than having to coordinate the system alone. [3]

The 2022 report contains a more direct baseline for acceptance itself. Among the consultation responses analysed in the acceptance-and-inclusion section, 54% considered general acceptance and inclusion on the Island to be low or very low, 25% considered it partial ("somewhat"), and only 10% described it as moderate or high. These were reported perceptions among the voluntary direct-autistic and proxy respondents, not a population estimate for all Isle of Man residents. They also predate the later campaigns. A comparison with the 2026 survey should therefore preserve the different respondent populations, question wording, missing answers and category denominators rather than subtract the two headline percentages as though they measured the same population. [3][13]

The same 2022 consultation found that 44% regarded autism as having both positive and negative aspects; direct autistic respondents were more inclined than proxy respondents to view autism positively, and less inclined to view it negatively. The published first-hand accounts also describe questions being misread as challenges, honesty as criticism, absent eye contact as inattention, and chosen solitude as social rejection. These reports do not establish a universal autistic viewpoint or independently prove that each interpretation was wrong. They do establish locally reported situations worth testing through concrete clarification and accessibility practices. A useful 2027 follow-up would preserve direct/proxy distinctions, ask which social interpretations were corrected, and investigate whether the ensuing barriers actually diminished. [3]

The 2022 report also contains accounts of people being afraid to request adjustments because they expect rejection or judgement, alongside an account of substantial energy spent masking autistic presentation. Those are first-hand and proxy consultation accounts, not estimates of the proportion of residents who avoid asking. They expose a specific measurement gap: a service that counts only recorded adjustment requests, grants or complaints may miss those deterred before first contact or before disclosure. A complementary evaluation should examine, through voluntary and accessible channels, attempted but abandoned requests, feared consequences, unmet needs that were never formally raised, and whether anticipatory accessibility reduced the need for self-disclosure. [3]

A second, setting-specific finding in the 2022 report is useful for assessing what acceptance means in practice. Figures 17 and 18 indicate that respondents most frequently identified home or being with supportive people as places where they felt accepted, while public spaces, education settings and social groups were often identified among the least accepting contexts. These responses reflect reported perceptions, not measured accessibility rates for each setting. They call for a follow-up that distinguishes freely chosen solitude from exclusion or withdrawal caused by barriers: the aim is neither to impose sociability nor to accept inaccessible public life, but to establish whether people can use ordinary places, services and education on terms that respect their chosen forms of interaction. [3]

The 2022 report also contrasts places where adjustments were reported with places where they were not made (Figures 22 and 23). Across most settings, it records as many or more accounts of failures to accommodate as of successful adjustments. This does not establish a failure rate for each provider or for the Island as a whole: the figures come from voluntary reports without a common denominator of all encounters or requests. The operational follow-up is to examine, for each relevant setting, whether an adjustment could be requested through an accessible channel, whether it was granted or refused with reasons, whether the person abandoned the process before asking, and whether a successful change became routinely available rather than remaining an exceptional favour. [3]

3.2 A separate 2025 health-access baseline

In June-July 2025, a Manx Care exercise about healthcare access received contributions from 151 individuals and families in a population spanning learning disabilities and neurodivergence. In the published findings, 63% said previous negative experiences had led them to avoid seeking healthcare; 62% did not know about their right to request reasonable adjustments. Participants asked for alternative appointment channels, quieter waiting spaces and additional consultation time. These are the reported percentages among respondents, not autism-specific or island-wide prevalence estimates. [26][28]

Manx Care has since announced responses including training, reasonable-adjustment guidance, work on booking options and the Health Passport launched on 2 March 2026. The question is therefore not whether these ideas have been proposed for the first time, but whether they have been implemented in particular services, can be used without unnecessary obstacles, and have reduced avoided care or adverse experiences. The Health Passport should be assessed as a real initiative, not treated as still hypothetical. [5][25][26]

There is also a concrete local practice to examine rather than propose as if no precedent existed. Manx Care announced that its Advice and Liaison Service (MCALS) opened a public counter at Garaghyn Glass in July 2024 and made a quiet room available for confidential, arranged discussions. This is evidence of a specific option at that location, not evidence that every clinic, hospital, reception or advice service offers the same arrangement. The Strategy could document whether the option is still available, how people can book it without a telephone call, whom it reaches, and what could usefully be replicated elsewhere. [66]

3.3 What the record does and does not prove

The published First Annual Report and Phase 2 Action Plan (October 2025) documented activity on training, waiting lists, education, accessible information, employment and community initiatives. Its grouping of 33 out of 41 actions as "completed/on track" includes different states; the official action tracker expressly places three actions that had not started in this group because they were still within schedule or had been superseded or absorbed by other actions. Thus "33 completed/on track" must not be represented as 33 completed actions, still less as 33 outcomes demonstrated in people's lives. [4]

The Phase 3 Action Plan extends from October 2026 to March 2028. Its announced directions include a prospective adult ASC/ADHD pathway, accessible information, feasibility of annual health checks, further professional training, workplace and community accessibility, education and criminal justice. A future target date is not a delivered service. The detailed action concordance in Section 7 makes this distinction explicit. [10][11][79]

Local public discussion provides another, differently weighted type of evidence. In interviews reported on 8 May 2026, autistic members of the ASC Strategy Steering Group who were also involved in a new local peer-support initiative, Isle of Neurodiversity, described costs and difficulties associated with adult private diagnostic assessments, gaps in adult support and examples of adjustments already being tried, including advance meeting agendas and quieter access at a careers event. The same report attributed to Manx Care a statement that adult diagnostic services were not then included in its mandate. These are attributed accounts and a reported institutional position as of May, not a representative survey, independently verified service inventory or evidence that every autistic adult has the same needs. They suggest practical questions for the adult pathway and employment work: which existing community options remain usable, who cannot access them, and which concrete adjustments can be established as ordinary practice. [73]

4. An Autistan framework for practical policy decisions

Autism itself should be distinguished from disorders and suffering

Our analytical position is that autism itself should not be treated as synonymous with illness, suffering or behavioural disorder. An autistic person may have autistic-specific disorders or difficulties, may have unrelated or co-occurring health conditions, and may experience substantial disability. But these elements should not automatically be attributed to the existence of autism itself.

This distinction matters because public policy changes depending on the cause of the difficulty. A sensory crisis caused by an avoidably loud environment calls for an environmental response. Anxiety produced by repeated misunderstanding may call for both mental-health support and changes in the surrounding system. A co-occurring medical condition calls for appropriate clinical care. Treating all of these as a single “severity of autism” can obscure the most effective intervention.

This is a policy-analysis distinction, not a proposal to replace diagnostic classifications or to deny clinical needs. Its purpose is to prevent causal shortcuts: where a difficulty has a specific clinical, environmental, procedural, informational or support-related mechanism, policy should identify and address that mechanism rather than attributing the whole problem to autism as an undifferentiated category.

Autistan's 2023 letter to a WHO specialist: eleven characteristics (A-K)

Original English document and meeting context: Autistan, Fundamental Distinction — English letter and transcript (2023; characteristic list, original PDF section 1.1.2, pp. 6–8).

The Autistan letter of 10 November 2023, prepared for discussion with WHO autism specialist Chiara Servili, expressly separates an attempt to describe autistic nature from a catalogue of disorders. Section 1.1.2 (PDF pp. 6-8) presents the following A-K series; section 1.1.3 then discusses resistance that can protect or preserve these traits. The original author explicitly describes the list as incomplete, imperfect and not sufficiently ordered. It must not be interpreted as a clinical diagnostic checklist, proof that every autistic person has every characteristic, or an official WHO taxonomy. Its purpose here is argumentative: before

designating a trait as a defect, ask what it does, for whom, in which environment and by reference to which real purpose. [44]

The following faithful, concise restatement preserves the ordering and the particular distinctions of that source. The descriptions are examples from the author's 2023 text rather than statistically established generalisations about all autistic people:

A — Limited desire for certain interactions with a social environment that may be unfamiliar, uninteresting, worrying or hostile. A lack of enthusiasm for imposed interaction is not automatically a defect; it can nevertheless create real communication difficulties when that interaction is required or when other people conceal intentions or rely on unwritten conventions.

B — Relative lack of interest in socially conventional preoccupations, accompanied by interest in other subjects. The important question is whether any concrete activity is impeded, not whether a person shares the majority's preferred subjects of conversation.

C — Less concern with other people's opinions or presumed judgements. This may protect independence of thought and self-respect; it can also generate friction in settings that require constant attention to social appearance. It should not be converted into a universal claim that autistic people never care about others.

D — Strong focus and perseverance on subjects found genuinely interesting. These capacities can be valuable for sustained work or inquiry, while conflicts can occur when institutions require continual interruption or impose tasks without intelligible purpose.

E — Readily noticing anomalies, errors and inconsistencies, and wanting to correct them. What is dismissed as excessive attention to detail may contribute to quality assurance, safety and improvement; the appropriateness of any correction still depends on facts and proportionate consequences.

F — Seeking order, coherence, completeness and harmony. A request for a consistent explanation or end-to-end solution can benefit everyone, even when a hurried institution characterises it as rigidity or unnecessary complication.

G — Sensitivity to sensory and other disturbances. This can expose a person to genuine pain or exhaustion, while also revealing a removable environmental defect. The sensible response may involve both immediate protection and correction of the source, not automatic training to endure it.

H — Pursuit of accuracy and precision, understood by the author as an effort to approach the truth. A precise correction should be checked against evidence instead of being rejected merely because it sounds blunt, inconvenient or socially unusual.

I — Respect for what is considered reliable, true or just, and resistance to unexplained or unjustified changes. The issue is not whether every preference must prevail, but whether a rule or change has an intelligible, reality-based justification and a proportionate effect.

J — Perception of broader patterns, trends or underlying structure. The original text presents this as a possible consequence of coherence-oriented attention; it is an illustrative possibility, not an inherent gift guaranteed by autism.

K — Behaviours, movements, activities or interests outside the social conventions of a particular place or period. An unusual gesture, movement, outfit or chosen activity is not

harmful merely because it is visible or unfamiliar, and should not be suppressed without identifying a genuine, evidenced concern.

These examples require a dual test. First: is there an actual and significant limitation, danger, unmet need or medical condition requiring assistance? Second: which part of the observed difficulty comes from an avoidable social rule, hostile interpretation, sensory setting or unavailable communication route? The same characteristic may confer a benefit in one situation, cause friction in another, and coexist with a legitimate need for specialist support. An autism-acceptance campaign need not idealise every characteristic; it should prevent a negative judgement from being built into the description before the circumstances have been examined. [44][82]

The letter's list also provides a concrete way to explain 'autistic strengths' without depicting autistic people as necessarily gifted, uniformly precise, or obliged to be economically productive. The positive potential of accuracy, originality, sustained attention, defect detection or resistance to arbitrary conventions can be recognised while ensuring that anyone who lacks these capacities retains equal dignity, rights, access and support. This avoids both defectology and romanticisation. [44][46]

Socially generated impingements

Many difficulties experienced by autistic people are generated or intensified by environments, procedures and attitudes that were not designed to accommodate autistic functioning. We refer to these as socially generated sensory, mental or other impingements; attitudinal barriers can be sources or mechanisms of such impingements. Examples include unnecessary noise, excessive temperature, unpredictable changes, mandatory telephone contact, ambiguous instructions, rushed interactions, repeated demands to justify adjustments, or defensive responses from staff when a problem is reported.

This concept does not imply that every autistic difficulty is socially generated. It isolates the avoidable part that policy can change. The policy objective should be to identify avoidable impingements, remove or reduce them where practicable, and measure whether this changes participation, distress, health, autonomy or service use. This addresses disabling conditions without making “appearing less autistic” the measure of success.

From incorrect consideration to suffering: systemic misadjustments and violations of harmony

A core Autistan proposition is that autistic people do not suffer from autistic nature itself: a very substantial and preventable portion of their suffering results from the absence of correct consideration of autism throughout the social system. This proposition does not deny the reality of co-occurring medical conditions, intrinsic limitations or difficulties arising in non-social environments. It insists instead that externally generated and correctable causes must not disappear behind a label of autism. In practical decision-making, a claim about causation must be reconstructed from actual events, the person's account, observable conditions and plausible competing explanations. [44][46][82]

The causal pathway can be reconstructed explicitly: (1) a socially produced setting, norm, procedure, interaction or object is poorly designed, adjusted or maintained; (2) it produces a sensory, mental or other impingement on a particular autistic person; (3) that impingement

may disrupt equilibrium, coherence or what Autistan terms natural harmony, sometimes through multiple small or repeated 'micro-violations'; (4) the person experiences distress, fatigue, pain, reduced freedom or a protective reaction; (5) outsiders may mistake the reaction for aggressiveness, non-cooperation or a fixed autism symptom; (6) an inappropriate response may aggravate the original exposure; and (7) the ensuing difficulty is wrongly counted as evidence that the autistic person, rather than the setting, needs to be normalised. Each link is a proposition to test in the case, not a universal sequence imposed on every person. [44][82]

The terms 'sensory', 'mental' and 'other' describe DIFFERENT TYPES of impingement, not clinical diagnoses. Sensory examples include unnecessary noise, touching without consent, excessive heating or cooling, intrusive odours, or repeated artificial stimuli. Mental impingements may arise through contradictory instructions, false insinuations, arbitrary accusations, unexplained decisions, deception, injustice or sustained pressure to decipher unspoken social rules. Other impingements may concern administrative exclusion, temporal constraints, lost opportunities, cumulative exhaustion or mixed mechanisms. A spoken message can convey a mental impingement without thereby becoming a sensory impingement; the physical carrier must be distinguished from the harmful content. [44][82]

The reference to harmony and balance must also be operational, rather than used as a substitute for explanation. Ask what is out of balance, compared with which reasonable setting, and what evidence demonstrates the effect. A moderately loud sound that is voluntary and meaningful need not cause the same difficulty as a quieter, repetitive, avoidable sound that signals a malfunction and cannot be escaped. A small contradiction repeated in a decision process may accumulate into serious mental pressure. Neither intensity alone nor the majority's tolerance proves whether an arrangement is acceptable. [82]

The public-policy reversal follows from this account. Rather than trying only to suppress the autistic response, the responsible body should identify and correct unnecessary stimuli, incoherent rules, inaccurate interpretations and inaccessible procedures; protect the person immediately where needed; offer support for any persistent difficulties; and verify that real access and relief have improved. The user should not have to bear all the effort of correcting a situation generated or controlled by others. This is what the organisation means by 'correct consideration of autism everywhere' translated into practical accessibility: an obligation to examine and improve everyday systems, not merely a slogan or an individual service. [46][82]

Individual support is necessary but not sufficient

Some autistic people require substantial individual assistance and specialised services. That support must be available when needed. However, a strategy based only on support risks leaving inaccessible environments unchanged and then funding people to cope with the resulting obstacles. Accessibility and support should therefore be developed together.

Many systemic accessibility measures are operational rather than service-intensive: quieter spaces, moderated temperature, advance information, written options, flexible appointment procedures, remote participation, clear signage, patient explanations and non-defensive communication. Some may also benefit other users, but their effects on stress, missed appointments, complaints and conflict should be measured rather than assumed.

Some accessibility measures may also reduce avoidable costs or resource use. Examples include avoiding unnecessarily excessive heating or cooling, reducing missed appointments through clearer and more flexible communication, enabling remote participation where appropriate, and preventing escalation or complaints through early, patient problem-solving. These savings should be measured rather than assumed, but cost-effectiveness should be part of the evaluation of accessibility measures.

Benefits for society as a whole: wellbeing, energy, prevention, justice and productive opportunities

Correcting recurrent misadjustments can serve autistic people first while also improving a public system for others. The potential benefits should be understood as distinct mechanisms to test, not as a single unverified promise that every accommodation saves money. Many measures resemble universal design: plan from the outset for different users to participate, understand, communicate and make choices, instead of requiring repeated individual exceptions. In this framework, 'autism-friendly' and autism accessibility overlap, but they are not identical: a label or a dedicated quiet event does not show that the ordinary environment has become accessible. The bottom, broadest level of Autistan's pyramid is therefore SYSTEMIC MEASURES FOR ACCESSIBILITY FOR AUTISTIC PEOPLE; 'accessibility for autistic people' describes the entire goal. [46][82][83]

Energy and environmental efficiency provide a concrete example. An institution that avoids unnecessarily extreme heating, cooling, lighting or noise may simultaneously reduce sensory impingements and electricity use. The causal pathway must be documented by comfort or accessibility feedback, equipment settings and energy consumption before and after appropriate correction, adjusted for seasons and usage; it cannot be assumed that every sensory adjustment reduces energy costs. Good control, not simply reducing consumption, is the relevant principle.

Administrative and legal efficiency provide a second example. Clear reasons, accurate records, reliable written channels, fair opportunities to correct misunderstanding and non-defensive staff responses may prevent repeat contacts, failed submissions, unnecessary escalation, formal complaints and some disputes. Where legal proceedings occur, their reduction would also save public and private resources. The appropriate measures are re-contact rates, staff time, abandoned applications, informal-resolution rates, complaints, time to resolution and demonstrably avoidable litigation, not raw reductions in complaints alone: a rise in reporting may initially indicate improved trust.

Health and prevention provide a third example. Better sensory conditions, less humiliation or coercive normalisation, effective remedies and meaningful choice may plausibly reduce cumulative distress and improve quality of life. Bullying and social isolation are among risk factors examined in systematic reviews of suicidality in autistic people; this makes prevention of hostile, isolating environments a serious public-health objective. But no available evidence establishes that the particular measures proposed here will, by themselves, reduce suicide deaths by a known amount. Any prevention programme must also preserve timely clinical assessment, mental-health care, crisis response and freely chosen support. Evaluate distress and wellbeing safely and ethically rather than claiming a causal reduction in suicides in advance. [86]

Economic participation and productivity provide a fourth example. In an appropriately designed task, a particular autistic person's precision, sustained concentration, detection of anomalies, originality or refusal to accept an incoherent process may strengthen quality, safety and efficiency. Yet those same traits can be suppressed when recruitment, management, communication or evaluation rewards small talk and conformity rather than actual performance. Institutions can test alternative communication, reduced unnecessary interruptions, suitable sensory settings, clear task specifications and performance judged by work output. The UK's 2024 Buckland Review identifies many workplace adjustments as low-cost or free and describes persistent obstacles to obtaining them; a small UK study of employers and employees likewise identified low-cost, practical adjustments but does not prove a universal productivity gain. [44][87][88]

These benefits can extend to non-autistic people: intelligible procedures are easier for everyone, consistent decisions reduce avoidable conflict, comfortable environments benefit many users, and fair employment design can recognise competences obscured by social presentation. The claim is not that all people have identical sensory preferences or that each measure is universally optimal. A policy should allow flexibility and compare its real effects across groups, without placing non-autistic needs in automatic opposition to autistic needs.

For the Isle of Man, we suggest a modest, transparent evaluation across suitable Phase 3 and 2027 campaign pilots: record the baseline, the actual change, who can access it, personal choice, reported distress, staff and user time, resource use, complaint and dispute patterns, job or service outcomes, implementation costs and possible unintended consequences. Distinguish immediate savings from long-term benefits, avoid double-counting, and report null or adverse findings. Accessible design should be justified first by dignity, rights, freedom and prevention of unnecessary suffering; economic advantages, where proven, are additional benefits rather than a condition of an autistic person's worth. [82][87][88]

Detection, diagnosis and people who do not know they are autistic

The 2022 consultation was explicitly open to people who thought they might be autistic without a diagnosis. Public policy should therefore not assume that all autistic people are already identified, diagnosed or able to interpret recurring difficulties through an autism lens. Some people may first need trustworthy information and opportunities for self-understanding before deciding whether formal assessment would be useful. [3][17]

Public policy should distinguish four tasks: voluntary detection or recognition; competent diagnosis where useful or necessary; individual support; and general accessibility. These tasks overlap but are not interchangeable. General accessibility should not normally require proof of diagnosis, and absence of an autism diagnosis should not by itself be treated as a reason to refuse consideration of a disability-related adjustment. The applicable legal question is the disability-related barrier and the reasonableness of the adjustment, not merely the presence of an autism label. Conversely, a role specifically reserved for autistic representatives may legitimately require proportionate safeguards to verify eligibility for that reserved role. Diagnostic processes themselves should also be recognised as fallible, with error or uncertainty possible in either direction. [25][27]

Professional attitudes: irritation, perceived aggression and actual danger

A recurring risk in interactions with services is the interpretation of autistic distress through a non-autistic social lens. Irritation, a loud voice, direct language, repetitive movement or visible agitation may be perceived as aggression even when there is no intention to threaten or harm. Perceived aggression must in turn be distinguished from actual dangerousness.

Training should therefore address not only "what autism is", but how professionals regulate their own reactions, remain patient, ask what is causing distress, provide space and time, avoid escalating a defensive interaction, and refrain from making consequential decisions based primarily on appearance or tone.

Autonomy, experimentation and flourishing

A successful autism policy should not be evaluated only through crisis prevention, diagnosis and basic support. It should also examine whether autistic people can pursue self-chosen interests, creativity, relationships, physical activity, travel, work, education, independent projects and forms of life that fit them. Relevant evidence can include access, continuity, choice, self-reported satisfaction and avoidable barriers to participation. The outcome is greater autonomy and possibility of flourishing, not greater conformity to non-autistic behavioural expectations.

Eligibility for reserved representative roles and proportionate safeguards

The Strategy should distinguish two different questions: access to an accessible society, and eligibility for roles specifically reserved to autistic representatives. The 2026 Government recruitment sought autistic adults as lay members of the ASC Steering Group. For a role genuinely reserved to autistic representatives, proportionate verification may have a legitimate safeguarding function; documented clinical diagnosis can be one possible method, but diagnostic error or uncertainty can occur in either direction. Any verification should minimise unnecessary disclosure and remain separate from ordinary access to reasonable adjustments, participation, information or autism-friendly environments, which should not generally require proof of diagnosis. [24]

Anticipatory accessibility is consistent with the Manx equality framework

The Isle of Man Equality Act 2017 provides a sector-specific statutory framework. Section 21 defines the three requirements of a reasonable-adjustment duty, including accessible-format information where appropriate; section 22 addresses failure to comply. In Part 3, section 31(7) makes Schedule 2 (services and public functions: reasonable adjustments) effective; the specific duties must be interpreted with section 21 and the service/public-function provisions. Under Schedule 2, paragraph 2(2), the references to a disabled person in section 21(3)-(5) concern disabled persons generally, consistent with an anticipatory approach in this sector. Government guidance accordingly advises providers to consider accessibility before an individual arrives, including written alternatives to telephone-only

contact. These provisions should not be mechanically extended as the same legal test to employment or education, which have their own Parts and Schedules. [20][21][27]

This local equality-framework principle supports a central recommendation of this contribution: accessibility should be designed into ordinary systems rather than activated only after an autistic person discloses a diagnosis and negotiates an exception. For autism, anticipatory accessibility can include multiple contact methods, predictable information, sensory-aware environments, clear procedures, quiet options, sufficient processing time and flexible participation. Individual reasonable adjustments remain necessary, but they should sit on top of an accessible baseline.

Separately, Manx Care's published Reasonable Adjustments guidance states that a diagnosis does not need to be in place before a healthcare adjustment is made and asks staff to listen to what the patient says they need. This is health-service guidance rather than a universal legal rule for every sector, but it provides a local operational example of a needs-based approach to accessibility. [25]

A four-level policy architecture: accessibility, adjustments, general assistance and individual assistance

Autism policy is clearer when four distinct but complementary levels are distinguished. First, ordinary systems should have an accessible baseline: multiple communication channels, predictable information, sensory-aware environments and procedures that avoid unnecessary barriers. Second, individuals should be able to obtain additional reasonable adjustments when the baseline is not enough. Third, general autism assistance should be available to autistic individuals, families, the public and services seeking timely help to understand or resolve an autism-related situation, without assuming that an individual support package already exists. Fourth, individualised assistance should be provided where a person needs it, according to their needs and choices; specialised or clinical services must also be available when appropriate. These levels complement one another but should not be collapsed into a single category of "support" or used to leave avoidable systemic barriers in place. [46]

For example, an accessible appointment system provides written and telephone channels as standard (level one). A particular appointment may require extra processing time or a different waiting arrangement (level two). A general assistance contact can help a receptionist and an autistic visitor resolve an unforeseen misunderstanding before it escalates (level three). A person whose continuing daily needs are not met by those steps may also require freely chosen, individually tailored assistance (level four). When a clinical condition needs treatment, appropriate clinical care is provided for that need; it is not treated as a substitute for the other levels. These distinctions follow the Autistan Model Structure for a National Autism Plan (2026) and are proposed as an operational policy framework, not as four separate statutory rights under the Manx Equality Act. [46]

This distinction also helps prevent a recurrent policy error: treating the need for specialised support as the defining feature of autism, while leaving ordinary systems unchanged. A person may need little or no specialised support and still face severe socially generated impingements from inaccessible environments; another may need substantial individual assistance even in an accessible environment.

Operational boundaries: four service levels and distinct policy tasks

The four service levels above describe the different forms of accessibility and assistance that a system should make available. They are not a competing list of the separate policy tasks identified earlier: voluntary recognition of possible autism, competent diagnosis where appropriate, individual assistance, and accessibility of ordinary environments. The task describes a policy need; the level identifies the type of response. For example, a person considering diagnostic assessment may simultaneously need an accessible booking process, an individual adjustment, general information or advice, and continuing personalised assistance. None of these should automatically be conditional on acceptance of the others; any special eligibility safeguards should be relevant to the particular service. This clarification preserves the Autistan four-level model rather than multiplying or collapsing its functions. [46]

General assistance is particularly relevant to the Isle of Man because an otherwise conscientious worker may not know how to interpret a direct question, an atypical response, a sensory complaint or an accessibility request. An easy-to-reach, written or asynchronous advice route could help the worker clarify the situation before an erroneous refusal or escalation. It must not replace a provider's existing legal duties, a person's own account, a competent clinical assessment where warranted, or independently accessible complaint and appeal routes. An initial demonstrator should document the nature of inquiries, response time, actual corrections, confidentiality safeguards, costs and whether the original barrier was subsequently removed. [46]

Education about autism and non-autistic social mechanisms, protection of rights, effective remedies and continuing evaluation are cross-cutting functions. They cannot be counted as a fourth or fifth service only to make the model look complete: their purpose is to ensure that each of the four operational functions can be used, corrected and improved in real encounters. [46]

Beyond tolerance: when harmless autistic differences become ordinary

A society may move from open rejection to tolerance, then to acceptance, while still treating the mere appearance of a minority characteristic as an event that attracts attention, explanation or surveillance. Autistan's comparative study of 17 August 2026 describes a further practical possibility: harmless difference becomes so ordinary that bystanders need not remark on it at all. This is not a demand that people feel no empathy or awareness; it is a proposal that an autistic person should not have to perform a satisfactory explanation of harmless self-expression as the price of moving through public space. [81]

The comparative example concerns two people of the same sex holding hands in public in places and circumstances where nobody reacts. It is deliberately limited: experiences differ greatly across countries, neighbourhoods and settings, and sexual orientation and autism are not interchangeable. Its analytical value is the change in the social response. Where a practice causes no substantiated harm, its visibility alone need not create an interpersonal issue. The same question arises when an autistic adult flaps their hands, wears unconventional clothing, avoids eye contact, speaks directly, rocks, chooses not to join a conversation or occupies space differently without endangering anyone. [81]

This proposal must not be misunderstood as telling public officials to ignore the person. The intended distinction is between (a) not reacting adversely to an innocuous trait or movement and (b) failing to respond to the person's genuine communication, accessibility request, medical need, complaint or invitation to interact. The former can be a sign of social ease; the latter can constitute a profound attitudinal or administrative barrier. A service must be ready to notice relevant information while declining to police harmless difference.

Nor should ordinary non-attention create a new rule that autistic people must be invisible. A person may freely wish to explain autism, participate in public life, celebrate a community identity, advocate, ask for an adjustment or attract attention to an issue. Others may prefer not to be distinguished from surrounding users. Both choices belong within acceptance; the public institution's task is to preserve meaningful control and equal access rather than prescribe either publicity or concealment.

The policy test must therefore ask what would happen if the person did NOT disguise their harmless difference. Could they enter a school, clinic, shop, office, workplace or leisure activity without unsolicited reprimand, suspicion, infantilisation, laughter or exclusion? Would staff still address the purpose of the visit, evaluate actual risk on evidence, and supply required assistance? A campaign that produces agreement with a slogan but fails this ordinary encounter test has not demonstrated the stronger form of acceptance. [81][82]

The causal inversion: do not attribute social rejection to autistic nature

The 17 August comparative study develops a further methodological warning. Consider a person with a minority characteristic, the hostility directed at that person, and the suffering or exclusion that follows. If the entire sequence is shortened to 'the person suffers because of the characteristic', the hostile environment disappears from the causal record. This can make changing the person's expression seem more rational than correcting the bullying, discrimination, incoherent rule or inaccessible practice that produced the difficulty. The comparison is offered as a tool for reconstructing causation, not as evidence that autistic characteristics and sexual orientation have identical origins or consequences. [81]

Immediate prudence and long-term public policy need not prescribe the same act. Someone may voluntarily choose to hide a difference, withdraw, avoid confrontation or use a survival strategy in a hostile environment. Such self-protection can be reasonable in context and should not be condemned. Yet the practical usefulness of concealment in a hostile setting does not establish that institutions should preserve the hostility or teach concealment as the principal measure of success. The public objective remains to remove remediable sources of rejection and make free choice safer. [81]

This distinction is testable. An employer may report fewer difficulties because autistic workers have stopped disclosing; a school may report fewer incidents because pupils suppress distress; a service may report fewer complaints because people have abandoned the process. None of those counts, on its own, proves better access. Reports should seek corroboration through voluntary and confidentiality-protective accounts of effort, abandonment, avoidance, actual service use, permitted self-regulation and changes to the setting itself. Higher disclosure or more complaints may sometimes reflect increasing trust rather than worsening conditions. [81][82]

Acceptance should not mean behavioural normalisation

Acceptance should not mean that an autistic person is welcomed only when they can suppress visible autistic characteristics or imitate non-autistic communication successfully. Policies and campaigns should avoid equating good outcomes with appearing less autistic. The relevant questions are whether the person is safe, understood, able to communicate, able to participate by appropriate means, and free to make choices without unnecessary pressure to perform socially expected behaviours.

This principle does not prevent support for behaviours that are genuinely dangerous, painful or unwanted by the person. It instead requires distinguishing such situations from harmless differences in movement, expression, tone, pacing, social style or need for solitude.

Special accessibility measures should complement, not replace, ordinary accessibility

Quiet Hours, quiet rooms, special sessions, priority arrangements and similar measures can be useful, particularly when they respond to concrete sensory or communication needs. The Isle of Man's 2026 Quiet Hours initiative itself encouraged businesses to consider longer-term practice. Such measures should therefore be used as learning mechanisms as well as optional arrangements, not as a segregated substitute for improving ordinary opening hours, mainstream services and standard procedures. [23]

The practical test should be whether a person can participate in ordinary life with fewer avoidable barriers, while still having access to optional quieter or more supported arrangements when these are useful. Successful measures tested in special sessions should therefore be examined for wider application wherever feasible.

Autism-friendly is a claim to examine, not an accessibility outcome in itself

Autistan's October 2026 multilingual inventory documents a variety of 'autism-friendly', 'sensory inclusive' and related initiatives across several countries. They range from quiet cinema screenings and prepared airport journeys to organisational training, community programmes, guidance, audits and private recognition schemes. These can contain useful interventions, but the labels cover different standards and domains. A charter, marketing statement, training attendance, voluntary certificate, legal duty and verified real-world outcome are not interchangeable. [83]

The Isle of Man already has examples of Quiet Hours, a Health Passport, staff learning and accessible information. The next evaluation should record not just whether an initiative exists but the exact barrier it addresses, the ordinary settings covered, hours and conditions of availability, the ability to request it without revealing unnecessary personal information, whether it can be used independently, and the changes people report. Positive practice should be recognised without treating a successful pilot or special session as evidence that access is already general.

Four questions can prevent overclaiming. What does the provider PROMISE? What does it actually DELIVER in a specified place and period? Can an intended user obtain the benefit reliably, including through an alternative communication route? Does the person gain

freedom, safety and access without having to camouflage harmless autistic functioning, with a workable path for correction when the arrangement fails? The answers should be recorded separately, with meaningful denominators where feasible. [82][83]

Where a quiet session is the only time a person can enter a shop, the session may be valuable yet also expose the inaccessibility of ordinary hours. Where a lanyard helps a person obtain assistance, it should remain an option rather than the compulsory identifier for access. Where an 'autism-friendly' programme gives a badge to an organisation, the independent check is the user's ability to navigate an actual appointment, dispute a mistaken interpretation and secure an accountable response. In other words, an award or a special accommodation may be part of a solution without constituting the solution's totality.

A comparable institutional question appears in Autistan's August 2026 study of Brazil's proposed PL 3080/2020. Its analysis highlights draft accessibility provisions directed at modifiable environmental stimuli, rather than only at treatment or training of the individual. It separately cautions that encouraging gradual acceptance of a sensory experience must not become a pretext for normalising harmless preferences or pressuring someone to tolerate an avoidable nuisance. These are observations about a Brazilian legislative proposal, not descriptions of obligations under Manx law. Their transferable test is whether institutions correct an avoidable barrier before making adaptation by the autistic person the default response. [85]

The descending pyramid of autistic freedom and accessibility

Autistan's five-level pyramid is a conceptual model of complementary measures, developed in its earlier policy work and clarified in October 2026. The person appears at the summit, symbolically above the barriers that constrain access to ordinary society. The desired direction is DOWNWARD, through increasingly general conditions towards the ground of everyday freedoms: choice, relationships, exploration, work, mobility, travel and a life shaped by the person's own purposes. It is not a ladder on which someone must climb to deserve support or social participation. [82][46]

The original illustration is reproduced here with its labels translated into English and its previously ambiguous base label corrected. The word 'accessibility' names the purpose of the WHOLE architecture. The broad bottom level must instead name the kinds of action it contains: SYSTEMIC MEASURES FOR ACCESSIBILITY FOR AUTISTIC PEOPLE. Neither the original coloured levels nor their spatial placement represent clinical severity or a compulsory sequence of services. [82]

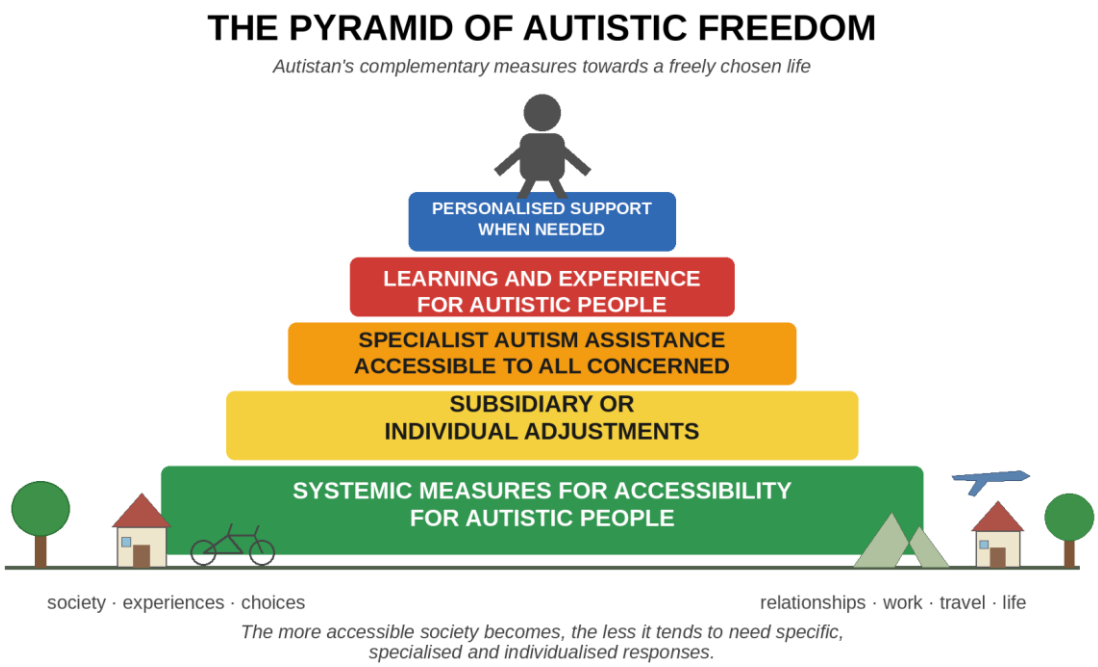


Figure 1. Autistan's descending pyramid of autistic freedom. Original Autistan figure (2026), translated and relabelled to distinguish the systemic base from accessibility as the whole objective. The direction is from the isolated person at the top towards ordinary society below. [82][84]

BASE — SYSTEMIC MEASURES FOR ACCESSIBILITY FOR AUTISTIC PEOPLE. This is the foundation: changing environments, public procedures, staff attitudes, everyday communication, predictable information, sensory conditions, institutional rules and routes for correcting misunderstandings. It is not merely the provision of diagnosis, support or training to individuals. These general measures can overlap with universal design but should not be treated as identical to that term without examining the precise scope of each measure. [82]

SECOND LEVEL — SUBSIDIARY OR INDIVIDUAL ADJUSTMENTS. Some situations require additional measures tailored to one person or setting even when the general system is reasonably accessible. These may intersect with legal reasonable-adjustment duties, but the pyramid's practical category is not automatically coextensive with any single statutory definition. The need for one adjustment does not absolve a service from correcting a recurrent barrier for everyone else.

THIRD LEVEL — SPECIALIST AUTISM ASSISTANCE ACCESSIBLE TO ALL CONCERNED. Effective assistance should be reachable not only by autistic individuals but also, where appropriate, by relatives, employers, teachers, receptionists, health providers, emergency services and public officials who need to solve a real autism-related difficulty. Assistance should facilitate correction at its source rather than impose a permanent intermediary between the person and ordinary life. [82][46]

FOURTH LEVEL — LEARNING AND REAL-LIFE EXPERIENCES FOR AUTISTIC PEOPLE. Understanding non-autistic social conventions can be compared to learning a second language: potentially useful for understanding, choice and self-protection, without having to renounce one's autistic nature or imitate majority behaviours as an end in itself. Opportunities to travel, work, try hobbies, meet others, make decisions and learn from experience are part of a freely chosen life. Institutions must provide conditions in which such

learning and experiences are possible rather than substituting instruction for access. [81][82][46]

FIFTH LEVEL — PERSONALISED SUPPORT WHERE NEEDED. Some people need substantial continuing assistance, including in an otherwise accessible society. The pyramid does not imply that good systemic access makes individual support unnecessary or that the amount of support measures the worth, nature or freedom of a person. The task is to enable choices and rights, not to maintain unnecessary dependence or overprotection. [82][46]

These levels can be provided together and need not be traversed in fixed chronological order. The base is structurally essential because absent general accessibility can defeat the value of the other levels: a person can have a competent assistant and still be excluded by a rigid transport system, a false accusation or a service that will not accept written contact. Conversely, a well-designed public system does not eliminate every individual's specific needs. The Island's Phase 3 review can assign each action to the relevant levels and ask whether the resulting combination opens more usable routes into ordinary life.

An operational 'pyramid check' can ask: (1) which general barrier remains; (2) which subsidiary adjustment is needed; (3) who can obtain specialist advice promptly; (4) which opportunities for chosen learning or experience are actually open; and (5) which continuing personal support does the person want or need? Assign the responsible institution for each action and check its effect independently. A strategy should not report a new individual service as proof that a public system has become accessible, or vice versa. [82][46]

Match the response to the source of the difficulty

Before describing a difficulty as “severity of autism”, policy should identify the most plausible source or combination of sources: an autistic-specific disorder or difficulty; a co-occurring health condition; insufficient information or learned skills; insufficient individual assistance; a sensory, procedural or attitudinal barrier; or an interaction between these factors. The same outward difficulty can require very different responses depending on its mechanism.

The intervention should then be matched to that mechanism — clinical care where there is a clinical condition, learning or information where knowledge is missing, personalised assistance where support is required, and environmental, procedural or attitudinal change where the system is generating the obstacle. Evaluation should test whether the targeted mechanism and its real-life consequences actually changed. This avoids using a single undifferentiated concept of “autism severity” to explain every problem.

Accessibility should expand options, not impose a single “autistic” standard

Autistic sensory, communication and participation preferences vary. An autism-friendly environment should therefore not be defined by one fixed recipe — for example, always quieter, dimmer or more remote. The accessible baseline should increase choice and control: quieter space when wanted, alternative waiting arrangements, written or spoken communication options, predictable information, in-person or remote participation where suitable, and the possibility of using ordinary arrangements when these work better for the person.

The evaluation question is not whether a setting looks stereotypically “autism-friendly”, but whether people with different needs can use it with fewer avoidable barriers and without being forced into a special route. Pilots should therefore record which options helped which users, which did not, and whether any measure created new disadvantages.

The right to chosen social distance and non-compulsory participation

In its 2024 international autism-policy review, the Autistan Diplomatic Organization proposed explicit respect for chosen social distance: solitude, limited interaction or unconventional social relationships can be legitimate preferences, not necessarily problems to be removed. This is not advocacy of imposed isolation. It means that access to schools, public offices, healthcare, employment and culture should not depend on displaying sociability, eye contact, conventional warmth or group participation. The practical test is whether the person has meaningful choices and can avoid unwanted interaction without forfeiting access to ordinary rights and services. [31][32]

Ordinary social accessibility and the risk of disabling overprotection

Autistan's 12 May 2026 reference model also describes natural social accessibility: preparing the people in an ordinary setting to respond without mockery, fear, pity, infantilisation, automatic medicalisation or assumptions of incompetence. In a school, club, reception desk or public service, this may require very simple preparation: explain differences without stereotypes, encourage patience and direct clarification, and identify a responsible person who can help when an encounter becomes difficult. These preparations complement accessible physical environments, reasonable adjustments and assistance; they are not a new obligation for an autistic person to be sociable. For a 2027 pilot, test whether staff and participants know what to do in a concrete encounter, whether the autistic individual was able to pursue a chosen activity, and whether avoidable misunderstandings or refusals were corrected. [46]

The same model warns against disabling overprotection: a family, school or service may deny an autistic person ordinary opportunities to try, make mistakes, learn, develop confidence or take decisions because it assumes the person cannot cope. Actual risks and freely chosen individual assistance remain important, but protective intentions are not evidence that a blanket exclusion is justified. Reviewers should record what the person wished to try, the specific evidenced risk, the less restrictive adjustments considered, the person's informed preferences and the possibility of reconsidering the restriction. This principle must coexist with respect for chosen solitude: people should be able to participate when they want to and to decline optional social activity without forfeiting ordinary access. [46]

People who are absent from consultations: the "non-voices"

The people most able to attend public meetings, speak in committees, navigate forms or volunteer for a steering group are not necessarily representative of all autistic profiles. Others may avoid meetings due to sensory overload, distrust, trauma, limited energy, complex support needs or simple preference for solitude. The "non-voices" are not presumed incapable or politically uniform; their absence is a method problem. Written/asynchronous pathways, trusted intermediaries chosen by individuals, accessible

invitation procedures and a transparent record of the groups not reached can reduce that bias. No person should be forced to participate merely to prove their needs. [31][32]

Realistic interpretation, autonomy and protection against imagined threats

Accessibility decisions should be grounded in actual effects, threats and evidence rather than reactions to unfamiliar tone, appearance or behaviour. Professional discomfort, a perceived breach of a social convention and a verifiable safety risk are not identical. A proportionate response tests the observable situation, asks the person what is happening where practical, reduces avoidable stressors, considers less restrictive options and records evidence for any exceptional restriction. This does not erase genuine safety obligations or the need for appropriate crisis support; it guards against converting an imaginative social inference into an established fact.

International context and precise attribution

The World Health Organization's September 2025 autism fact sheet retains clinical terminology, while also recognising the need for community- and society-level accessibility and inclusion. Our distinction between autistic nature, associated disorders and socially generated impingements is an Autistan policy position, not a WHO diagnostic consensus. The distinction is used to improve causal explanations and intervention choices, not to discourage medical treatment when appropriate. [29][30]

The United Nations Committee on the Rights of Persons with Disabilities, in General Comment No. 6 (2018), clarifies equality, non-discrimination, reasonable accommodation and attitudinal barriers; General Comment No. 7 addresses participation through representative organisations and accessible decision-making. These principles inform our comparisons but are not represented here as a directly enforceable treaty obligation in the Isle of Man absent proof of relevant territorial extension. Manx law is analysed separately. [33][34]

The territorial question is not merely formal. A 2021 Commonwealth Parliamentary Association British Islands and Mediterranean Region election-observation report stated that the Convention had not then been extended to the Isle of Man. The United Nations Treaty Collection record consulted on 2 November 2026 notes the United Kingdom's 2024 extension to Bermuda but records no corresponding extension to the Isle of Man. Thus the Committee's general comments are used here as international comparative guidance, rather than as if they directly imposed obligations in Manx law. Any subsequent territorial notification would need to be checked independently, and the domestic Equality Act 2017 remains a separate legal basis for the duties discussed below. [62][63]

The distinction between an accessible ordinary baseline, individual adjustments, and specialised or clinical support is a functional policy tool used here. Accessibility, participation and accommodation are well established in international and Manx materials; no claim is made that the Autistan Diplomatic Organization invented these general rights. Our particular combination with socially generated impingements, chosen social distance, non-voices and mechanism-based evaluation is traceable to our earlier published work. [20][29][31][32]

From awareness to acceptance: an observable meaning

Acceptance is a practical relationship, not merely a sympathetic opinion. A person may be familiar with autism terminology yet still demand eye contact, telephone-only contact, unquestioning agreement with an arbitrary rule, or concealment of harmless autistic movements. Conversely, a person who knows little about autism can behave accessibly by taking a stated need seriously, asking what adjustment would help and avoiding unsupported judgements. For campaign evaluation, the critical outcome is whether autistic people can live, communicate, access public services and maintain their dignity without first having to perform a socially acceptable version of themselves. The Canadian framework distinguishes acceptance from awareness; Autistan adds the stronger mechanism-based test of what happens in the actual encounter. [35][44]

An acceptance campaign must not turn the idea of "contribution to society" into a condition of respect. Autistic people are entitled to dignity, accessibility, liberty and appropriate support whether or not they display special talents, work productively, enjoy public visibility or contribute anything celebrated by non-autistic institutions. Autistan stated this expressly in its 2023 discussion of autistic interests and the supposed need to be an exceptional autistic genius before receiving normal human consideration. Examples of autistic contributions can enrich a campaign, but they should not become an eligibility test for acceptance. [44]

The fundamental distinction as a causal decision rule

A policy can recognise clinically significant difficulties without making a conceptual identity claim that autism consists of nothing but those difficulties. Autistan's 2023 document addressed to the World Health Organization argued that being characterised by associated features is not the same as being identical with those features. Its position is to distinguish autistic nature from autistic-specific disorders or difficulties; from separately co-occurring conditions; from externally originating, socially generated sensory, mental or other impingements; and from the situations of disability created when a person encounters an inaccessible system. The categories can interact, and the same event may involve more than one mechanism. They should not be merged solely because the person is autistic. [44]

For the Isle of Man this is a tool for better investigation rather than a proposed unilateral change to ASC diagnostic terminology. An individual who needs treatment for epilepsy or depression should obtain the relevant healthcare; an individual facing a deafening waiting room needs environmental change; an individual unable to understand an arbitrary procedure may need intelligible reasons and a correction of the procedure; an individual who needs daily personal assistance may still need that assistance after all avoidable barriers have been removed. In each case officials should record what they believe is causing the difficulty, what evidence supports that account, which other explanations remain plausible, what action is proposed and whether the action worked. Classification alone is not causal proof. [29][44]

Autistan's term "socially generated impingements" describes what reaches and perturbs a person from outside; it should not be silently translated into the language of an impairment inhering in that person. The original Autistan distinctions are sensory impingements, mental or psychic impingements, and other possible impingements. It is important to distinguish the

harmful content — for instance absurdity, incoherence, injustice or an imposed contradiction — from the carrier of that content, such as a spoken sentence, electronic message, rule or official decision. A mental impingement in this usage is not itself a psychiatric diagnosis. This is the organisation's conceptual vocabulary, not a clinical taxonomy endorsed by the WHO. [44]

Naturalness, artificial systems and the disputability of social norms

Autistan's natural/artificial framework contrasts what it calls a natural reference — coherence, consistency with reality, accuracy, authenticity, justness and natural harmony — with human-built conventions that can become arbitrary, contradictory or damaging. This is a philosophical and policy-analysis reference developed by the organisation, not a verified biological finding that all autistic people have superior access to truth. "Naturalness" here does not mean simply countryside, the absence of modern technology or a romantic ideal of nature. Nor is an artificial tool inherently harmful: a well-designed written procedure, remote appointment or assistive technology may be more accessible than an unexamined social convention. What must remain open to scrutiny is the function and justification of the rule. [31][44][45]

An acceptance programme should therefore teach that social conventions are examinable and sometimes contestable. Before calling an autistic behaviour deficient, uncooperative or inappropriate, an institution should ask: Which actual right, safety requirement or legitimate practical need does the convention serve? What observable difficulty resulted from not following it? Is that difficulty intrinsic to the act, or produced by the expectations of onlookers? Could the underlying need be met by a less restrictive or more precise alternative? If the behaviour causes no substantiated harm, social unfamiliarity alone should not make it a problem to be treated. These are questions about evidence and proportionality, not an invitation to ignore genuine legal obligations or objectively dangerous conduct.

Consider the expectation that a service user maintain eye contact while an official explains a decision. If attention and understanding can be established in another way, enforcing eye contact requires a reason beyond conventional appearance. Likewise, a person who asks for a written explanation may be seeking precision, not trying to challenge the authority of the staff member. A fair acceptance test records the legitimate goal and whether the alternative reached it, instead of treating nonconformity itself as failure. The same logic can be used for waiting, small talk, clothing conventions, repetitive movements and forms of social participation, provided actual effects and any competing rights are considered. [42][44]

Reality and false inferences: who should correct the misunderstanding?

A major Autistan accessibility argument concerns interpretations that are imagined rather than verified. An autistic person's direct wording, silence, unusual tone, insistence on consistency or visible irritation may lead another person to infer hostility, deception or dangerousness without adequate evidence. Once such an inference is silently treated as fact, the institution may demand explanations, impose restrictions or discount the person's account. The distinction is not between autistic truthfulness and universal non-autistic falsehood; it is between a reportable fact and an inference whose accuracy must be checked. Research on rapid first impressions shows that non-autistic observers can make

less favourable social judgements about autistic people from brief observations; it does not prove that every particular official judgement is mistaken. [42][44]

A workable standard is to record the exact words and observable behaviour, separate them from the intention or risk imputed to the person, make the inference explicit and correctable, ask a proportionate clarifying question, and avoid decisions based on untested assumptions where consequences are serious. If the service has itself made the unsupported inference, the individual must not bear an impossible duty to anticipate every concealed suspicion or learn deceptive social conventions in order to prevent it. Staff are responsible for checking their own inferences; the individual may assist with clarification if this is feasible and does not place an unfair burden on them. This principle applies to appointments, complaints, employment, education, emergency responses and justice, with proportionate safeguards for real threats. [42][44]

For example, an official notes that an individual "became aggressive" after a procedure changed without explanation. A factual review should separately establish whether the person spoke loudly, whether any threat was made, what change was imposed, whether the person had an accessible chance to understand and respond, what distress or barrier was reported, and which preventive adjustment could have avoided escalation. The record can then distinguish irritation, aggression perceived by an observer and actual danger. Such precision protects both the autistic person and the legitimate responsibilities of the service. [42]

The possible social usefulness of autism: a warning signal, not an obligation to be useful

A further Autistan proposition is that certain autistic responses can reveal defects in everyday systems: contradictions, misleading communication, lack of justification, excessive stimulation, unjustified hierarchy or inconsistent rules that others may have learned to overlook. In this conceptual sense an autistic person may function as a sensor or alarm for a correctable problem. Silencing distress or training away a visible reaction without investigating the alleged cause can resemble turning off an alarm without checking the danger. This is a metaphor and a policy hypothesis, not established evidence that autism arose biologically for this purpose or that every autistic perception is objectively correct. The alleged systemic problem must be investigated on its own evidence. [44][45]

If an accessibility complaint leads to better instructions, more accurate records, calmer environments, fewer arbitrary decisions or fairer procedures, its benefits may extend beyond autistic users. This possible wider value should be evaluated, including unintended effects and costs, rather than asserted as an automatic saving or used to demand public benefit from an individual before respecting that person's rights. At the same time, any autistic person who wants to pursue creativity, precision, research, specialised interests or another form of flourishing should have that possibility without being channelled into a narrow "talented autism" narrative. Recognition of possible contributions and unconditional acceptance are complementary only when the second does not depend on the first. [31][44]

Learning without imposed assimilation, and freedom not to socialise

Autistan's previously published education proposals distinguish learning how non-autistic social conventions work from being required to adopt them. A useful analogy is learning a second language: understanding unfamiliar usages, implicit rules and risks may increase practical autonomy without requiring a person to abandon their original way of thinking, speaking or relating. The learning must also be reciprocal. Parents, colleagues, teachers, healthcare professionals and officials should learn autistic functioning and examine their own informal norms rather than assigning every adaptation task to the autistic individual. Whether a skill is useful should be judged by the person's goals, safety and functioning, not by how non-autistic their behaviour appears. [45]

This distinction has empirical relevance but should not be oversimplified. A 2024 systematic review and meta-analysis associated autistic camouflaging with poorer mental-health measures, while calling for stronger longitudinal evidence before causal conclusions; a separate eight-country study of 306 autistic adults found associations between acceptance and lower depression and between camouflaging and greater distress. These studies do not mean that every acquired social skill is harmful, every form of adaptation is masking or every autistic individual wishes to avoid social connection. They support assessing the cost, voluntariness and benefit of adaptation rather than treating conformity as a self-evident goal. [39][40]

Similarly, public policy should distinguish unwanted loneliness and exclusion from freely chosen solitude or limited interaction. England's autism strategy (2021–2026) sought to reduce loneliness and to increase access to community life. That legitimate aim should coexist with the Autistan proposal that a person may decline sociability while retaining equal access to services, learning, work, culture and legal remedies. The relevant indicators are genuine choice, the availability of desired interactions and absence of coercion, rather than a required number of social activities, meetings or friendships. [31][38]

International comparisons: useful convergences and important differences

Canada's 2024 Framework for Autism explicitly separates autism awareness from autism acceptance and identifies public behaviour change as part of acceptance; it also retains the federal legal and clinical vocabulary of autism spectrum disorder. Ireland's Autism Innovation Strategy includes an autism-affirming society among its pillars and commissioned a synthesis of public and professional attitudes as a basis for a national campaign. England's strategy focuses both on public understanding and practical inclusive participation. Australia's National Autism Strategy 2025–2031 emphasises rights, choice and acceptance, while Autistan's own later comparative review explains why thematic overlap must not be mistaken for proof that one organisation caused another government's decision. These are distinct national approaches, not a single international endorsement of Autistan's fundamental distinction. [31][32][35][36][37][38]

Two research findings are instructive for the Isle of Man's own campaign measurement. A 2024 registered, cross-cultural observational study included 306 autistic adults in eight countries and found associations between external and personal acceptance and lower depression; the study was not a representative poll of those eight countries or a causal test

of a public campaign. A 2024 UK National Autistic Society survey had 8,238 respondents, but the composition of autistic respondents and family/support respondents differed substantially and the convenience survey cannot be used as a population estimate. Its reports of negative assumptions and poor responses to distress are nevertheless useful to formulate testable scenarios. The Isle of Man should likewise report direct autistic responses separately from proxies and explain recruitment and denominator limitations. [39][41]

A 2024 systematic review of 20 quantitative papers concerning autistic identity found associations between external acceptance/support and more positive autistic identity. This evidence offers a reason to track identity safety and autonomy, but it does not prove that a particular poster, training course or awareness campaign causes psychological improvement. A 2017 experimental study of quick non-autistic first impressions of autistic people identified potential bias in social judgments; extrapolation to police actions, healthcare or Manx institutions requires local testing and cannot be assumed from the experiment alone. These limitations should shape evaluation design, not be buried in a bibliography. [42][43]

Concrete acceptance tests for the Island's 2027 campaign

The following scenarios are proposed as practical campaign content and optional evaluation prompts. They are not reconstructions of existing Manx incidents, not assertions that these failures have occurred in every listed service, and not a substitute for directly asking autistic residents which changes would help them. Each scenario links an identifiable behaviour or rule to a corrective option and an observable result. They complement the original three campaign priorities rather than adding an unsupported fourth priority. [35][36][41][44]

Scenario / obstacle	Institutional response to test	Evidence of genuine acceptance
A service accepts contact only by telephone.	Offer an accessible written or asynchronous route; publish response times and any necessary identity checks.	Requests completed without unnecessary phone calls; abandoned attempts, delays and user-reported accessibility.
A direct answer or raised voice is labelled "aggressive".	Separate actual words and conduct from inferred intention; check facts and relevant stressors before escalation.	Share of incident reviews documenting facts, inference, clarification, adjustment and proportionate risk assessment.
A waiting room is noisy, or a decision is arbitrary and unexplained.	Address sensory stimulation and the distinct mental impact of contradictions, absurdity or injustice; supply understandable reasons.	Recorded availability and use of alternative waiting or communication arrangements; complaints resolved at source.

Scenario / obstacle	Institutional response to test	Evidence of genuine acceptance
A person does not maintain eye contact, join informal chat or attend group events.	Do not equate absence of conventional sociability with lack of respect or inability; support desired contact and chosen distance.	Access to the same essential service without behavioural conformity; voluntariness of participation.
A campaign features only visible, socially confident autistic representatives.	Diversify access modes and recognise unknown non-participants; do not attribute views to people not consulted.	Response channels, role-specific counts, gaps in reach, accessible non-group opportunities and feedback tracing.
An individual receives a favourable adjustment only after a label or badge is shown.	Make general systems accessible; use evidence and eligibility checks proportionate to the distinct decision.	Requests resolved without irrelevant diagnostic proof; clarity of criteria for specialised or reserved roles.
An autistic person identifies an illogical or inconsistent procedure.	Investigate the alleged defect rather than treating the complaint itself as maladaptation.	Verified corrections, reversals or justifications; time to correction; whether other users benefit.

Reciprocal communication: evidence, failed replication and responsible application

A much-cited experiment by Crompton and colleagues (2020) examined story transmission in autistic, non-autistic and mixed-neurotype chains of eight adults (72 participants in total). It reported steeper loss of information in mixed chains, while all-autistic and all-non-autistic chains did not significantly differ. This is pertinent to the assumption that a breakdown in communication must be a deficit located in the autistic participant. It was, however, a specific experimental task with a modest sample, not an assessment of all forms of empathy or a proof about public-service encounters. [47]

Crucially, a larger preregistered replication and extension by Crompton and colleagues, published in Nature Human Behaviour in 2025 (N = 311), found no difference in information retention between same-neurotype and mixed-neurotype chains. The authors reported higher rapport in non-autistic chains and improved rapport when diagnostic status was disclosed. These outcomes are not a replication of the 2020 mixed-chain information-loss effect. The contradiction should remain visible rather than be smoothed away to support any preferred theory. [48]

The theory itself is the subject of a current methodological debate. Livingston, Hargitai and Shah (2025) questioned the conceptual derivation and cautioned against premature applied conclusions; a 2026 review by Fellowes found that many studies labelled as tests of double empathy did not directly measure cognitive or affective empathy. Kilgallon and colleagues (June 2026) defended a relational, probabilistic and power-sensitive interpretation, rather than treating it as a universal claim about individual social-cognitive ability. This debate does not establish the Autistan account of naturalness or any general proposition that autistic interpretations are invariably more truthful. [49][50][51]

A practical, evidence-sensitive inference is nevertheless available for services: communication failure should be investigated as a property of the actual interaction, with its wording, timing, procedure, expectations, sensory conditions, power imbalance and opportunities for repair. Before categorising the autistic person as uncooperative or socially deficient, ask whether an alternative channel, an explicit rule, a clarification, an interruption-free pause or a change in staff response would resolve the concrete problem. Record successes and failures; the literature alone cannot establish what happened on the Island. [47][48][49][50][51]

Fact, inference and the burden created by unspoken suspicion

The Autistan framework proposes a distinction between the reality of an event and a socially inferred intention. What the person literally said or did can be compared with a recording, message or reliable witness. The claim that the person intended disrespect, manipulation, defiance or threat is a further proposition; it may be true, false, mixed or unresolved. It cannot be promoted silently to established fact merely because the speaker has an unfamiliar tone, avoids eye contact, responds very literally or insists on correcting an inconsistency. The framework does not grant infallibility to autistic people or deny that non-autistic observers can be accurate. [44][46]

An especially serious accessibility barrier arises when the negative inference is not communicated. An autistic person may be expected to prevent a suspicion they have never been told about, foresee intricate interpretations they would not spontaneously formulate, and then defend themselves against a conclusion already embedded in a decision. Requiring advance mastery of every possible deceitful or hostile social inference is not a reasonable substitute for the institution checking its own reasoning. A clear clarification process can prevent avoidable impingements while respecting actual safeguarding concerns. [44][46]

Proposed local procedure, particularly where a refusal, security response or exclusion is contemplated: preserve the words or observable conduct; distinguish the official's immediate impression from independently evidenced facts; say what interpretation is being considered and why; ask a straightforward, non-accusatory question through an accessible channel where safe; check relevant environmental or administrative factors; document the real risk, if any, and the least restrictive proportionate response; and preserve a meaningful opportunity to correct an erroneous account or challenge the decision. Immediate protective action can remain necessary when there is reliable evidence of imminent danger; the requirement is to avoid treating unfamiliar presentation as such evidence. [44][46]

This approach helps separate three different objects of evaluation: the person's genuine behaviour, another person's discomfort or offence, and a substantiated impact on safety or

other people's rights. Discomfort can be worth acknowledging without automatically authorising restriction; conversely, a genuine danger is not dismissed merely because the person is autistic. A public training programme can use carefully designed examples to test whether staff maintain these distinctions under time pressure, and can audit corrections after disputes. [42][44]

Visibility is an unreliable shortcut for deciding need or capacity

A qualitative Norwegian study published in April 2026 interviewed nine autistic adults about their encounters with support systems. It describes a two-sided pattern: a person who masks autistic characteristics may be judged too capable to need adjustments, while a person who does not mask may be presumed incompetent or unsuitable for opportunities. The study proposes the term "visibility logic" for over-reliance on outward presentation. Its sample is small, retrospective and located in Norway; it cannot establish the prevalence of either mechanism in Manx services. [53]

A second qualitative study, based on an asynchronous group of eight autistic adults, identified communication themes including a preference for truthful wording, pressures from unstated expectations, and perceived inequality in mutual accommodation. These themes resemble some of Autistan's concerns about misleading interpretations and hidden rules, but eight participants cannot define how all autistic people think or prove that their accounts apply universally. They are sources of precise, contestable hypotheses for institutional practice. [52]

For the Island, staff making an eligibility or adjustment decision could be asked to record the person's expressed need, the actual activity or task at issue, the environmental conditions, the functional evidence relevant to the rule and any uncertainty. Eye contact, verbal fluency, visible agitation, an articulate complaint or calm appearance should not automatically substitute for that evidence. Where a specialised clinical or reserved representative role legitimately requires proof of eligibility, its safeguards should be proportional and separate from general access to ordinary services. [24][46][53]

Precisely identifying an impingement without conflating its forms

Autistan's 2026 reference model asks investigators to distinguish the SOURCE of an externally generated impingement, the CHANNEL by which it reaches a person, the CONTENT or nature of the impingement, and its CONSEQUENCES. For example, an unnecessarily repetitive mechanical sound may be a sensory impingement even when it is not especially loud. If it also signals an avoidable defect, a persistent refusal to correct it, or an unjustified imposition, a separate mental or psychic impingement may be present. One kind of impingement has not transformed into the other; they can coexist, follow one another and reinforce the resulting distress. [44][46]

Equally, the mental component is not adequately described merely as exposure to words, emails or explanations. Those may be carriers. The potentially perturbing CONTENT may be a contradiction, absurd requirement, injustice, arbitrary order, factual falsehood, humiliation, incoherence or unexplained reversal of an administrative decision. The externally arising impingement must also be distinguished from the person's ensuing fatigue, anger, shutdown, bodily discomfort or other reaction. These are analytically separate elements even if causation is difficult to resolve in a particular case. [44][46]

An institution should therefore investigate both the conditions imposed and their actual effects, without assuming all distress has an external cause, that every perceived inconsistency is objectively established, or that clinical needs vanish once a barrier is removed. The test is whether changing a specified, controllable condition reduces a documented obstacle for the relevant person, with adverse effects and other plausible mechanisms recorded. This is a practical research method, not a diagnostic taxonomy. [29][44][46]

Seven questions for deciding how adaptation duties should be shared

Autistan's comparative study specifies seven considerations for assigning the effort of adaptation: factual CAUSALITY; whether there is REAL, substantiated harm to anyone; the difference between causal responsibility and moral blame; the comparative COSTS and burdens of possible changes; PROPORTIONALITY; reciprocal effort without an arbitrary '50/50' division; and the distinction between immediate self-protection and the desirable long-term public system. These are analytical questions, not a claim that every individual request must automatically prevail. [81][82]

Consider a waiting-room rule that obliges everyone to remain in a crowded noisy space. If a quiet alternative would be simple and beneficial without impairing another person's rights, assigning all the burden to an autistic visitor is difficult to defend. By contrast, two service users may have genuinely conflicting sensory requirements; then choice, separation, timing or other alternatives need to be studied. Where an official has incorrectly attributed hostile intent, the facts and record should be corrected by those empowered to do so, rather than requiring the autistic person to adapt indefinitely to a false narrative. [81][82]

Making social norms genuinely contestable: a proportionality test

The fact that a convention is familiar or widely practised does not prove that it is morally correct, necessary, safe or relevant to the service provided. Nor does the fact that a rule is socially constructed prove it is arbitrary or unjust. A defensible review asks separately: (a) What legitimate purpose does the rule serve? (b) What verifiable negative result follows from not observing it? (c) Does the rule protect actual safety, public order, rights or an essential technical function, or mainly outward conformity? (d) Are there competing rights or operational needs? (e) Can a less intrusive alternative attain the same purpose? (f) What are the burden, cost and effects of each alternative on the person and institution? These are questions for investigation, not automatic findings of discrimination. [44][46]

For example, protective clothing in a genuinely hazardous workplace may have a demonstrable safety purpose, whereas a demand for eye contact when the information has been correctly received may lack an equivalent justification. A communication rule can be made explicit, taught as an optional skill and examined for effectiveness without treating compliance with a local social expectation as a measure of human worth. Rights-based accessibility is concerned with legitimate functions and the proportionality of actual demands, not with compelling a single style of social performance. [44][46]

Autistan's reference model adds a practical question to this proportionality test: who should adapt, and what would the effort actually cost each party? Saying that 'everyone should make an effort' is inadequate where burdens are very unequal. The model identifies six considerations: adverse effects (including sensory or mental impingements and exhaustion);

proportionality of the effort; respect for autistic functioning rather than compulsory masking; the real usefulness of the requirement; reciprocity; and clarity of expectations. For instance, supplying precise written instructions may be a minor change for a service while asking an autistic person repeatedly to navigate unexplained or contradictory rules can impose a substantial and avoidable burden. A pilot should compare the legitimate objective, evidenced constraints, feasible alternatives, implementation costs, the burden on each party and direct results for the person. These are Autistan's proposed policy criteria for allocating adaptation efforts, not a substitute for applicable Manx equality law, nor a rule that any requested measure must automatically be granted. [46]

The Autistan idea that autistic people can act as useful warning signals for defects in social systems is most productive here as a testable investigative hypothesis. A complaint about unnecessary noise, opaque instructions or unsupported suspicions may reveal a process fault from which many users would benefit. That wider benefit should be checked through performance, complaint and resource data, not presumed. The individual's access and dignity must never depend on furnishing a socially useful discovery. [44][45][46]

Comparative public-policy checks available by November 2026

Canada's 2024 framework is particularly instructive for terminology: its glossary defines acceptance in terms of recognising autistic differences as valid, yet another glossary entry describes "autism" as also known as "autism spectrum disorder." This coexistence shows why endorsement of acceptance does not amount to express adoption of Autistan's fundamental distinction between autistic nature and disorders. The framework is useful evidence for a public-policy goal and its evaluation, not a proof of agreement about ontology. [35]

Ireland's National Disability Authority reports that the Autism Innovation Strategy has been extended to the end of 2026, lists 83 actions in four pillars, and describes a majority-neurodivergent oversight and advisory group. Its 2025 synthesis of attitudes is intended to inform a national acceptance campaign. These are specific governance and preparatory measures; their existence alone does not establish that public understanding or ordinary access has improved. Where local comparators are useful, the Island could distinguish the participation mechanisms, methods, evidence of actual implementation and outcomes rather than copy headings or count committees. [36][37]

Australia's National Autism Strategy 2025–2031 provides a further caution about progress language. On its official site, the Australian Government states it has commenced work on 81% of First Action Plan actions; "commenced" does not mean completed, delivered to intended users, or shown to improve daily life. On 6 October 2026, it issued first-year implementation information about reviews of community awareness, assessment and diagnosis, employment support, peer support and provider training. This illustrates the usefulness of subject-specific public reporting while also making it essential to distinguish reviews, engagement activities, implementation and observed outcomes. The Isle of Man's own Phase 1/Phase 2/Phase 3 concordance should maintain the same distinctions. [54][55]

Four practical checks for the 2027 campaign and Phase 3

The following are proposed evaluation exercises rather than reported incidents on the Isle of Man. Each can be developed with consenting autistic participants, without requiring

disclosure to use an already accessible baseline. Evaluators should record baseline conditions, selected participants and exclusions, any legal or safety constraints, adverse effects, follow-up, and the difference between an official response and the person's own assessment of what happened. These checks fit the existing campaign themes and Phase 3 actions; they do not require a separate fourth campaign priority. [10][22][46]

Problem tested	Action in an ordinary setting	Observable result and caution
Invisible inference in a complaint	A public office records the service user's actual words and distinguishes them from staff assumptions; offers written clarification before a consequential refusal.	How often corrections are invited, received, reflected in decisions; whether escalation or repeated contact falls. Legitimate danger assessed separately.
Masking and support-eligibility decisions	A healthcare or employment service checks reported barriers and task-specific needs instead of using verbal fluency, a calm appearance or visible distress as the primary proxy.	Document reasoned grants/refusals, review rates, subsequent service access and direct user feedback. Does not remove lawful eligibility criteria.
Sensory and mental impingements	A venue tests one avoidable sound or temperature problem together with the clarity and fairness of how adjustment requests are handled.	Compare exposure, problem correction, availability of choice, complaints, reported distress and implementation costs. Do not conflate stimulus, external impingement and reaction.
An implicit social requirement	A school, office or employer examines whether eye contact, social attendance or verbal immediacy is really needed for a given task, and pilots equivalent written, delayed or low-contact alternatives.	Compare completion of the legitimate task, fairness, cost, other users' rights and free choice; do not score "looking normal" as the outcome.
Non-participants in public consultation	Publish a usable written/asynchronous response route, and invite direct autistic feedback without compulsory public meeting attendance or compulsory self-disclosure.	Number of submissions by channel and source category, accessibility failures, topics raised, action taken, and clearly described sampling limitations.

The most important comparison is not how many positive attitudes a survey records, but whether the same person can now obtain a decision, correction, appointment, learning opportunity or remedy with fewer unsupported inferences, fewer avoidable impingements and less compulsory social performance. That outcome must be tested against the Island's own earlier evidence and the results of the measures it has already announced. [3][10][22][26]

Testing whether acceptance campaigns change what people actually do

A systematic review by Kim and colleagues examined 26 interventions intended to reduce stigma towards autistic people. The interventions were mostly single-session activities, often using videos or computers and frequently studied among students. The review identified widespread risks of bias and warned against unwarranted causal conclusions, particularly where behavioural outcomes, follow-up and structural stigma had not been adequately assessed. This is not evidence that campaigns never work. It is evidence against treating a short post-campaign opinion score as proof of sustained acceptance in daily life. [56]

A South Korean randomised controlled study with 208 university students reported improvements in knowledge, perceived similarity and stigma measures following culturally adapted online autism training; 25% of participants in the intervention group showed reliable individual improvement on the specific perceived-similarity measure examined. These are findings about the measures and participants actually studied, not proof of enduring change among Manx public-service personnel or the whole population. An intervention that improves immediate knowledge may still fail to change how an actual complaint, job interview, health appointment or unexpected autistic reaction is handled. [57]

For 2027, distinguish at least four outcomes: (i) who encountered the campaign; (ii) what factual misconceptions were corrected; (iii) how staff, organisations or residents subsequently respond to a realistic situation; and (iv) whether autistic people encounter fewer avoidable barriers over time. When practicable, compare similar scenarios before training, shortly afterwards and at later follow-up, including direct feedback from autistic people. Disclose the sampling method, dropout, recruitment bias, staff awareness of evaluation and other changes that might explain any improvement. A voluntary pilot should compare practices without withholding reasonable adjustments or any existing entitlement. [22][56][57]

The acceptability of goals: safety and autonomy versus outward conformity

An online study of 235 autistic adults in 2024 found substantial support for intervention goals connected with safety, communication and quality of life, but much less support for reducing self-stimulatory behaviour, intense interests or increasing eye contact merely for conformity. Its sample was self-selected, predominantly White and strongly weighted towards the United States; the study concerned attitudes to behavioural-intervention goals, not the effectiveness of a Manx public-awareness campaign. It nonetheless provides an important, carefully bounded question for policy design: who judges the purpose of a proposed behavioural change, and on what grounds? [58]

The practical distinction is not between learning and never learning. Someone may choose to learn a workplace convention as a useful second language while retaining their own manner of communicating; support may also legitimately address a safety risk, self-injury or an explicitly unwanted difficulty. What is not equivalent is requiring the person to suppress harmless autistic characteristics merely to satisfy an observer. Before funding a training or support programme, the Island could ask the intended users to assess its goals, methods, freedom of choice, possible impingements and results. This is consistent with the Autistan

distinction between useful learning, accessibility and forced assimilation, while recognising that autistic people themselves may disagree about particular aims. [44][46][58]

Autism disclosure must remain a meaningful choice

Whether, when and to whom a person discloses their autistic identity is not a trivial question of promoting public visibility. A 2024 pilot programme for autistic adults supported context-sensitive disclosure decisions: 32 people enrolled, but only 19 completed both the intervention and subsequent assessment. Reported experiences suggested possible benefits, yet the small sample and attrition do not establish a generalisable intervention effect. It illustrates why campaigns should inform individuals of their options and potential consequences rather than presenting either disclosure or concealment as a universal obligation. [59]

In public services, an accessible baseline should work for someone who is autistic but undiagnosed, a person who does not wish to disclose, and a person whose documentation is unavailable at the moment of need. Where particular eligibility rules do require evidence, these should be transparent, privacy-conscious and relevant to the reserved service or role. Evaluation should check whether staff actually provide the ordinary alternative when a person does not volunteer an autism label, passport or lanyard. This approach does not remove the need for accurate diagnosis or eligibility safeguards where genuinely relevant. [24][25][59]

Healthcare access must be examined across the entire journey

A 2026 qualitative evidence synthesis from England reviewed 15 studies concerning healthcare appointments for autistic adults or adults with learning disabilities. It found barriers and facilitators at individual, relational, organisational and policy levels, including booking arrangements, communication, professional attitudes and trust. Because the study populations and geography differ, its conclusions should not be presented as statistics about Manx autistic adults. They do, however, indicate that a local review confined to a quiet waiting room or a completed staff-training course may overlook why a person could not arrange, attend, understand or follow up an appointment. [60]

The Island could therefore test the complete health-access sequence: finding a service; making contact by an accessible channel; arranging an appointment; anticipating and avoiding sensory or procedural barriers; obtaining an appropriate examination or assessment; understanding the proposed action; receiving accessible written information and follow-up; correcting errors; and using a complaints or review pathway if necessary. Record both service-level evidence and first-hand accounts, including people who abandoned the attempt before an appointment was made. This would build on, rather than disregard, the 2025 Manx Care consultation and the already launched Health Passport. [5][26][28][60]

Employment priorities: distinguish focused initiatives from universal coverage

In its April 2026 Annual Report on Poverty Measures, the Isle of Man Council of Ministers described a Phase 2 employment emphasis on adults with ASC who do not have a learning

disability, pursued through reasonable adjustments and employer engagement. A targeted priority is not itself evidence that autistic adults with co-occurring learning disabilities have been formally excluded from every employment measure; neither is the description evidence that all groups have benefited. This precise scope deserves a transparent comparison with the Strategy's more general employment objectives. [61][14]

When reviewing the employment forum, recruitment changes and employer engagement, report eligibility and uptake for different support needs, co-occurring disabilities and routes into voluntary or paid work where lawful and feasible. Report direct user choice, accessible recruitment and retention, and why people abandon opportunities. In a small jurisdiction, suppress or aggregate categories where necessary for confidentiality rather than publishing identifiable subgroup counts. Autistic people with different support requirements should not be described as having identical employment goals, and worthwhile lives must not be measured only by paid-work participation. [10][46][61]

A bounded, ethical implementation experiment for 2027

An economical and verifiable improvement would be to pilot a common decision-record form in a small number of ordinary services. For each voluntary case, record: the person's stated objective; actual words or observable conduct; any staff interpretation of intention, danger or competence; the evidence supporting that inference; the rule or decision being applied; an accessible opportunity to correct a misunderstanding; the adjustment offered; and the resulting ability to complete the legitimate task. Where appropriate, note whether the external source of an impingement was changed, without confusing that source with the individual's response. The record must not become a new bureaucratic requirement imposed on the autistic person. [44][46]

At the evaluation stage, compare what changed for the person rather than merely the number of forms completed. Did the service correct an unsupported inference, reverse a mistaken decision, offer an alternative channel, prevent an avoidable escalation, or achieve access with less masking and distress? Track time, effort, cost, complaints and adverse effects. Invite contradictory user assessments, recognise small numbers and do not infer causal success when improvements may reflect case mix or unrelated procedural changes. Rights and required reasonable adjustments must never be withheld for evaluation purposes. [20][56][60]

5. Local legal and administrative foundations

The Isle of Man is not part of the United Kingdom and its own statutory framework matters. The Equality Act 2017, section 21, provides three reasonable-adjustment requirements; section 22 addresses failure to comply. In Part 3, section 31(7) activates Schedule 2 for services and public functions. Schedule 2 paragraph 2(2) uses the phrase "disabled persons generally" for the three requirements, supporting an anticipatory element in those settings. Work and education have distinct provisions and must not simply be assumed to share every test. Legal classification of disability and proportionality still matter. [20][21][27]

A further statutory safeguard is often overlooked: section 21(7) provides, subject to any express provision to the contrary, that a person subject to the reasonable-adjustment duty cannot require the disabled individual to pay the duty-holder's costs of compliance. This is

distinct from the provider's own implementation costs and does not turn every requested measure or every specialised support service into a statutory entitlement. When auditing adjustments, the Island could record whether a legally required adjustment was withheld, delayed or made conditional on the user paying for it. [27]

The duty also has specific boundaries. Schedule 2 paragraph 2(7) does not require a service-provider to take a step that would fundamentally alter the nature of the service or its trade or profession, and paragraph 2(8) does not oblige an authority exercising a public function to take a step outside its powers. Paragraph 3 contains detailed transport-specific rules and exceptions. Those provisions call for case-specific legal analysis, not a blanket refusal to consider accessible alternatives. The broader strategy may legitimately propose good practices beyond the minimum legally required, provided it distinguishes policy aims from enforceable duties. [27]

A public-facing government health guidance page currently cites the UK Equality Act 2010 instead of the Manx Equality Act 2017. The same page offers valuable operational guidance, including that healthcare staff should listen to adjustment needs without insisting that an autism diagnosis be established first. Correcting the legal citation while preserving that useful guidance is a specific, proportionate recommendation; the page alone is not evidence of wrongful clinical practice. [25][27]

A diagnostic label is not a general prerequisite for considering what adjustment can reasonably remove a disability-related obstacle. Conversely, reserved representative positions and specialised clinical services can legitimately involve eligibility verification appropriate to their purpose. Diagnostic false positives and false negatives, inaccurate declarations, forged documentation and differences of political opinion are different issues; no one should be accused of misrepresentation on the basis of appearance or an unconventional view. [24][25]

The legal framework must also be read with its commencement instruments. The Isle of Man Equality Act 2017 was enacted in 2017, but the principal disability-discrimination and reasonable-adjustment provisions were brought into operation for remaining purposes on 1 January 2020 under the Equality Act 2017 (Appointed Day) (No. 5) Order 2018. An account of rights in 2026 should distinguish the original as-enacted text, commencement, and any subsequently applicable amendments, regulations and exceptions. The Government publishes a guide to the Act, but the applicable wording and procedures must be checked for the specific claim; this contribution does not purport to give individual legal advice. [27][67][68]

6. Action programme: priorities and responsibilities

The 26 recommendations below are grouped by practical implementation purpose. They connect proposed actions with identifiable decisions, deliverables or tests of implementation and real-life results.

In applying the Principles of Autistan, each proposed measure should start from a specific difficulty or restricted freedom, reconstruct what actually causes it, distinguish autistic nature from a medical or support need and from socially generated sensory, mental or other impingements, identify which actor can change the relevant condition, and test the

consequence in a real encounter. The answer may involve systemic measures for accessibility for autistic people, a supplementary adjustment, specialist advice, personalised assistance or appropriate healthcare, sometimes together. A claim of greater acceptance is incomplete unless the person can use the service without needless suffering, concealment or exclusion. These are analytical decision rules for the proposed actions, not assertions about uninvestigated Manx incidents. [44][46][82]

6.1 Evidence, accountability and direct participation

01. Maintain a public phase-to-phase concordance table

Starting from the published First Annual Report and Phase 2 Action Plan (GD 2025/0069), link each Phase 2 commitment to evidence of delivery, unresolved issues and the relevant Phase 3 action. Where evidence is not available, say “not yet evidenced” rather than “failed”. [4][10][19]

Deliverable: published crosswalk of Phase 1, Phase 2 and Phase 3 commitments, dates, owners, supporting evidence and uncertain results.

11. Publish Steering Group evidence more consistently

The Terms of Reference anticipate regular meetings, updates and reporting. The Phase 3 Plan already commits to annual progress updates to Tynwald, six-monthly public meetings and departmental monitoring of training effectiveness reported to the Steering Group. Publish meeting records, implementation data and decisions promptly enough to show what was accepted, rejected, deferred or actually improved, beyond counting meetings and training attendance. [10][15]

13. Preserve direct autistic participation

Keep direct autistic voices distinct from family, professional, provider and organisational perspectives. This is supported by the Isle of Man Government's own 2022 results: autistic respondents' leading barriers to accessing support were professional expertise, public understanding and waiting times; proxy respondents prioritised funding, waiting times and professional expertise, while professionals prioritised funding, staffing or retention and waiting times. These distinct rankings should not be collapsed into one group-wide list. Future reporting should present the number of direct autistic contributions, their own ordered concerns, whether and how decisions responded, and the limits of non-representative samples, missing answers and small subgroups. The other perspectives remain useful but are not interchangeable. [3]

Test: independent direct-response totals, transparent treatment of proxy and multiple-role responses, and a decision-response record.

14. Maintain a longitudinal problem-based scorecard tied to the 2022 baseline

Unlike the phase-to-phase delivery concordance in Recommendation 01, this scorecard should start from the problems reported in 2022 and ask whether each problem is actually diminishing over time. For each domain, show the relevant Strategy action, evidence of availability, lived-result indicator, unresolved gap and next review date. This would make longitudinal progress visible without treating administrative completion as problem resolution.

Deliverable: longitudinal 2022 problem-to-policy scorecard retaining comparable definitions and disclosing changes in sample composition.

The scorecard should therefore register not only whether an autistic person received a service but WHY a previously reported barrier remained or disappeared. For a recurring problem such as inaccessible appointment booking, identify the actual rule or environmental condition, its sensory or mental effect if reported, the correction made, and whether attempts were successfully completed afterwards. Separate improved access from people ceasing to complain, masking their reactions or withdrawing. Compare 2022 concerns with later evidence only when the question and respondent population permit it; otherwise report a new, non-comparable baseline. This applies the fundamental distinction by measuring a change in the disabling situation rather than a supposed reduction of autism. [3][44][82]

19. Publish a visible feedback-to-action trail

For substantial issues raised through public meetings, surveys, complaints or Steering Group participation, publish a simple chain such as: “You said / We verified / We decided / We did / We measured”. Where a proposal is rejected or deferred, publish the reason when confidentiality allows. This would make participation more credible and help distinguish consultation activity from actual policy influence.

For a small sample of reported accessibility problems, the public feedback trail should identify the disputed condition and what changed in the institution: for example, a corrected telephone-only rule, an amended inaccurate incident note, or a more proportionate waiting arrangement. Report whether the person then completed the intended activity and whether the same barrier reappeared. A reduction in visible complaints without evidence of safe access must not be labelled a success. This allows autistic people to see whether identifying a systemic defect led to repair rather than only a sympathetic acknowledgment. [44][82]

26. Make ASC consultations themselves demonstrably accessible

The 22 October 2026 announcement directs residents to an online Microsoft Forms survey but does not itself advertise paper, email, meeting or alternative-format response routes. This does not establish that accommodations are unavailable. However, a 2025 Manx Care consultation on healthcare access explicitly offered online and paper responses, email return, face-to-face or Teams discussion, and assistance or alternative formats. Future ASC consultations should state comparable options at launch and record response mode and accessibility support, so people who cannot or will not use a standard online form are not systematically less visible. [22][28]

The Treasury's published 2022 equality-impact guidance also describes consultation while proposals are formative, a choice of formats including paper, accessible documents and online questionnaires, and an explicit check on whose perspectives remain absent. This is evidence of an earlier Manx government method, not evidence that the current ASC survey itself offers all those routes. Future ASC consultation notices could publish the available non-digital and written alternatives at launch, identify an accessible point of contact for difficulties with the form, and report both gaps in reach and how comments affected decisions. An external organisation's documentary analysis should remain distinguishable from first-hand responses by Island residents. [69]

A local precedent for an additional participation channel should also be preserved: the Government notice of 23 April 2026 about the ASC Strategy update meeting of 28 April expressly invited people who could not attend, or preferred not to ask a question in person, to send questions or comments by email to Autism in Mann by 24 April. This demonstrates that written input was offered for that particular meeting, not that the October-November 2026 Microsoft Forms survey automatically accepts email submissions. Future consultation notices can state the relevant written alternatives and how these will be acknowledged and handled, without requiring people to discover or infer arrangements from earlier events. [74]

The Government announcement of 1 October 2026 concerning Phase 3 also gives ASCstrategy@gov.im as a written contact for requesting audio, braille and other accessible formats of the Action Plan. This establishes an official contact for the ASC Strategy team and a concrete precedent for accessible formats. It does not establish that the October-November 2026 online survey itself accepts email submissions or that a non-resident institutional analysis would be counted as a resident survey response. Future consultation notices should identify their own applicable alternative response channels, any eligibility limits, and how contributions outside an online form can be acknowledged and considered without misrepresenting who is reporting first-hand Island experience. [22][79]

The acceptance and accessibility principles also apply to the consultation itself. A person who cannot use a rigid online form, does not wish to disclose autism, needs extra time or prefers a carefully written submission should not be treated as a deficient participant. At launch, publish the actually available alternatives, contact point and response handling; test whether a user can start, complete and correct a submission through those channels, and identify groups not reached rather than treating their silence as satisfaction. Keep institutional policy submissions separate from first-hand resident experience so neither is lost or falsely represented. [3][82]

6.2 Accessible ordinary systems and environments

02. Create an interdepartmental autism-accessibility standard

Cover sensory conditions, written and asynchronous communication, alternatives to telephone contact, predictability, quiet space, remote options, waiting arrangements, clear information and respectful handling of adjustment requests.

Deliverable: a small cross-department standard, with named service owners and access tests using realistic scenarios.

The proposed cross-government standard should also be tested against the lowest level of Autistan's pyramid: systemic changes to ordinary environments and procedures. It must not be reduced to private badges, special sessions, diagnosis pathways, discretionary kindness or individual support packages. Each department should identify the preventive baseline, the responsible decision-maker, the route for correction and evidence that everyday access improved. [82][46]

The standard should include two explicit tests of the distinction between autistic nature and difficulties generated by the system. First, when a visitor speaks directly, does not make eye contact or moves repetitively without substantiated harm, staff continue the transaction without labelling the person uncooperative or unsafe. Second, when a visitor reports noise, a contradictory instruction or a compulsory telephone-only route, the service examines the

actual setting or rule and offers a correctable alternative rather than treating distress as proof of an intrinsic behavioural disorder. For each test, record the access problem, the systemic correction, any further individual adjustment, a named owner and whether the person completed the task. [44][82]

03. Do not make diagnosis a general gateway to accessibility

Use diagnosis where proportionate for specialised clinical pathways or specifically reserved roles, but do not make a particular diagnostic document the default gateway to ordinary accessibility. Where the disability-related barrier and requested adjustment can be understood directly, assess the need and reasonableness of the adjustment without demanding evidence that adds no decision-relevant information. In healthcare, Manx Care guidance explicitly states that a diagnosis does not need to be in place before a reasonable adjustment is made. Audit a sample of adjustment requests to check whether diagnostic proof was demanded unnecessarily. [25]

15. Audit accessibility without requiring prior self-identification

Use service and environment audits to identify barriers that affect autistic people who may not know that they are autistic, people who do not disclose autism, and people who abandon inaccessible processes before making a complaint. This complements surveys of people already known to services.

An audit that recruits only people already diagnosed or willing to disclose autism cannot establish whether the ordinary system is accessible. With informed and voluntary participation, test the public-facing journey from information search through attempted contact and appointment completion, including an optional written route, a missed or abandoned request, and a person who asks for an adjustment without naming autism. Record steps required, delays, reasons for failure and actual remedies; do not infer a person's diagnosis from their behaviour or stage deceptive clinical encounters. The practical criterion is whether accessible design works before a person has to explain or prove autistic identity. [3][25][82]

16. Audit existing services against the anticipatory accessibility duty

Where the Part 3 services and public-functions duty applies, audit existing high-contact services against the anticipatory requirements of the Equality Act 2017 and Schedule 2, not only new policies. Departments and commissioned providers should test real access to appointments, written contact, physical settings, public information and adjustments for people who have not disclosed an autism diagnosis; assign a responsible owner and record remediation. For employment, education and other sectors, conduct accessibility reviews under their distinct legal regimes instead of assuming that every institution has exactly the same statutory duty. This implements the baseline in Recommendation 02 and complements the pre-launch impact check in Recommendation 18. [20][21][27]

The Isle of Man Government has already described how the public-sector equality duty should be applied when services are commissioned: in an equality impact assessment published with a 2022 Treasury consultation, its explanatory notes say that responsibility cannot simply be delegated to a contractor and that the public authority should address compliance through contractual arrangements and ongoing monitoring. That historical administrative guidance does not establish how any particular contract operates in 2026. For

ASC Strategy measures provided through contractors, the proposed audit should identify the commissioning authority, the accessibility expectations applicable to the contract, the provider's actual delivery, and who is responsible for remedying failures. The test is not the existence of a contractual statement but access in practice. [69]

18. Introduce an autism-accessibility impact check for new policies and services

Before a new policy, digital service, appointment system, public building procedure or commissioned service is introduced, include a short autism-accessibility check covering sensory conditions, communication channels, predictability, waiting, disclosure requirements, remote or asynchronous alternatives and foreseeable attitudinal barriers. This can operationalise anticipatory accessibility without requiring every issue to be discovered later through individual complaints.

The public-law basis for an autism-accessibility impact check deserves to be made explicit. Under section 143 of the Isle of Man Equality Act 2017, relevant public authorities must have due regard, when exercising their functions, to eliminating prohibited discrimination, advancing equality of opportunity and fostering good relations. Section 143(3)-(4) specifically refers to removing or minimising disadvantage and taking steps to meet different needs, including disability-related needs. A practical autism-accessibility screening record is proposed as one way of informing and checking decisions, not as a form expressly required by section 143 or as a guarantee of any particular outcome. Its use must take account of the applicable legal scope, exceptions and any amendments. [27][67]

An instructive local warning already exists. In its annual report covering 2024–25 (published in February 2026), the Tynwald Social Affairs Policy Review Committee criticised the Equality Impact Screening Assessment for the October 2024 Inclusive Education Policy: in the Committee's view, disability had been treated as a physical-access issue rather than a learning issue, and a full equality impact assessment was warranted. The Committee also raised concerns that substantive stakeholder feedback had not been adequately incorporated. These are findings and criticisms of the parliamentary committee, not a judicial ruling that the Department breached the Equality Act. The proposed autism-accessibility check should therefore require decision-makers to identify the actual sensory, communication, cognitive, educational and attitudinal barriers considered, record how the evidence affected the proposal, and explain any important observations not acted upon, instead of equating a completed screening form with adequate consideration. [7]

The Island's own published evaluation method provides a concrete starting point. An equality impact assessment annex issued by the Treasury in July 2022 calls for consideration before decisions, sufficient evidence, genuine use of consultation feedback, proper record keeping and monitoring afterwards; it cautions that completing an assessment form does not, by itself, meet the equality duty. Recommendation 18 therefore proposes adding autism-specific scrutiny to procedures that already exist, rather than creating a parallel mandatory form or assuming that every proposal needs a full equality impact assessment. Where proportionate screening concludes that further assessment is unnecessary, record the reasons for that conclusion in relation to any foreseeable sensory, communication, cognitive, procedural and attitudinal effects. The 2022 annex is evidence of a published government method, not proof that it is uniformly applied today. [69]

The Attorney General's written answer of 18 February 2025 confirms that section 143's due-regard duty is proportionate to the facts and seriousness of potential equality impacts, and does not compel a particular outcome. This local explanation reinforces the distinction between a genuine, documented assessment and an automatic requirement to adopt every proposed measure; it does not affect separate enforceable duties concerning discrimination or reasonable adjustments. [80]

An impact-screening entry could require four short answers before approval: (1) Which activity or freedom does the policy make harder, and for whom? (2) Is the apparent difficulty attributable to a medical or support need, to a modifiable sensory, procedural or attitudinal condition, or to an interaction that has not yet been established? (3) What ordinary systemic correction is feasible before relying on disclosure, special sessions or individual resilience? (4) How will the authority check actual access, unintended effects and the route for requesting further adjustment? A response that simply says 'autism considered' or 'staff trained' should not count as an answer. Apply this as a proportionate evidence-and-decision method, not a new statutory form. [27][82]

20. Test a small set of practical cross-government accessibility demonstrators

Select a small number of ordinary settings — for example a public office, healthcare waiting area, school or training environment, workplace process and community venue — and test a defined menu of practical measures, prioritising low-cost or low-resource options where feasible: moderate temperature, reduce unnecessary noise, provide a genuinely usable quiet space where appropriate, give clear advance information, offer written/asynchronous contact and remote participation when suitable, provide alternative waiting arrangements, and use patient, non-defensive staff responses. Treat these measures as configurable options rather than a universal sensory prescription. Publish the baseline, implementation cost, uptake, user feedback, which options helped which users, unintended disadvantages, problems encountered and measurable effects. This would turn "autism-friendly" from a general aspiration into tested operational practice that other services can copy.

Pilot: five ordinary settings, baseline access audit, interventions, costs, direct feedback, measured outcomes and adverse effects.

The demonstrators should deliberately contrast at least one sensory obstacle with one non-sensory mental or procedural impingement. For instance, test controllable noise or temperature in a waiting area separately from an unexplained appointment change or an unsupported assumption of aggression. For each, document the source, the channel, the substance of the disturbance, the change made and what happened to completion, reported distress, staff time or repeat contact. An improvement achieved because users stopped attending or hid their reactions must not be scored as an environmental success. Energy and administrative savings may be measured where relevant, but rights and accessibility do not depend on proving a net saving. [44][82]

21. Keep passports, lanyards and disclosure tools voluntary and non-gatekeeping

The Health Passport, Hidden Disabilities Sunflower and similar tools can help communication and preparation, but they should remain optional. The Health Passport was itself launched for people who may benefit from a personalised approach regardless of diagnosis or label. A person should not have to carry a particular document or symbol, or disclose autism, in order to use the accessible baseline. For individual reasonable

adjustments, a specific diagnostic document should not be required by default where the disability-related barrier and adjustment need can be established otherwise; any evidence request should be proportionate to the decision being made. Evaluation should test whether staff respond appropriately when no passport, lanyard or diagnostic document is presented. [5][9][25]

22. Mainstream successful adjustments beyond special sessions

Evaluate Quiet Hours and other special-access arrangements not only by attendance but by what they teach about ordinary service design. Where lower noise, moderated lighting or temperature, clearer information, reduced waiting pressure or more patient interaction proves useful, consider which elements can become normal practice rather than remaining confined to designated times or places. [23]

For each special session or optional aid, publish a realistic route from demonstration to ordinary service accessibility: what worked, which parts can be made routinely available, which needs still require dedicated provision, which users might be missed, and how failure can be reported and corrected without compulsory disclosure. A label such as 'autism-friendly' should be accompanied by verifiable conditions of use rather than treated as an outcome indicator by itself. [82][83]

25. Correct and localise public-facing reasonable-adjustment guidance

The government health page "Reasonable Adjustments" offers useful practical guidance, including a needs-based approach before a diagnosis is in place. Its legal introduction, however, cites the UK Equality Act 2010 rather than the relevant Isle of Man Equality Act 2017. The statutory reference and related explanations should be corrected and localised while preserving the helpful examples. The wording of a web page alone does not establish that staff have applied the wrong law. [25][27]

Deliverable: revised local guidance citing the right statute, with no claim of legal violation inferred from a web-page wording error.

6.3 Identification, diagnosis, health and individual support

04. Develop detection and self-understanding pathways

Provide trustworthy information and routes for adults who suspect autism or who repeatedly encounter compatible difficulties, without forcing diagnosis or self-identification.

05. Open and evaluate the adult ASC/ADHD pathway with transparent capacity data

Report funding, recruitment, eligibility, waiting time, assessment quality, post-diagnostic support and outcomes. The Phase 3 action budget (£41,172 for the 18-month plan) explicitly excludes the future adult ASC/ADHD assessment and support service, which is subject to a separate Treasury Business Case; financing and operational readiness should therefore remain separately visible. [10]

Test: confirm a functioning adult pathway, resourcing and eligibility, and report waiting, refusals, drop-out and access before diagnosis.

A specific unmet need described by professional respondents in the 2022 consultation was limited access to occupational-therapy input and sensory-profile assessments for autistic adults. This was a reported concern at that time, not verified evidence that such services are

still unavailable in November 2026. As the adult pathway is developed, the Island could report separately on diagnostic assessment, occupational-therapy or other competent sensory-needs assessment, and practical follow-through. The audit should establish who can refer, what is available and funded, waiting times, reasonable adjustments during assessment, access before formal diagnosis where appropriate, and whether identified barriers are subsequently reduced. A greater number of diagnoses alone would not demonstrate these distinct results. [3][10][14]

The formal policy timetable should be distinguished at three levels. On 21 April 2026 Tynwald endorsed a phased all-age neurodivergent pathway aimed at 2029, conditional on funding, and adopted an amendment requiring the Department of Health and Social Care (DHSC) to bring detailed, costed funding proposals, timelines and anticipated outcomes to Tynwald no later than its December 2026 sitting. An adult autism/ADHD diagnostic service was described in the ministerial debate as intended for 1 April 2027; that narrower initial service is not equivalent to a fully implemented all-age pathway. As of 7 October, public reporting still described government work on a business case. Recommendation 05 should therefore track what was merely proposed, formally approved and actually financed, and what adults can access before and after each milestone, with public explanations if timetables or definitions change. [75][76][77]

07. Strengthen health accessibility across commissioned services

Maintain written contact and alternative appointment-booking routes, quiet waiting where appropriate, sufficient consultation time, adjustment recording, advance information and voluntary Health Passports across commissioned providers. These are not all new proposals: following its 2025 consultation, Manx Care already announced plans on alternative general-practitioner (GP) appointment booking, reasonable-adjustment guidance and recording, preparation materials, sensory equipment and possible quiet Emergency Department waiting; the Health Passport was launched in March 2026. The required follow-through is to report, measure by measure, what is merely planned, piloted or routinely available, where, to whom, and with what direct user results. Where measures are comparable, assess whether the 2025 barriers decrease, without presenting that mixed learning-disability/neurodivergent sample as autism-specific or representative of all residents. [5][26]

Because the Department of Health and Social Care (DHSC) has planning and assurance responsibilities under the Mandate Framework while Manx Care is an operationally independent statutory provider, implementation reports should assign a named owner for each measure and distinguish the Department's assurance role from the provider's actual delivery. The same named measure should be traceable from the Mandate or plan to implementation evidence and the user's experience, without presuming that these institutions perform identical functions. [12]

Test: a repeat voluntary health-access exercise on avoided care, adjustment awareness, usable booking channels and care experiences.

A separate patient-safety follow-through concerns original Strategy action 2G. Its 2024 success measures had two stages: staff awareness that an ASC diagnosis must not by itself be used to justify a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decision, and review within nine months of records of patients with an ASC diagnosis to identify any

such DNACPR entries and take appropriate action. The 2025 annual report records endorsement of the principle, no known local cases at the time and preparation of a learning-bulletin message, but does not document whether the promised record review took place. The Strategy should therefore confirm, without publishing identifiable records, whether that review was completed, its coverage, the oversight used and any corrective action, or transparently explain its status. This is a request to verify the original commitment, not an allegation that an inappropriate DNACPR decision exists on the Island. [4][14]

24. Strengthen diagnostic quality, review and record safeguards

Diagnosis can be useful or necessary for specialised pathways and for some reserved roles, but it should not be treated as infallible. Services should support competent differential assessment, communicate uncertainty where it exists, allow appropriate second opinion or review, protect diagnostic privacy, and provide a workable route for a revised or superseding clinical conclusion to be reflected clearly in the record when an earlier diagnosis is later considered inaccurate. These safeguards address both failure to identify autism and mistaken identification without making ordinary accessibility dependent on diagnosis.

The April 2026 parliamentary debate identifies a further local quality-assurance issue: the Health Minister said the Department was examining whether privately obtained diagnoses could be recognised through agreed diagnostic and prescribing standards, potentially allowing safe shared-care arrangements. This was a proposal under examination, not proof that a shared-care scheme or automatic recognition was already in force. It is relevant to both mistaken positive diagnoses and people with a valid private assessment who may otherwise be excluded. The future policy should identify clinical competence, evidence requirements, review of doubtful assessments, privacy, challenge and correction processes, and fair access for those unable to pay privately. Recognition of an individual diagnostic assessment must remain distinct from generally accessible environments and ordinary reasonable adjustments. [76]

6.4 Learning, work, professional conduct and campaign delivery

06. Measure the effect of training, not only participation

Connect training to changes in practice: adjustments granted, complaints, avoidable incidents, communication quality, waiting experience and direct feedback from autistic service users.

Test: compare staff training with observed appointment, communication and adjustment outcomes reported by users.

Evaluate professional learning through scored decisions in realistic cases, not a recall test of diagnostic vocabulary alone. Cases should include (a) an accurate but unusually direct correction of an official error; (b) a visitor who avoids eye contact or flaps harmlessly; (c) an actual sensory complaint; and (d) distress following a contradictory, unjustified instruction. Require staff to distinguish the observable fact from inferred intent, check real safety concerns, select a proportionate change to the environment or procedure, and explain the available adjustment or assistance. Recheck performance in ordinary service encounters after training and record which errors persist. [44][82]

08. Measure educational outcomes beyond training counts

Track attendance, exclusions, participation, transitions, attainment where appropriate, student-reported accessibility, and whether adjustments are timely and effective.

Test: records of actual pupil adjustments, sustained learning options, transitions, exclusions and firsthand pupil experiences.

A separate independent education evidence stream was published on 1 July 2026. According to the Government summary, Etio, the external education validation provider, evaluated 14 schools and three education services through external validation visits undertaken between January and October 2025, identifying positive examples of inclusive practice and relationships alongside needs to improve curriculum planning, use of assessment evidence, adaptive teaching and leadership. These findings must not be erased by the 2026 parliamentary criticism of a particular inclusive-education impact assessment, nor treated as a direct audit of autism-specific adjustments. Recommendation 08 could link this existing quality-assurance process to anonymised, directly reported experiences and measurable access outcomes for autistic learners, distinguish service-wide observations from autism-specific results, and document how mixed or adverse findings prompt practical corrections. [72]

For education, a meaningful accessibility result is not merely that an autistic pupil appears quieter, makes more eye contact or joins more group activities. A school can examine whether the learner can understand the lesson, pursue interests, concentrate without unnecessary interruptions, report a sensory barrier, request a clearer explanation and participate in chosen activities without avoidable distress or exclusion. Where appropriate, assess actual educational engagement and work quality alongside voluntary pupil feedback, the adjustments supplied and any remaining medical or individual support needs. Chosen solitude must be distinguished from exclusion; genuine safeguarding and educational requirements still apply. [44][82]

09. Measure employment outcomes beyond awareness activity

Track accessible recruitment, adjustments, retention, return to work, remote/flexible options and the reasons people leave or abandon recruitment processes.

Test: accessible recruitment, retention, choice of working arrangements and reasons for non-take-up, with confidentiality safeguards.

A specific cross-check is warranted because the April 2026 poverty report describes employment initiatives focused on autistic adults without a learning disability. The public evaluation should clarify which employment initiatives are narrowly targeted, which remain open to other autistic people, whether alternative provision exists, and what outcomes the different groups report. This is a request for disaggregated evidence, not a finding that a class of residents has been denied services. [61]

Employment practice should use the distinction between a characteristic and an actual work limitation. At recruitment and appraisal, distinguish evidence of the task being performed from impressions based on small talk, eye contact, unusual movements or a preference for written instructions. Where relevant to the particular worker, offer a trial of fewer interruptions, predictable tasks, sensory control or asynchronous communication, and assess task quality, error detection, retention and the person's own experience before and

after. Record costs and adverse effects; do not assume every autistic worker has exceptional talents, or make productivity a condition for rights, acceptance or support. [44][87][88]

12. Use Autism Acceptance Month to disseminate tested accessibility practices

Use each campaign to communicate tested adjustments, implementation lessons and measured results from ordinary services and organisations. This makes Autism Acceptance Month a dissemination mechanism for practices that have already been tried, rather than relying mainly on generic awareness messages.

A practical campaign exercise should test the move beyond mere tolerance: a participant encounters harmless hand-flapping, atypical clothing, limited eye contact or chosen social distance. The accessible response is usually to continue the ordinary service interaction without adverse scrutiny, while remaining attentive to any request or real safety issue. The exercise should also test whether participants distinguish a voluntarily concealed difference from a genuinely accepting environment. [81]

For each proposed campaign message, publish the corresponding practice that a service will test during ordinary opening hours. A useful paired scenario is an employee who does not react negatively to harmless hand-flapping but does respond promptly when that same person asks for a written explanation or a quieter waiting arrangement. Record separately (i) unwarranted intervention or suspicion, (ii) successful completion of the person's original purpose, (iii) any adjustment requested and supplied, and (iv) whether participation required masking or disclosure. This operationalises acceptance as ordinary freedom plus responsive assistance, rather than indifference to the individual's needs. [81][82]

17. Train for non-defensive problem-solving when barriers are reported

When an autistic person reports that a procedure, environment or interaction is causing difficulty, staff should first seek to understand and reduce the barrier. Training should explicitly discourage defensive responses, premature judgments about attitude or intent, and escalation based on tone or appearance. The practical sequence should be: listen, clarify, identify the barrier, offer options, agree the next step, and record what worked when appropriate.

Use a two-track response when an impingement is reported: relieve the immediate difficulty where possible, then investigate and correct its source. An intense or upset response to noise may call for sensory relief; an upset response to an arbitrary refusal may require a factual explanation, review of the rule and correction of an error. The same outward reaction should not be used to assign the same cause automatically. Staff records should separate the person's exact words and observed conduct from assumptions about motive or danger, state who owns the correction, and include a short follow-up showing whether the barrier actually ceased. [44][82]

6.5 Complaints, justice and practical remedies

10. Make complaints, review and independent advocacy easy to navigate

Publish a simple map distinguishing the first complaint point, the Manx Care Advice and Liaison Service (MCALS), the Health and Social Care Ombudsman Body (HSCOB) and independent advocacy, with written/asynchronous access and clear escalation paths. [16]

The map should also show the separate equality-law route, not only health-service complaints. The Isle of Man Office of Fair Trading (OFT) explains that, for relevant Equality Act 2017 disputes involving goods and services, public functions, associations or premises, it can offer conciliation if the parties agree, while an eligible claim may proceed to the Employment and Equality Tribunal. Its guidance warns that the six-month period it describes for such proceedings is not suspended by conciliation. For employment disputes, the Manx Industrial Relations Service provides a distinct advice and conciliation route and also warns that discussions do not extend statutory Tribunal time limits. The applicable jurisdiction and deadline depend on the particular claim: neither the healthcare complaints procedure, MCALS, HSCOB nor an informal negotiation should be assumed to replace or pause separate legal rights. Public information should therefore specify the correct starting point, time-limit warnings, accessible written contact and where independent legal advice can be obtained. [16][64][65]

The statutory time limits require more precise differentiation. For claims within the non-work Tribunal subdivision, section 108(1) of the Equality Act 2017 provides an ordinary six-month period but permits such other period as the Tribunal considers just and equitable. That is a discretion, not an automatic extension, and the OFT expressly warns that its conciliation does not suspend the usual clock. Section 105(1)(c) includes education under Part 6 among the Tribunal's jurisdictions, while section 107 applies Schedule 18 to education cases; the OFT's published conciliation remit does not itself establish an education-conciliation service. By contrast, section 113(1) normally provides a three-month period for the work-discrimination complaints it covers, also with a just-and-equitable provision. Section 113(4) expressly refers equality-of-terms matters to a different set of provisions, and different statutory complaints may have different rules. Accessible public information should warn of these distinctions and encourage prompt, independent advice rather than suggesting that a single six-month deadline applies to all equality-related cases. [27][64][65]

A contemporary cross-jurisdictional risk also deserves an explicit warning. Great Britain's Employment Tribunal (Extension of Time Limits) Regulations 2026 (S.I. 2026/758) extended specified time limits from three to six months for relevant events on or after 1 October 2026 in England, Wales and Scotland. Those United Kingdom regulations do not, by themselves, amend the law of the Isle of Man. The Manx Equality Act 2017, section 113, remains the relevant statutory starting point for the work-discrimination complaints discussed here, subject to the applicable local law, procedural rules and individual circumstances. Public-facing guidance should mark its jurisdiction clearly and warn that a current Great Britain employment-tribunal deadline must not be copied into a Manx complaint without independent verification. [27][70][71]

The Tynwald Commissioner for Administration (Tynwald Ombudsman) is another distinct potential route for alleged maladministration or service failure by authorities within its statutory remit. Its published procedure generally requires a prior written objection to the relevant listed authority and addresses circumstances where the authority has completed reasonable internal steps or has not properly investigated and reported within 28 days (subject to the published exceptions). A complaint is ordinarily required within six months after notification of the listed authority's final decision, and additional limits concern jurisdiction, excluded matters and the complainant's connection to the Island. Written complaints and authorised representation are possible. This administrative scrutiny is not an

all-purpose appeal and should not be confused with an Equality Act Tribunal claim, independent legal advice, health-service complaints or their separate filing deadlines. The proposed complaint-route diagram should distinguish these alternatives and their practical written access requirements. [78]

The limits of this oversight are important for anyone seeking an effective remedy. The Tynwald Ombudsman investigates qualifying complaints and may make non-binding recommendations, but cannot order compensation or compel an authority to undertake remedial action. The Ombudsman cannot investigate general policy concerns “at large” without a qualifying complaint involving a person who experienced the relevant injustice or hardship. An Ombudsman complaint should not be assumed to stop any separate statutory time limit for an Equality Act Tribunal or other proceedings. The proposed accessible route map should therefore indicate which bodies can investigate, conciliate, recommend or grant an enforceable remedy, as well as their different eligibility and deadline rules. [78]

The Ombudsman guidance adds two practical gateways not explained above. Its complainant-eligibility rules distinguish a person resident on the Island when complaining from a person affected by an action while present there, subject to the published qualifications. Matters for which a statutory appeal or court remedy exists are generally excluded, but the Ombudsman can consider investigating where using that alternative would be unreasonable or inexpedient, including because of disproportionate costs or evidential difficulties. The route map should make these rules and exceptions visible before referring an individual to this form of administrative oversight. [78]

Deliverable: a single plain-language diagram of complaint and independent-advocacy routes, tested for written and asynchronous usability.

The practical test should include at least three scenarios: an adjustment request refused in a public-facing service, a concern about clinical care, and an employment-related discrimination complaint. A person should be able to identify the distinct authority or provider, the relevant route to independent review, any filing deadline, and a written or asynchronous way to act without being required to disclose more diagnostic information than the procedure actually needs. [64][65]

A fourth scenario should test a disputed adjustment or alleged discrimination in school, college or another education setting. The user should be able to distinguish the institution’s accessible complaint procedure, the specific education enforcement provisions referenced by section 107 and Schedule 18, the Tribunal route where applicable, and independent advice, without incorrectly assuming that OFT conciliation for goods and services covers the case. The test should examine whether written or asynchronous action is possible in time, including when a person cannot use the telephone. [27]

The accessible complaint pathway should also allow the complainant to document the original event without having to accept a prior label such as 'aggressive', 'non-compliant' or 'overreacting'. A usable form or written exchange can separate (a) the observable incident, (b) the institution's interpretation, (c) the potentially avoidable sensory, procedural or mental impingement, (d) the decision or restriction imposed, and (e) the correction requested and ultimately delivered. Reviewers should check these separately and record the accessible remedy, time spent and any repeat disputes. This evidence discipline supplements, but

never replaces, the independent legal deadlines and jurisdiction-specific routes already explained above. [44][27]

23. Develop end-to-end autism-accessible protocols for police, emergency and justice pathways

Phase 3 already includes work with the Criminal Justice Board to identify information, training and support needs, while the February 2026 public meetings recorded concern that eye contact, body language or other autistic presentation could be misinterpreted in police interactions. At police and emergency stages, protocols should distinguish irritation, overload or perceived aggression from actual dangerousness; allow additional processing time and clear communication; use written or alternative communication where appropriate; and record reasonable adjustments without assuming that atypical behaviour itself indicates threat. Actual safety risks should still be assessed and managed proportionately. [1][10]

Test: case-pathway review from first contact to remedy, with actual threats distinguished from perceived demeanour and escalation.

The Criminal Justice Board workstream could test a realistic sequence in which an autistic person's direct speech or visible agitation is read as dangerous. A case review should reconstruct the observable conduct, independently evidenced safety facts, any noise, delay, unexpected touching or contradictory instructions, the accessible opportunity to clarify, and the justification for every restrictive response. Test whether trained personnel offer time, an appropriate communication route and de-escalation while still acting promptly on genuine threats. Track avoidable escalation, adjustments made, documented reasons, onward legal access and opportunities to correct inaccurate records; do not infer either innocence or danger from autism alone. [44][82]

7. Phase-to-phase concordance: actions, continuity and evidence gaps

The original Strategy uses 41 codes in six goals (1A-1D, 2A-2K, 3A-3E, 4A-4E, 5A-5G and 6A-6I). Phase 3 identifies two main areas of focus: Health and Reasonable Adjustments. The published action tables comprise Health (Section 1) and, under Reasonable Adjustments, Employment (2a), Community based support (2b) and Whole-life impact (2c). For the longitudinal concordance below, this contribution labels the 18 published action entries H1-H5, E1-E5, C1-C2 and V1-V6 for navigation. These letter codes and our links to earlier Strategy commitments are analytical, not official Government action identifiers. A thematic link does not prove that a later action fully discharges an earlier commitment. [4][10][14][79]

7.1 All eighteen Phase 3 actions

Phase 3	Published direction and objective (analytical paraphrase)	Related 2024 codes*
H1	Establish an adult ASC/ADHD diagnosis service as part of the three-year plan for an all-age neurodivergent support-and-diagnosis pathway. DHSC; April 2027 target, with separate Treasury funding still to be	3A, 3B; 2C

Phase 3	Published direction and objective (analytical paraphrase)	Related 2024 codes*
	sought. Test actual opening, staff capacity, assessment criteria, referrals and post-diagnostic support.	
H2	Develop accessible Easy Read information explaining services, beginning with a guide for parents after a child's diagnosis. Manx Care; ongoing. Check access and usefulness for adults, people without diagnoses and other groups.	1C, 2B, 3A
H3	Scope the feasibility of annual health checks for autistic people. Manx Care; September 2027. A feasibility study is not an established health-check service; its assessment should consider accessibility, choice and actual follow-through.	2J, 3B
H4	Build local capacity to deliver Oliver McGowan Tier 2 training through accredited trainers, including participation of people with lived experience. DHSC; December 2026. Test accreditation, availability and effect on conduct.	2D, 4A
H5	Extend the availability of Oliver McGowan Tier 1 training, or other appropriate training, to primary-care staff (including GP, dental and optical practices) and other commissioned services. Manx Care; December 2027. Audit offer, participation and changes in practice separately.	2D, 4A
E1	Convene a cross-sector employment forum involving public bodies, employers, voluntary organisations and autistic people to identify employment barriers. DHSC; March 2027. Check decisions and practical changes after the forum.	6B, 6C
E2	Review support for disabled people, including autistic people, entering or returning to employment. DHSC; September 2027. Test eligibility, accessible support and outcomes in freely chosen work.	6B, 6G
E3	Work with stakeholders across Isle of Man Government to further improve the clarity, accessibility and inclusiveness of recruitment processes for all applicants. Office of Human Resources; March 2028.	6B, 6C, 4A

Phase 3	Published direction and objective (analytical paraphrase)	Related 2024 codes*
	Review forms, interviews, alternative communication and adjustment requests.	
E4	Provide public managers and employees with practical resources on autism at work. Office of Human Resources; December 2026. Test changes in working arrangements, not distribution alone.	4A, 4D
E5	Continue cooperation with the Chamber of Commerce to encourage autism-accessible workplaces and reasonable adjustments. Steering Group; December 2027. Examine changes in recruitment, adjustment and retention.	6B, 6C
C1	Commission the development and promotion of a suite of resources to help community groups, event organisers and activity providers make events and services autism-friendly and inclusive. DHSC; September 2027. Test whether the resources lead to actual environmental, communication and participation improvements.	4C, 6A
C2	Encourage accessible community clubs, groups and activities, with particular attention to autistic adolescents. DHSC; ongoing. Check voluntary participation, diversity of choices and provision for other ages.	6I
V1	Work with the Criminal Justice Board to identify gaps in autism-related knowledge, training, information, guidance or support, and develop proportionate actions where required. DHSC; March 2028. Identifying gaps and planning action must not be misrepresented as safeguards already implemented.	2F, 4A; new justice scope
V2	Review information held by government services about autistic residents, service demand and unmet need. DHSC; September 2027. Include data protection, people outside services and people without diagnoses.	2A, 2K
V3	Gather experiences and needs of families with autistic children receiving home education. Steering Group; September 2027. Record children's views when they wish and can contribute; do not prejudge home	5D, 5E, 5F

Phase 3	Published direction and objective (analytical paraphrase)	Related 2024 codes*
	education as the preferred solution.	
V4	Expand the Neuroinclusive Education Network (NEN) Programme in Schools to include a 'Transition in Schools' module, and initiate development of an Early Years NEN Package. Department of Education, Sport and Culture (DESC)-related; March 2028. Distinguish starting package development from delivering a completed early-years programme, and measure practical educational effects.	5B, 5C, 5F
V5	Extend the NEN Programme to other agencies working with children and young people accessing educational settings. DESC-related; March 2028. Test actual uptake and accessibility improvements rather than assuming the extension is complete.	5B, 4A
V6	Develop a tool enabling autistic people and others with additional support needs to communicate how they prefer to be supported and engaged with across transport, emergency services, utilities and other customer-facing services. Steering Group; September 2027. Evaluate voluntary use, privacy, practical accessibility and the right to receive adjustments without the tool.	1D, 4C

*Related codes are our thematic correspondences for audit, not an official replacement table. The exact deliverables, accountable bodies, dates and any financing are governed by the published Phase 3 Plan, not by these abbreviations. [10]

Section 6 (Expenditure) of the Phase 3 Plan estimates £41,172 for the eighteen-month plan but explicitly excludes the prospective adult ASC/ADHD assessment and support service, for which a separate Treasury business case was envisaged. The original £150,500 Strategy allocation and subsequent allocations/rephasing must not be added to the separate service estimate as if they were the same budget. This is a useful test of transparent commitment-versus-spend reporting. [10]

The expenditure table on page 13 of the official Plan reports less than 0.5% of the original allocated funds used in 2024-25 and less than 3% in 2025-26; the corresponding published projections are 59% for 2026-27 and 27% for 2027-28, with 11% estimated to remain unspent in 2027-28. These are figures as reported in the Plan, including forecasts, not independently audited expenditure by individual Phase 3 action. The Plan does not provide a cost breakdown for each of its 18 actions, and the separate adult diagnostic service is expressly excluded. A public financial reconciliation should distinguish forecasts from actual spending and explain the carried-forward balance. [10]

The phase timetable itself should be included in the public concordance. The October 2025 First Annual Report described the anticipated Phase 3 period as October 2026 to September 2027, whereas the plan actually published in October 2026 covers October 2026 to March 2028. This six-month extension is a documented change in the planning horizon; it is not, without further evidence, proof of delay, failure or irregularity. A useful public explanation would identify when the horizon changed, which milestones were rebaselined, any consultation or funding consequences and how residents should compare the two plans. [4][10][79]

The same October 2025 report costed Phase 2 delivery at GBP 84,000 and explicitly described that amount as part of the original GBP 150,500 Strategy allocation rather than new funding, with use approved across the 2025/26 and 2026/27 financial years. These figures describe a financial plan, not expenditure proven to have occurred. Alongside the later GBP 41,172 Phase 3 estimate and the separately proposed adult ASC/ADHD pathway, a reconciliation should distinguish the original allocation, sums approved or earmarked, actual payments, transfers, remaining balances and any new authorisations. Overlapping envelopes must not be summed as if each were independent additional investment. [4][10]

The April 2026 parliamentary debate described a proposed wider neurodivergent pathway with a headline multi-year estimate of GBP 2.8 million and a planned adult diagnostic first stage. This was a discussed proposal subject to financing, not evidence that GBP 2.8 million had been appropriated or spent. In its formal decision Tynwald required detailed costed proposals and anticipated outcomes by December 2026. Financial monitoring should therefore maintain at least three separate lines: the original ASC Strategy allocation and Phase 2 rephasing; the Phase 3 action-plan estimate of GBP 41,172 excluding the adult service; and the distinct, larger neurodivergent pathway business case, showing proposal, approval, expenditure, milestone and service availability at each stage. The public record should reconcile any differing descriptions of the business-case readiness in April and October 2026 without assuming they referred to identical stages or scopes. [4][10][75][76][77]

7.2 The 41 original commitments: preserve each line

Code	2025 documentary position / evidence needed	P3 link*
1A	Annual acceptance campaigns held in 2024 and 2025; effectiveness assessment envisaged. Verify lasting improvements in public knowledge, behaviour and barriers.	No direct match demonstrated
1B	Reasonable-adjustments information and communication pages updated; linked administratively with 1A. Actual use and effects of adjustments not proved by publication.	No direct match demonstrated
1C	ASC information website established; user feedback on usability envisaged. Check whether people can locate accurate, current, relevant support information.	H2

Code	2025 documentary position / evidence needed	P3 link*
1D	Health-sector passport development reported in 2025; Manx Care Health Passport launched in March 2026. Wider use across all public services remains to be demonstrated.	V6
2A	Consultation with partners and some new Manx Care information; linked with 3B. Check definitions, privacy and inclusion of people outside service databases.	V2
2B	Directory of public and private support services published; action reported complete. Check completeness, ease of use, accuracy and updating.	H2
2C	Service gaps identified and integrated into work on 3B; a separate completed support-service plan is not established from the cited description.	H1
2D	Oliver McGowan Tier 1 mandatory in Manx Care from spring 2025; 202 employees reported trained. Verify denominator, Tier 2 rollout and changes in service practice.	H4, H5
2E	Information about respite, centres and complex support published; action reported complete. Check real availability, comprehension and useful access.	No direct match demonstrated
2F	Independent advocacy needs examined and public commissioning planned. A 2026 procurement notice is identified; awarded contract, start date and use not confirmed.	V1
2G	Principle against DNACPR based solely on autism accepted; staff bulletin prepared. The original second step of reviewing patient records is not evidenced by the public summary.	No direct match demonstrated
2H	Contributions to mental health and wellbeing strategy sent; publication expected in 2026. Verify actual incorporation and final policy text.	No direct match demonstrated
2I	Suicide prevention awareness and community training reported, including work with barbers. Autism-specific reach and outcomes require separate evidence.	No direct match demonstrated
2J	Individualised care and alternative psychosocial,	H3

Code	2025 documentary position / evidence needed	P3 link*
	educational or other options affirmed; service shortages acknowledged. Test availability, consent and freedom from normalisation pressure.	
2K	Proposed autism data collection through the 2031 Census redirected following statistical and privacy concerns. Check whether alternative data exclude undiagnosed people.	V2
3A	Assessment pathway information published, action reported complete. Accurate explanation of limited adult provision is not the same as an accessible adult service.	H1, H2
3B	All-age assessment/support project paused and later revived through political commitments. Verify funded service, implementation, access and outcomes.	H1, H3
3C	Responsible services and pathway links for children in public care identified. Test continuity and practical access for the children concerned.	No direct match demonstrated
3D	CAMHS investment and reduced waiting-list figures reported. Verify cohort definitions, denominators, time periods, autism-specific outcomes and continued capacity.	No direct match demonstrated
3E	Standard operational procedures for transitions between mental-health services reported in use. Examine user experiences and problems avoided.	No direct match demonstrated
4A	Training made mandatory for Manx Care, while other public employees were offered access. Do not equate training availability with universal mandatory rollout.	H4, H5, E3, E4, V1, V5
4B	Sunflower scheme promoted at various locations; government-wide participation proposed for Phase 2. Check staff recognition and service response without forced disclosure.	No direct match demonstrated
4C	Accessibility initiatives in sport, heritage, entertainment, transport and housing noted. Audits alone do not establish completed changes or general accessibility.	C1, V6
4D	Staff-development plan related to broader People	E4

Code	2025 documentary position / evidence needed	P3 link*
	Strategy and existing administrative training. Check whether the original cross-service objective was implemented.	
4E	Central professional resource platform deferred, with interim information channels available. Do not mistake the missing platform for absence of all resources.	No direct match demonstrated
5A	ASC advice service reorganised, more consultation reported and additional staffing envisaged; action reported complete. Test actual capacity and response time.	No direct match demonstrated
5B	Autism Education Trust material and training adopted; about 250 staff in eleven schools reached in one training stream. Test educational adaptations and student outcomes.	V4, V5
5C	Childcare Inclusion Scheme introduced in September 2025. Verify actual access, eligibility and changes in declined or interrupted places.	V4
5D	Environmental audits in April 2025 and additional places in special provision centres reported. Check adjustments following audits and the choices available to learners.	V3
5E	Inclusive Education Policy and guidance published; parliamentary committee subsequently criticised consultation and equality impact assessment. Review responses and implementation.	V3
5F	Continuum of Learning and Inclusion review underway in 2025. Check publication, final version and implementation in schools.	V3, V4
5G	Digital additional-educational-needs record introduced, with modules in deployment. Test actual use, privacy and practical effect on individual pupils.	No direct match demonstrated
6A	Small practical-accessibility work included communication software licences and general accessibility support. Identify beneficiaries, services and effects.	C1

Code	2025 documentary position / evidence needed	P3 link*
6B	Employment subgroup with autistic representatives and work on flexible working/caring. Test employers' practical changes and workers' own outcomes.	E1, E2, E3, E5
6C	Some career and Job Centre training completed and other training scheduled; feedback mechanisms proposed. Retention and accessible employment outcomes not established by training counts.	E1, E3, E5
6D	Annual acceptance award not yet operating in 2025; recognition letters used pending further co-design. Do not count an annual award as delivered.	No direct match demonstrated
6E	Proposal to seek political support for Manx autism-specific legislation was expected to be delayed and revisited in Phase 3. Check the policy purpose and any legislative text.	No direct match demonstrated
6F	Carers Strategy 2024-2034 approved in June 2024; action reported complete. Test results for carers and the autistic people concerned.	No direct match demonstrated
6G	Skills Strategy finalised in March 2024, leaving the originally planned influence unachievable. Subsequent Skills Board commitments are a new opportunity, not retrospective completion.	E2
6H	Childcare Inclusion Scheme introduced in September 2025; quarterly monitoring announced. Check outcomes after its first operating year.	No direct match demonstrated
6I	Autistic Bright Minds weekly group for 18-25-year-olds reported. Assess continued access, choice and options for other ages.	C2

* A nearby Phase 3 action may develop, narrow, broaden or only touch on an earlier obligation. No equivalence, completion or abandonment is presumed. The 2025 descriptions are based on GD 2025/0069 and retain its timing; effects on residents remain a different question. [4][10]

7.3 Six cross-phase tests requiring an explicit government answer

1D / V6 – Passports

A Health Passport is available in healthcare. The original 1D referred to all public services; the later wider communication tool should be examined for coverage, voluntariness, privacy and continued access without special documentation.

3A–3B / H1 – Adults

The adult pathway should be assessed against actual opening, capacity, eligibility, waiting and support before diagnosis. A target of April 2027 is not proof of an open service.

2D–4A / H4–H5 – Training

Distinguish mandatory Tier 1 training in Manx Care, availability in other departments, Tier 2 development and changed staff conduct. Verify the share of staff actually trained and the outcomes in practice.

6B–6C / E1–E5 – Work

Employment forums and published guidance are inputs. Ask for actual accessible recruitment, adjustments, retention, freedom of choice and self-reported experience.

5A–5G / V3–V5 – Education

Link the education work to the original accessibility commitments and the parliamentary concerns about implementation and impact assessment; include pupils' own experiences and genuine alternatives.

Justice / V1 – Criminal Justice Board

A new explicit justice workstream should test the entire pathway from recognising a legal problem to advice, police contact, legal representation, court participation, decisions and remedies. Do not equate this workstream with existing guarantees that have already been delivered.

8. Evaluation instrument: decisions, indicators and practical tests

For each action or public-facing service, a usable monitoring entry should contain (a) policy promise, (b) responsible institution, (c) schedule and financing, (d) evidence of an implemented change, (e) availability, (f) use by relevant people, (g) obstacles and socially generated impingements removed or created, (h) direct user-reported effects, (i) unintended consequences, (j) next review and corrective decision. An unanswered question should be "not documented", not "successful" or "failed".

Level	What must be demonstrated
1. Commitment	An identifiable action, accountable owner, target and resource decision.
2. Delivery	The described activity, service or adjustment actually exists.
3. Availability	Intended users can reach and use it, including users without standard contact, disclosure or participation methods.
4. Experience	Direct, voluntary and appropriately categorised reports of what happened to users, including neutral/negative results.

Level	What must be demonstrated
5. Effect	Evidence that the targeted barrier or impingement diminished over time, with methodological limitations acknowledged.

For any indicator used to judge progress, define the measure before interpreting it: data source, numerator and denominator where relevant, baseline, target or threshold, accountable owner, review date and the decision that follows if the result is below expectation. This turns “monitoring” into a usable management mechanism rather than a list of numbers.

An action marked “completed” should therefore not automatically be treated as a social problem that has been solved. Likewise, a problem that remains open should not erase the value of intermediate progress.

The 2022 consultation provides a useful baseline of recurring concerns: resource availability, mental health, public understanding, professional understanding, social support, education, information and employment. [3] Long-term evaluation should retain a stable subset of these domains for comparability while still allowing new issues to emerge.

For each stable 2022 domain, a longitudinal dashboard should report whether the evidence indicates progress demonstrated, partial response, commitment in progress or problem not closed. These categories should guide investigation, not replace the underlying evidence or the underlying domain-specific indicators.

Where sample sizes are small, suppress or combine breakdowns that could identify individuals, but still publish aggregate findings, anonymised qualitative themes and the method used to decide what was withheld. This protects confidentiality without making the evidence trail disappear.

Low complaint numbers should not be interpreted automatically as evidence of good accessibility. People may abandon a process, miss an appointment, stop applying for a service, avoid a venue or decide that complaining is too difficult. Evaluation should therefore look for non-take-up, drop-out, repeated missed contact, abandoned applications and other signs of inaccessible processes, while protecting confidentiality.

Diagnosis counts, training counts and numbers of people contacting a service should not be used as proxies for accessibility. Evaluation should keep separate: identification or diagnosis; access to specialised support; accessibility of ordinary systems; socially generated impingements; and lived outcomes. A rise in diagnoses may reflect better recognition, changed thresholds or increased demand, while an accessible environment can benefit people who are not diagnosed or who do not disclose autism.

For Autism Acceptance Month itself, reporting should likewise distinguish at least five levels: campaign exposure; message recall; accuracy of understanding; intended or reported behavioural change; and actual environmental or procedural change. A campaign may perform well at one level and poorly at another, and combining them into a single “impact” measure would hide that difference.

When survey results are published, provide the denominator for each question, the number of missing or not-applicable responses, and the treatment of multiple-response questions.

Where confidentiality permits, publish role-specific results so that direct autistic experience is not statistically absorbed into larger mixed groups. If categories overlap because respondents selected several roles, state this explicitly rather than presenting the groups as mutually exclusive. [13]

For major Strategy reviews, consider an independent or externally peer-reviewed evaluation of the evidence chain from commitment to lived result. This need not replace local governance; it can provide an additional check on whether indicators actually measure accessibility and quality of life rather than administrative activity alone.

A practical demonstrator should not select only people who already use the service or attend an autism meeting. Try to understand failures before first contact, refusal to disclose, repeated abandoned applications, sensory reasons for non-attendance and missed opportunities that never became formal complaints. Aggregate reports to prevent reidentification within a small island population.

An additional early-action test for the 2027 campaign: compare the way the same service handles a request before and after a staff training or simple environmental modification. Record response time, number of steps, need for disclosure, available choices, response tone and user outcome. Where matched groups or comparison periods are not available, report the change as observed association rather than causal proof.

For each proposed demonstrator, audit or campaign indicator, a reviewer should be able to follow a complete operational chain: autistic characteristic or expressed need; observable difficulty; possible cause (including socio-generated sensory, mental or other impingements); any clinical or individual-support need considered separately; systemic correction and supplementary assistance chosen; responsible organisation; and the resulting access, freedom, wellbeing or unresolved problem. The same chain prevents an intervention directed only at making people LOOK less autistic from being mistaken for an improvement in their lives. Where causal evidence is incomplete, document the competing explanations and how they could be tested, rather than forcing a single cause. [44][82]

To make shared benefits measurable without creating unsupported promises, the pilot record should keep distinct indicators for (a) accessibility and completed activity, (b) voluntary user-reported suffering or distress, (c) unnecessary staff and user time, repeat contacts and complaints, (d) environmental settings and energy consumption where relevant, and (e) task quality, learning or employment outcomes where appropriate. Record the baseline and change, adjustment costs, population and limitations; check whether apparently better numbers result from people avoiding the service. Changes in suicidality cannot safely be inferred from a small short-term pilot or reduced complaint counts. Any long-term health evaluation requires appropriate expertise, privacy protection and mental-health care. [82][86][87]

9. Consultation design and substantive participation

The 2022 National Autism Strategy consultation openly supported response online, by email, by post and through in-person sessions. A 2025 Manx Care consultation offered several written and discussion options. The announcement for the October-November 2026 survey points mainly to Microsoft Forms without itself setting out all alternatives. This does not

demonstrate that alternatives were impossible; it establishes a specific publication/design question for future surveys. [17][22][28]

The questionnaire's first questions concern awareness and campaign contact; later questions include wider perceptions of services and the Strategy. These dimensions should not be merged in one measure of impact. Reports should disclose when multiple roles were selected, when personal lived experience was supplied indirectly, how "no experience" answers were handled, and whether any comparison to 2022 uses genuinely equivalent questions and groups. [3][13]

Consultation design should provide the choice of written communication, a freely structured text contribution and an opportunity to state "I cannot judge". Meeting participation should never be the only way to influence a decision. A credible response process should publish "you said / we checked / we decided / we did / we measured", including reasons for deferral where publication is appropriate and lawful.

To protect the legitimacy of reserved seats held by autistic representatives, eligibility can be assessed proportionately and in a privacy-preserving manner. Participation in open consultation, however, is a different issue; a public body should not extrapolate eligibility rules for a reserved seat to all people who may experience barriers or have evidence to offer. Neither diagnosis nor self-description alone is a complete solution to representation, and neither guarantees that a person speaks for every autistic profile.

The Autistan national-plan model also calls for attention to relevant conflicts or convergences of interest when service providers, representative bodies, consultants and other organisations help shape or evaluate a policy. For the Isle of Man, a proportionate transparency test would identify the role of each participating body, relevant interests in funded services or procurement, how any specific decision is handled when such an interest arises, and how direct autistic opinions, including dissenting ones, are recorded separately. This is a preventive governance recommendation, not an allegation of an improper conflict by any named organisation or a reason to exclude useful specialist expertise. [46]

10. Conclusion and requested consideration

The public record supports recognition of sustained government, local community and Manx Care activity, together with specific practices worth reinforcing. It does not support a single definitive judgment that the ten-year Strategy has succeeded or failed for all autistic Islanders. The next stage should make the evidence chain visible and test what actually changed in everyday conditions. [4][5][10]

For the 2027 campaign, the most useful shift would be from messages that merely praise acceptance to examples of properly understood autism and barriers that organisations have demonstrably removed. For the Strategy, the most important shift would be to link the 2022 concerns and original 41 commitments to documented implementation, access and the lived consequences of Phase 3 work, including areas where outcomes remain unknown.

The Autistan Diplomatic Organization offers complementary information, analysis, ideas and possible solutions for autism policy, with an emphasis on accessible society-wide conditions for autistic individuals with disabilities, while recognising the legitimate role of personalised assistance and appropriate medical care. These observations are intended to

support the Island's own decision-makers and autistic residents rather than to substitute for them.

The international and Autistan material examined here also suggests a concrete test for the meaning of acceptance. By the next campaign cycle, can an autistic person obtain an essential service without pretending to be non-autistic, without being made responsible for unvoiced suspicions, and without being excluded for declining optional sociability? Can an institution identify and correct a real procedural defect revealed by an autistic complaint? These questions are not substitutes for local evidence; they are proposed tests that can be asked of the Island's existing strategy, campaign and Phase 3 measures. [35][36][39][41][44]

For consideration in Phase 3, these proposals apply the Principles of Autistan as an investigation and improvement method: distinguish autistic nature from actual difficulties, trace avoidable socio-generated sensory, mental and other impingements, correct unjustified systemic barriers before requiring individual conformity, and preserve specialist assistance, clinical care and personal choice whenever needed. The practical result sought is a more accessible ordinary society, not an autistic population trained to appear less autistic. The Island can test these propositions against its own evidence, recognise what already works, and report precisely where outcomes remain unknown. [44][46][82]

Annex A. Practical acceptance and accessibility field checks

The following checks translate Autistan's comparative framework and descending pyramid into observations that the Island may adapt for its 2027 campaign or Phase 3 pilots. They are illustrative instruments, not claims about the existing content of the 2026 questionnaire. Any collection of personal evidence must remain voluntary, accessible, proportionate and confidential, with safeguards against turning observation into surveillance of autistic people. [81][82][83]

B1. Harmless visible difference should not create a service problem

Scenario: an adult enters a shop, reception area or civic event while rocking, flapping their hands, wearing unusual clothing or avoiding eye contact. First record whether the conduct actually creates a material safety risk or impairs another person's rights; do not infer one from unfamiliarity. Test whether staff can handle the ordinary request without ridicule, a compulsory explanation, admonishment or a demand to stop harmless movement. The indicator is successful access without enforced conformity, with the person's voluntary account of the experience.

B2. A person's request must not disappear behind polite non-attention

Scenario: a person asks for written contact, clarification, a different waiting arrangement or help correcting a misunderstanding. The same staff who properly refrain from commenting on harmless differences must notice and address this request. Observe whether the request reaches someone empowered to respond, how the reasons and alternatives are communicated, whether the problem is actually resolved and whether the person needs to

repeat the explanation multiple times. 'Ignoring' a harmless characteristic and ignoring a person are opposite outcomes.

B3. Apparent calm, concealment and withdrawal are not proofs of success

Scenario: reported incidents or requests fall after an awareness initiative. Investigate whether barriers were removed, or whether people masked more, avoided the venue, refrained from disclosing, changed providers or stopped asking for help. Use anonymous, voluntary methods to collect abandoned attempts, perceived safety to disclose, remaining sources of strain and willingness to return. A numerical decrease alone cannot establish the direction of change; an increase in reports may reflect improved trust. [81]

B4. A public-service error must be correctable without punishment

Scenario: an official records a direct question or unusual tone as aggression, or attributes a hostile intention that the available evidence does not establish. Distinguish directly observed words and acts, the interpretation given, alternative explanations, actual risk and the consequences of the label. Test whether the person can provide a written correction, obtain a response addressing the disputed facts, and have any consequential record or decision reviewed. The institution's responsibility to examine its own inference cannot be discharged solely by asking the person to speak more conventionally.

B5. Autism-friendly commitments must work during ordinary life

Scenario: an organisation advertises quiet sessions, staff training, a passport, badge, certification or special accommodation. Visit or audit routine processes as well as the advertised activity: opening hours, bookings, identification requirements, access to quiet options when needed, staff understanding, communication choices and complaint routes. Record the number of actual opportunities and unsuccessful attempts rather than assuming that an award, training count or event attendance measures accessibility. Compare results across service types without inventing a universal score. [83]

B6. Score the five complementary levels separately

For each pilot, distinguish the systemic baseline; subsidiary individual adjustments; accessible specialist assistance for the person and relevant interlocutors; freely chosen learning and experiences; and continuing personalised support. Ask who is responsible for each layer, whether it is available in practice, what remains blocked and what the person actually chooses. A successful result need not mean maximal independence from other people: the desired outcome is more real freedom and access with whatever assistance the person needs. [82][46]

B7. Test adaptation duties with real constraints rather than slogans

When staff and an autistic user disagree, reconstruct the circumstances and identify the practical changes available. Record evidence of actual harm, causal responsibility, costs to each party, proportionate alternatives, applicable law and the difference between prudent short-term coping and a justified permanent rule. Do not treat the non-autistic convention as

automatically correct because it is widespread, or any autistic preference as automatically decisive without checking factual impacts on others. [81]

B8. Evaluate chosen social distance and ordinary opportunities together

The audit should protect both the option to decline eye contact, small talk, group attendance or social disclosure and the option to access employment, education, culture, health care, relationships and chosen activities. Count barriers removed and genuinely usable opportunities; do not make compulsory sociability a condition of belonging. Ask whether a person who wishes to be left alone can still obtain the same service, and whether a person who wishes to participate can enter without unnecessary exclusion or infantilisation.

For reporting, keep at least four distinct evidence fields: the institutional measure promised, its verified availability, the participant's voluntary and properly attributed account, and any longer-term change in ordinary access or freedom. Uncertainty, non-response and conflicting experiences should remain visible; a successful demonstration in one setting is not a population-wide impact estimate.

References and provenance

References distinguish Isle of Man government and legal sources, international comparative material, scientific publications and the Autistan Diplomatic Organization's own texts. Planned activities, reported delivery and demonstrated outcomes are treated as different forms of evidence; the reference details identify unpublished material where relevant.

[1] Isle of Man Government, Summary of public meetings held February 2026. Government source

[2] Isle of Man Government, Summary of six-monthly Autism in Mann meeting held April 2026. Government source

[3] Isle of Man Government, DHSC National Autism Strategy Consultation: Results (2022). Government source

[4] Tynwald, Autism Spectrum Condition Strategy 2024–2034 — First Annual Report and Phase 2 Action Plan, GD 2025/0069. Government source

[5] Isle of Man Government / Manx Care, Manx Care launches new Health Passport to enhance personalised and accessible care, 2 March 2026. Government source

[6] Isle of Man Government, Autism Spectrum Condition assessment and diagnosis pathway — September 2025. Government source

[7] Tynwald, Social Affairs Policy Review Committee Annual Report 2024–25, PP 2026/0010. Government source

[8] Isle of Man Government, Autism in Mann Strategy Feedback Session, April 2025. Government source

[9] Isle of Man Government, National ASC Strategy 2024–2034 page and downloadable documents. Government source

[10] Isle of Man Government, Phase 3 Action Plan: October 2026 – March 2028. Government source

[11] Isle of Man Government, Third phase of work to make island more autism friendly begins, 1 October 2026. Government source

[12] Isle of Man Government, Department of Health and Social Care, Mandate Framework. Government source

[13] Isle of Man Government / Microsoft Forms, Autism Acceptance and Strategy Impact Survey (2026). Government source

[14] Isle of Man Government, An ASC-Friendly Island: A national strategy for Autism Spectrum Condition 2024 to 2034. Government source

[15] Isle of Man Government, ASC Steering Group Terms of Reference, effective 18 December 2024. Government source

[16] Isle of Man Government / Manx Care, Manx Care introduces changes to complaints process for contracted services from 1 July 2026, 30 June 2026. Government source

[17] Isle of Man Government, Citizen Space, National Autism Strategy consultation (2022). Government source

[18] Isle of Man Government, Aim to be a more Autism Spectrum Condition (ASC) friendly Island, 5 March 2024. Government source

[19] Isle of Man Government, Report highlights impact of Autism Spectrum Condition Strategy, 25 September 2025. Government source

[20] Isle of Man Government, Types of discrimination (prohibited behaviours) — failure to make reasonable adjustments and anticipatory duty for service providers. Government source

[21] Isle of Man Government, Examples of discrimination by sector — examples of anticipatory adjustment, including alternatives to telephone-only procedures. Government source

[22] Isle of Man Government, Island residents invited to share views on Autism Acceptance work, 22 October 2026. Government source

[23] Isle of Man Government, Autism Acceptance Month encourages businesses to introduce quiet hours, 24 April 2026. Government source

[24] Isle of Man Government, Help shape the future of autism support on the Island — recruitment of autistic adults as ASC Strategy Steering Group lay members, 27 July 2026. Government source

[25] Isle of Man Government, Reasonable Adjustments — Manx Care guidance on needs-based adjustments and diagnosis. Government source

[26] Isle of Man Government / Manx Care, Improving Healthcare Access for the Learning Disability and Neurodivergent Community, 19 November 2025. Government source

[27] Isle of Man, Equality Act 2017, sections 21, 22 and 31(7); Schedule 2 — official legislation database. Government source

[28] Isle of Man Government / Manx Care, Citizen Space, Access to good healthcare for our Learning Disability and Neurodivergent population (2025 consultation). Government source

[29] World Health Organization, Autism, fact sheet, 17 September 2025. Comparative medical and public-health context. Government source

[30] Autistan Diplomatic Organization, Fundamental Distinction and autism as natural human variation: conceptual clarification in its C20 Brazil 2024 Working Group 6 contribution, section F. Autistan text

[31] Autistan Diplomatic Organization, Extensive Review of the National Autism Strategy Project of Australia (2024). Earlier policy proposals and analysis. Autistan text

[32] Autistan Diplomatic Organization, Autistan 2024 Review Revisited: national-strategy proposals and their attribution (September 2026). Autistan text

[33] UN Committee on the Rights of Persons with Disabilities, General Comment No. 6 (2018), equality and non-discrimination; comparative guidance, not assumed local statute. UN source

[34] UN Committee on the Rights of Persons with Disabilities, General Comment No. 7 (2018), participation through representative organisations; comparative guidance. UN source

[35] Public Health Agency of Canada, Framework for Autism in Canada (26 September 2024), including glossary definitions of awareness and acceptance. Government source

[36] Ireland, National Disability Authority, A synthesis of existing data on current attitudes towards autistic people in Ireland (2025). Government source

[37] Ireland, National Disability Authority, About the Autism Innovation Strategy (2024-2026). Government source

[38] Department of Health and Social Care (England), National Strategy for Autistic Children, Young People and Adults 2021 to 2026, section 3. Government source

[39] Keating and colleagues (2024), Cross-cultural variation in experiences of acceptance, camouflaging and mental health difficulties in autism: A registered report, PLOS ONE 19(3):e0299824. Observational study, N=306 in eight countries. Journal article

[40] Khudiakova, Russell, Sowden-Carvalho and Surtees (2024), A systematic review and meta-analysis of mental health outcomes associated with camouflaging in autistic people, Research in Autism Spectrum Disorders 118:102492. Journal article

[41] National Autistic Society (UK), Autism Awareness Campaign Survey, research report on 2024 respondents (4,231 autistic people; 4,007 supporting people). Non-probability sample. Survey report

[42] Sasson and colleagues (2017), Neurotypical peers are less willing to interact with those with autism based on thin-slice judgments, Scientific Reports 7:40700. Journal article

[43] Davies and colleagues (2024), Autistic identity: a systematic review of quantitative research, Autism Research 17(5):874-897. Journal article

[44] Autistan Diplomatic Organization (10 November 2023), Necessity of the Fundamental Distinction between Autism and Autism Spectrum Disorders (83 pages), explanatory document associated with the 2023 dialogue with a WHO specialist; the organisation provides the document and meeting transcript on its dedicated page (Autistan policy analysis, not an official WHO position). Autistan text

[45] Autistan Diplomatic Organization (6 May 2024), Key Points, Recommendations and Clarifications about Education, Autism, Disability and Human Naturalness (C20 Brazil 2024, Working Group 6). Autistan text

[46] Autistan Diplomatic Organization (12 May 2026), Model Structure for a National Autism Plan, V3.2, sections A1–A4 and A2.2 (original French organisational working source; publication status not asserted).

[47] Crompton CJ and colleagues (2020), "Autistic peer-to-peer information transfer is highly effective," Autism 24(7); original story-chain experiment, N=72. Journal article

[48] Crompton CJ and colleagues (2025), "Information transfer within and between autistic and non-autistic people," Nature Human Behaviour 9:1488–1500; preregistered replication and extension, N=311. Journal article

[49] Livingston LA, Hargitai LD, Shah P (2025), "The double empathy problem: A derivation chain analysis and cautionary note," Psychological Review 132(3):744–757. Journal article

[50] Kilgallon E and colleagues (23 June 2026), "What the Double Empathy Problem Is (and Is Not)," Autism in Adulthood; conceptual and methodological account. Journal article

[51] Fellowes S (2026), "Cognitive Empathy, Affective Empathy and Empirical Research on the Double Empathy Problem: A Critical Methodology Review," Journal of Autism and Developmental Disorders (online 8 May 2026). Journal article

[52] Sutherland HEA, Crompton CJ, Long J, Fletcher-Watson S (2025), "'Read My Lips, Not My Body': A Thematic Analysis of Autistic People's Social Communication Preferences, Experiences, and Expectations," Neurodiversity 3; doi:10.1177/27546330251333919 (qualitative study, eight autistic adults). Journal article

[53] Dalmo MOV (21 April 2026), "How support systems interpret and reinforce autistic masking: introducing the concept of visibility logic," Disability & Society 41(7):1910–1933; nine interviews. Journal article

[54] Australian Government, National Autism Strategy 2025–2031: First Year Implementation Update 2025, publication page dated 6 October 2026. Government publication

[55] Australian Government, National Autism Strategy 2025–2031, programme and implementation page; progress language on actions "commenced," accessed 1 November 2026. Government programme page

[56] Kim SY, Song D-Y, Bottema-Beutel K, Gillespie-Lynch K (2024), "Time to level up: A systematic review of interventions aiming to reduce stigma toward autistic people," Autism 28(4):798–815. Twenty-six studies; high risks of bias and limited behavioural outcomes. Journal record

[57] Kim SY, Kim S-Y, Ji H, Yoon W-H, Gillespie-Lynch K (2026), "Can a Culturally Adapted Autism Training Reduce Stigma Towards Autistic People in South Korea?", Journal of Autism and Developmental Disorders 56:1966–1979, Epub 2024. Randomised online training study, N=208 university students. Journal record

[58] Baiden KMP, Williams ZJ, Schuck RK, Dwyer P, Wang M (2025, published online 2024), "The Social Validity of Behavioral Interventions: Seeking Input from Autistic Adults," Journal of Autism and Developmental Disorders 55:1172–1186. Self-selected online survey, N=235. Journal publication

[59] Han E and colleagues (2024), "'Who, When, How to Share': Pilot study of a new disclosure decision-making programme for autistic adults," Autism 28(8). Pilot N=32 enrolled; N=19 completing follow-up. Journal record

[60] Cooper M, Tuschick E, Giles EL, Hodgson J, Stubbs E, Barker J (2026), "Barriers and facilitators to healthcare access for adults with learning disabilities and autistic adults in England: A scoping review and meta-aggregation," Journal of Intellectual Disabilities. Fifteen English qualitative studies, not Isle of Man outcomes. Journal record

[61] Isle of Man Council of Ministers (April 2026), Annual Report on Poverty Measures, GD 2026/0021, page 17. Phase 2 ASC employment priority for adults without a learning disability, not an exhaustive eligibility determination. Government report

[62] United Nations Treaty Collection, Convention on the Rights of Persons with Disabilities (2006), status and depositary territorial notifications, inspected 2 November 2026: the United Kingdom extension to Bermuda is recorded; no Isle of Man extension is listed. UN treaty record. UN depositary record

[63] Commonwealth Parliamentary Association, British Islands and Mediterranean Region, Isle of Man General Election September 2021: Election Observation Mission Final Report, legal framework, printed page 5. Independent election observation, not a 2026 legal opinion. CPA observation report

[64] Isle of Man Office of Fair Trading, Equality Act 2017 — Goods and Services: conciliation, Tribunal jurisdiction and time-limit warning (government guidance). Government — conciliation and limitation

[65] Manx Industrial Relations Service, The Employment and Equality Tribunal: employment conciliation and statutory time-limit guidance. MIRS — Tribunal and time limits

[66] Isle of Man Government / Manx Care, MCALS to open a public counter and quiet room service on 1 July 2024, news dated 26 June 2024. Government — MCALS quiet room

[67] Tynwald, Equality Act 2017 (Appointed Day) (No. 5) Order 2018, SD 2018/0329, articles 4 and 6 and Schedule 1 (commencement of disability and adjustment provisions on 1 January 2020). Tynwald — commencement order

[68] Isle of Man Government, Equality Act 2017: overview, protected characteristics and links to statutory guidance. Government — Equality Act overview

[69] Isle of Man Treasury, National Insurance Reform Proposals (18 July 2022), Appendix: Equality Impact Assessment (EQIA), especially guidance end-notes on proportionate screening, timely consultation, records and commissioned services. Evidence of a government method in 2022; not a claim of consistent practice in 2026. Manx Government — 2022 EQIA guidance

[70] Great Britain, Employment Tribunal (Extension of Time Limits) (Miscellaneous Amendments and Transitional Provisions) Regulations 2026, S.I. 2026/758 (coming into force 1 October 2026). Comparative legal warning, not Isle of Man legislation. United Kingdom — GB-only regulation

[71] Isle of Man Attorney General's Chambers, Equality Act 2017, official online compiled text (consulted 2 November 2026), especially sections 108, 113 and 143; the current applicable text, commencement and any further amendments must be checked for each claim. Isle of Man legislation — compiled text

[72] Isle of Man Government, Etio's second annual overview charts continued progress in educational settings, 1 July 2026 (summary of independent external validation visits to 14 schools and three services in 2025). Government - education review

[73] Isle of Man Today (Sadie Gilbert), I feel stuck: Adults paying hundreds to fund their own ADHD and autism diagnosis, 8 May 2026; interviews with local individuals and Isle of Neurodiversity representatives, with a reported Manx Care statement. Local interviews - attributed testimony

[74] Isle of Man Government, Public meeting to provide update on Autism Spectrum Condition Strategy, 23 April 2026; written questions and comments to Autism in Mann invited ahead of the 28 April meeting. Government - meeting participation

[75] Tynwald, Votes and Proceedings, 21-22 April 2026, PP 2026/0073, item 5: An All-Age Neurodivergent Support and Diagnosis Pathway; adopted amendment calling for detailed costed proposals by December 2026. Tynwald - adopted motion

[76] Tynwald Court, Official Report (Hansard), 21 April 2026, debate on An All-Age Neurodivergent Support and Diagnosis Pathway, especially pp. 90-101. Official parliamentary record; statements are attributed to the speakers. Tynwald - Official Report

[77] Manx Radio, Government actively working on ADHD and ASC pathway, 7 October 2026; reporting of then-current DHSC business-case work and an intended April 2027 start. Manx Radio - October status

[78] Tynwald Commissioner for Administration (Tynwald Ombudsman), official complaints guidance and checklist: listed authorities, prior written complaint, 28-day provisions, six-month time limit, jurisdictional exclusions and written representation. Government / parliamentary source. Tynwald — Ombudsman procedure

[79] Isle of Man Government, Third phase of work to make island more autism friendly begins, 1 October 2026: official ASC Strategy team contact for requests for alternative accessible formats of the Phase 3 Action Plan. This is not a formal opening of the 2026 resident survey to institutional email submissions. Government — Phase 3 announcement

[80] Tynwald, Attorney General’s written answer to Question W-202501-1436, published 18 February 2025, concerning section 143 of the Equality Act 2017: due regard is context-specific and proportionate; the duty does not dictate a particular outcome. Official parliamentary answer. Tynwald — legal interpretation Official source

[81] Autistan Diplomatic Organization (17 August 2026), Approche de l'accessibilité autistique à travers des comparaisons avec d'autres particularités et situations humaines (French-language comparative policy study, organisational working document; especially sections 1.1–1.9).

[82] Autistan Diplomatic Organization (18–23 October 2026), Autismologie — Étude de référence sur l'accessibilité autistique, V05 and cumulative corrected supplements (French-language research manuscripts; especially section 33 on adaptation and section 34 on the descending pyramid and corrected base label).

[83] Autistan Diplomatic Organization (19 October 2026), L'accessibilité en matière d'autisme — Inventaire international multilingue: programmes 'autism-friendly' et mesures concrètes (French-language preliminary comparative inventory, V0.1; a research catalogue, not independent proof of programme outcomes).

[84] Autistan Diplomatic Organization (17 October 2026), Análise aprofundada da reunião com Alessandra Eloi, V39 (Portuguese-language study containing an earlier original rendering of the Pirâmide da Liberdade Autista, used here only as an attributed conceptual illustration).

[85] Autistan Diplomatic Organization (30 August 2026), Estudo completo do PL 3080/2020 — Autistão (Portuguese-language detailed legislative analysis; especially discussion of environmental stimuli and the risks of coercive normalisation of harmless sensory preferences). Working comparative document, not Brazilian enacted law or a Manx legal authority.

[86] Tubío-Fungueiriño M et al. (2026), A Systematic Review of the Risk and Protective Factors for Suicide in Autism Spectrum Disorder, The Spanish Journal of Psychology 29:e30 (19 included studies; associations with mental-health conditions, bullying and other factors; limited evidence on protective factors, not an evaluation of the Isle of Man proposals).Source

[87] UK Department for Work and Pensions (2024), The Buckland Review of Autism Employment: Report and Recommendations (evidence that many workplace adjustments may be free or low-cost; UK context, not a Manx cost-benefit evaluation).Source

[88] Petty S, Tunstall L, Richardson H and Eccles N (2023), Workplace Adjustments for Autistic Employees: What is 'Reasonable'?, Journal of Autism and Developmental Disorders 53:236–244, doi:10.1007/s10803-021-05413-x (UK questionnaire of 98 employers and employees; context and sample limitations).Source

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