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Welcoming Practices in Primary Health Care: Mental Health Strategies for Adults with ADHD and Autism

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Abstract

This essay examines strategies for providing welcoming, inclusive, and person-centered mental health care to adults with attention-deficit/hyperactivity disorder (ADHD) and autism in primary health care settings. It is based on the recognition that communication-related, sensory, organizational, and professional barriers may compromise access to health care, continuity of care, and meaningful participation in clinical decision-making. A theoretical-reflective approach is adopted, drawing on scientific literature and institutional documents and organized around key themes, including accessibility, clinical assessment, co-occurring conditions, care coordination, and human rights. The discussion highlights the importance of attentive and responsive listening, clear and accessible language, appropriate environmental accommodations, context-sensitive assessment of psychological distress, and timely and responsible referral to specialized services when necessary. It argues that a diagnostic label should not replace an individualized understanding of each person's experiences, needs, preferences, and circumstances, nor should it justify paternalistic, discriminatory, or

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stigmatizing practices. Primary health care can play a central coordinating role in connecting general health care, mental health services, specialized care, and community-based resources, provided that adequately trained professionals, accessible care pathways, and effective coordination mechanisms are available. The essay also emphasizes the importance of involving neurodivergent people in the planning, implementation, and evaluation of health services, recognizing their autonomy, respecting their individual preferences, and acknowledging the diversity of their support needs. It concludes that equitable and welcoming care depends on the integration of clinical competence, inclusive communication, continuity of care, and a sustained institutional commitment to human rights. The recommendations presented are theoretical and interpretive in nature and require empirical evaluation across different primary health care contexts to assess their applicability and effectiveness. Implementation should take into account available resources and individual preferences.

Keywords: Primary Health Care; Mental Health; Autism Spectrum Disorder; Attention-Deficit/Hyperactivity Disorder; Welcoming Practices.

1 INTRODUCTION

Primary health care represents a strategic entry point into the health care system for adults with attention-deficit/hyperactivity disorder (ADHD) and autism spectrum disorder (ASD). Although both conditions are frequently associated with childhood, they extend across diverse life trajectories and may require ongoing support throughout adulthood. The need for health care is not limited to diagnostic confirmation; it also encompasses psychological distress, functional difficulties, co-occurring medical conditions, and barriers arising from interactions with health services (LORD et al., 2020; THAPAR; COOPER, 2016).

Welcoming care should be understood as an ethical and organizational practice rather than a mere administrative screening procedure. Attentive listening, recognition of individual needs, and collaboratively agreed referral pathways can foster therapeutic relationships and longitudinal continuity of care. For neurodivergent people, conventional communication practices and health care environments may constitute significant barriers, particularly when professionals interpret communication differences as a lack of cooperation (NICOLAIDIS et al., 2015; RAYMAKER et al., 2017).

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The co-occurrence of anxiety, depression, and other mental health conditions reinforces the importance of comprehensive assessment. Review studies have reported substantial prevalence rates of psychiatric comorbidities among autistic adults and people with ADHD, although these findings do not justify assuming that every neurodivergent person experiences psychopathology. Distinguishing neurodevelopmental characteristics from psychological distress associated with social barriers and from co-occurring disorders is essential (HOLLINGDALE et al., 2020; LAI et al., 2019).

In this context, this essay discusses strategies for welcoming and providing mental health care to adults with ADHD and autism in primary health care settings. It argues that comprehensive care depends on the integration of communication accessibility, clinical competence, shared decision-making, coordination across services, and efforts to combat stigma. These measures should avoid both neglecting support needs and indiscriminately medicalizing human differences (KAPP et al., 2013; WORLD HEALTH ORGANIZATION, 2022).

2 METHODOLOGY

This is a theoretical-reflective essay with a narrative and argumentative approach, grounded in scientific publications and technical and institutional documents addressing ADHD, autism, mental health, primary health care, and health care accessibility. The selection of sources prioritized reviews, influential empirical studies, clinical guidelines, and documents issued by international organizations, without claiming to be exhaustive or to reproduce the procedures of a systematic review.

The analysis was organized around the following thematic areas: barriers to access, listening and communication, recognition of co-occurring conditions, service accommodations, care coordination, and service user participation. The propositions presented are interpretive in nature and are not based on primary data collection or meta-analysis. Accordingly, practical recommendations are discussed in light of the available evidence, distinguishing research findings from the organizational implications proposed by the authors.

3 DISCUSSION

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The first challenge is recognizing that diagnosis in adulthood may occur late. Individuals who were not identified during childhood may present to primary health care with histories of academic, occupational, and interpersonal difficulties, often accompanied by moralizing interpretations of their experiences. Health professionals should explore developmental history and functional impact without turning the consultation into an exercise in prematurely confirming diagnostic labels (FARAONE et al., 2021; LORD et al., 2020).

In ADHD, clinical assessment requires attention to symptom persistence, their presence across different settings, and the associated functional impairment, while considering differential diagnoses and comorbidities. Assessing inattention or hyperactivity in isolation is insufficient, as similar manifestations may occur in the context of sleep deprivation, anxiety, substance use, and other conditions. Specialized guidelines recommend a structured and context-sensitive clinical assessment (NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE, 2018; THAPAR; COOPER, 2016).

In autism, welcoming care should avoid assumptions based on stereotypical presentations. Sensory heterogeneity, different forms of emotional expression, social camouflaging, and varying support needs make it inappropriate to rely on a single profile as a reference point. The individual's own account should be central to the assessment and may be supplemented by information from other sources when clinically relevant and provided with the person's consent (HULL et al., 2017; LORD et al., 2020).

Access barriers are not exclusively individual in nature. Difficulties scheduling appointments, noisy waiting rooms, unpredictable delays, and vague instructions may increase distress and sensory overload. Research involving autistic adults has documented communication difficulties and organizational barriers within health services, suggesting that relatively minor operational changes can improve the care experience (NICOLAIDIS et al., 2015; RAYMAKER et al., 2017).

Inclusive clinical communication begins by asking about individual preferences. Some people benefit from written instructions, direct language, additional time to process questions, or the option of asynchronous communication. Reduced eye contact, pauses, or atypical facial expressions should not be equated with a lack of understanding or interest. The goal is to ensure an effective exchange of information and informed consent (NICOLAIDIS et al., 2015; RAYMAKER et al., 2017).

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The physical environment is also an integral component of care. Opportunities to reduce visual and auditory stimuli, provide advance information about the stages of a consultation, and offer alternatives to waiting in crowded spaces constitute forms of accessibility. Such accommodations should be discussed and agreed upon with each individual, as sensory needs and preferences are not uniform among autistic people or people with ADHD (LORD et al., 2020; WORLD HEALTH ORGANIZATION, 2022).

Identifying psychological distress requires particular attention. Depressive and anxiety symptoms may co-occur with autism, while adults with ADHD also face an increased risk of other psychiatric conditions. However, health professionals must distinguish clinically significant distress from understandable responses to exclusion, discrimination, and environmental demands that are incompatible with individual needs (HOLLINGDALE et al., 2020; LAI et al., 2019).

Risk assessment should be individualized, particularly when signs of hopelessness, self-harm, or suicidal ideation are present. Evidence indicates relevant vulnerabilities among certain subgroups of autistic people, supporting the use of clear, sensitive questions adapted to each service user's communication preferences. Risk must neither be presumed on the basis of a diagnosis nor dismissed because of difficulties expressing emotions (CASSIDY et al., 2014; HIRVIKOSKI et al., 2016).

Continuity of care represents another decisive dimension. Isolated consultations, referrals without follow-up, and frequent changes in health care professionals make it difficult to build trust. Primary health care can assume responsibility for longitudinal care coordination by integrating specialist assessment when indicated, clinical follow-up, and psychosocial support, without relinquishing its responsibility once a referral has been made (WORLD HEALTH ORGANIZATION, 2022; WORLD HEALTH ORGANIZATION; UNITED NATIONS CHILDREN'S FUND, 2022).

Therapeutic interventions should be guided by goals that are meaningful to the individual. For ADHD, psychosocial strategies and pharmacological treatment may be considered according to clinical indications, personal preferences, and the monitoring of treatment effects. In autism, care should address co-occurring mental health needs and functional support requirements without assuming that eliminating autistic characteristics is a desirable outcome (FARAONE et al., 2021; NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE, 2018).

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Welcoming care for autistic adults also involves questioning excessively paternalistic models. The neurodiversity perspective helps distinguish neurological diversity from incapacity without denying limitations or support needs. Person-centered practice should simultaneously recognize rights, autonomy, psychological distress, and the heterogeneity of individual circumstances and contexts (KAPP et al., 2013; PELLICANO; DEN HOUTING, 2022).

The involvement of family members or caregivers can facilitate care coordination when desired by the individual, but it should not replace the voice of the adult receiving care. Health care teams should confirm whom the individual wishes to involve, which information may be shared, and what support is needed to enable autonomous decision-making. This approach is particularly important in situations involving functional dependence or a history of experiences in which the individual's accounts and concerns have been discredited (NICOLAIDIS et al., 2015; WORLD HEALTH ORGANIZATION, 2022).

Team training must go beyond recognizing lists of symptoms. It is necessary to develop competencies in accessible communication, clinical interviewing, assessment of co-occurring conditions, environmental accommodations, and appropriate referral. Studies examining autistic adults' experiences of health care indicate that gaps in professional knowledge can create barriers as significant as the lack of available services (RAYMAKER et al., 2017; ZERBO et al., 2015).

Integration with community resources and specialized services can reduce fragmentation of care. Employment support, adult education, social protection, and mental health services should be coordinated with the care plan whenever relevant and with the individual's consent. In this sense, comprehensive care does not mean providing every resource within a single service; rather, it means ensuring coordination, continuity, and shared responsibility across services (WORLD HEALTH ORGANIZATION, 2022; WORLD HEALTH ORGANIZATION; UNITED NATIONS CHILDREN'S FUND, 2022).

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Finally, evaluating the quality of welcoming care should include indicators that matter to service users, such as ease of appointment scheduling, understanding of care instructions, respect for individual preferences, continuity of care, satisfaction, and participation in decision-making. Developing these indicators in collaboration with neurodivergent people strengthens the legitimacy of improvement initiatives and prevents institutional efficiency from taking precedence over the care experience. Participatory knowledge production provides an important framework for this process (NICOLAIDIS et al., 2011; PELLICANO; DEN HOUTING, 2022).

4 CONCLUSION

Welcoming adults with ADHD and autism in primary health care requires a broader understanding of mental health that recognizes clinical needs without reducing neurodivergence to a problem that must be corrected. Communication accessibility, sensory accommodations, attentive listening, individualized assessment of co-occurring conditions, and shared decision-making are complementary components of equitable care.

Consolidating these practices depends on continuing professional development, the reorganization of care pathways, coordination with specialized services, and the meaningful participation of neurodivergent people in care evaluation. As a theoretical-reflective essay, this study does not allow the effects of specific interventions to be estimated. Nevertheless, it identifies organizational and research priorities for strengthening longitudinal and comprehensive care in primary health care.

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