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NEURODIVERGENT POPULATIONS AND MENTAL HEALTH: PATHWAYS TOWARD EQUITABLE, INCLUSIVE, AND HUMANIZED CARE

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Abstract

Mental health care for neurodivergent populations requires recognizing differences in cognitive, communicative, sensory, and behavioral functioning without reducing individuals to diagnoses or deficits. This essay aims to discuss pathways toward equitable, inclusive, and humanized care, considering institutional barriers, professional competencies, and the participation of people receiving care. A theoretical-reflective approach was adopted, drawing on scientific literature and normative documents addressing neurodiversity, autism, attention-deficit/hyperactivity disorder (ADHD), human rights, and the organization of health services. The analysis integrates the social model of disability, the person-centered approach, and the principles of psychosocial care. It argues that inequalities in access, communication difficulties, sensory overload, stigma, and fragmented care may exacerbate psychological distress and undermine continuity of care. Promising strategies include reasonable environmental accommodations, accessible communication, shared decision-

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making, interprofessional training, trauma-informed care, and integration across health care, education, and social assistance services. The heterogeneity of neurodivergent populations precludes uniform protocols and necessitates individualized assessments. It is concluded that humanized care depends on verifiable organizational changes, the reduction of power imbalances, and the recognition of neurodivergent people's autonomy, preferences, and rights in the ongoing development of more responsive and equitable services.

Keywords: Mental Health; Health Equity; Patient-Centered Care; Autism Spectrum Disorder; Access to Health Services.

1 INTRODUCTION

Neurodiversity refers to the variation in neurological and cognitive functioning within the human population, whereas neurodivergence commonly refers to experiences that differ from socially dominant neurocognitive expectations. Although it is not a diagnostic category, the concept has ethical and political relevance to health care because it directs attention toward the conditions necessary for participation and the barriers created by inflexible institutions. A rights-based approach does not preclude the identification of clinical needs; rather, it challenges practices that conflate difference with incapacity (KAPP et al., 2013; UNITED NATIONS, 2006).

The relationship between neurodivergence and mental health is complex. Autistic people and individuals with attention-deficit/hyperactivity disorder may experience co-occurring psychological distress, including anxiety and depression, in contexts shaped by exclusion, barriers to access, and negative experiences within health services. The coexistence of different conditions requires careful clinical assessment, without automatically attributing all symptoms to the underlying neurodevelopmental condition (LAI et al., 2019; SIMON et al., 2009).

In health care settings, seemingly minor obstacles can have substantial consequences: excessive noise, unpredictable waiting times, ambiguous language, the lack of advance information, and consultations with insufficient time. These barriers are not merely matters of comfort; they may hinder symptom communication, the development of trust, and adherence to treatment plans. Qualitative studies of primary health care highlight the importance of listening directly to autistic people's experiences (DOHERTY et al., 2022; NICOLAIDIS et al., 2015).

This essay aims to analyze pathways toward equitable, inclusive, and humanized mental health care for neurodivergent populations. The discussion addresses conceptual foundations, inequalities in access, professional competencies, institutional accommodations, and evaluation mechanisms, seeking to integrate the uniqueness of individuals with the responsibilities of health

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systems (WORLD HEALTH ORGANIZATION, 2022; WORLD HEALTH ORGANIZATION; UNITED NATIONS CHILDREN'S FUND, 2022).

2 METHODOLOGY

This is a theoretical-reflective essay with a qualitative and argumentative orientation, guided by a critical examination of the relationships between neurodivergence, psychological distress, equity, and the humanization of care. Its development drew on key scientific articles, documents issued by international organizations, and clinical guidelines, selected according to their conceptual relevance and applicability to the organization of care. The aim was not to conduct an exhaustive search, meta-analysis, or systematic review; therefore, no study selection flowchart or quantitative estimates of effect are presented.

The analysis was organized into the following analytical themes: foundations of neurodiversity; mental health needs; barriers to access; communication and sensory environments; participation and autonomy; interprofessional collaboration; and equity-oriented management. The sources were critically examined and compared, distinguishing normative recommendations, empirical findings, and the propositions advanced by the authors of this essay. The scope focuses primarily on autism and attention-deficit/hyperactivity disorder (ADHD), without assuming that these conditions represent the full diversity of neurodivergent experiences.

3 DISCUSSION

The first challenge is to avoid the false dichotomy between recognizing difference and providing clinical care. The neurodiversity perspective can coexist with interventions intended to alleviate distress, address co-occurring conditions, and enhance social participation. The decisive consideration is that therapeutic goals should be meaningful to the individual rather than restricted to conformity with socially valued behavioral norms (KAPP et al., 2013).

Equity requires responses proportionate to individual needs rather than the mechanical application of identical procedures. Longer appointments, written instructions, alternatives to oral communication, and opportunities to receive information about the care pathway in advance are

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examples of accommodations that may reduce disadvantages. Their implementation should be negotiated on an individual basis, as a measure that benefits one person may be unsuitable for another (DOHERTY et al., 2022; NICOLAIDIS et al., 2015).

Mental health should be understood beyond the presence or absence of psychiatric disorders. Experiences of rejection, isolation, bullying, and misunderstanding can affect well-being, whereas supportive relationships and predictable environments can serve as protective resources. Care should therefore explore individuals' life contexts and social determinants, avoiding an exclusively intrapsychic interpretation of psychological distress (WORLD HEALTH ORGANIZATION, 2022).

The literature documents a substantial prevalence of co-occurring psychiatric conditions among autistic people; however, estimates vary according to age, setting, diagnostic methods, and sample characteristics. This heterogeneity calls for caution when applying prevalence estimates to local populations. More important than generalizing numerical estimates is ensuring access to specialist assessment whenever new or persistent symptoms indicate a clinical need (HOLLANDER et al., 2018; LAI et al., 2019).

In attention-deficit/hyperactivity disorder (ADHD), difficulties with attention regulation and impulse control may coexist with other conditions and affect educational, occupational, and interpersonal trajectories. Longitudinal assessment that takes individual contexts into account helps prevent both the neglect of genuine needs and the reduction of personal identity to a diagnostic label. Clinical guidelines emphasize ongoing monitoring and the adaptation of interventions across the lifespan (NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE, 2018; SIMON et al., 2009).

Access to care begins before the consultation. Appointment systems that rely exclusively on telephone communication, unclear forms, and rigid bureaucratic requirements may exclude people with specific communication or executive functioning needs. Humanized management should map the patient journey, identify points at which individuals disengage from care, and provide alternative communication channels, with advance information about the location, duration, professionals involved, and stages of the appointment (DOHERTY et al., 2022).

The sensory dimension of health care environments warrants specific attention. Noisy waiting rooms, intense lighting, and unpredictable activity may cause significant discomfort for some individuals. Low-cost measures, such as appointments during less busy periods, quiet spaces, and advance notice of procedures, may improve the care experience, provided they are based on reported preferences rather than assumptions about all neurodivergent people (NICOLAIDIS et al., 2015).

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Humanized clinical communication requires direct questions, concrete language when preferred, sufficient processing time, and confirmation of understanding without infantilization. Professionals should avoid interpreting differences in eye contact, prosody, or emotional expression as a lack of cooperation. Communication may incorporate written, pictographic, or digital resources while preserving each individual's choice of how to express themselves (NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE, 2012).

Shared decision-making is a central principle. Meaningful participation requires presenting options, benefits, risks, and uncertainties in accessible ways, while respecting personal refusals and priorities. Family members and caregivers may contribute when the individual wishes them to do so or when legally appropriate, but their presence should not overshadow the voice of the person receiving care. The Convention on the Rights of Persons with Disabilities provides a framework for autonomy and nondiscrimination (UNITED NATIONS, 2006).

Another key area is addressing institutional stigma. Health professionals may unintentionally dismiss reports of pain, anxiety, or depression by automatically attributing them to autism or ADHD, a phenomenon known as diagnostic overshadowing. Intake protocols and clinical supervision should promote the investigation of physical, psychological, and social causes, without allowing clinical reasoning to be replaced by stereotypes (LAI et al., 2019; NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE, 2012).

Team training must go beyond occasional awareness-raising activities. The required competencies include recognizing communication needs, identifying mental health distress, understanding sensory differences, making appropriate referrals, and negotiating accommodations. Case-based learning and the paid participation of neurodivergent people in professional training can bring educational content closer to the realities of health care practice, without assuming that a single experience represents the entire group (DOHERTY et al., 2022).

Continuity of care depends on integration among primary health care, specialized services, community mental health services, and social support networks. Transitions from childhood to adulthood are particularly vulnerable to loss to follow-up and fragmented information. Individualized care plans, designated care coordinators, and intersectoral communication can help reduce disruptions, provided that confidentiality and consent are respected (NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE, 2012; WORLD HEALTH ORGANIZATION; UNITED NATIONS CHILDREN'S FUND, 2022).

Trauma-informed care is particularly relevant for individuals with histories of coercion, humiliation, violence, or negative experiences with health services. This approach involves

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explaining procedures, seeking permission, offering meaningful choices, and minimizing coercive interventions whenever possible. Humanized care should not be assessed solely in terms of professional courtesy, but also in relation to the distribution of power in decision-making and the subjective sense of safety experienced by those seeking help (WORLD HEALTH ORGANIZATION, 2021).

Health service management should translate principles into observable indicators. These may include waiting times, the availability of accommodations, satisfaction reported by neurodivergent people, continuity of follow-up, complaints of discrimination, and service users' participation in institutional decision-making. Indicators should be interpreted cautiously and stratified where appropriate, so that aggregate averages do not conceal inequalities between groups (WORLD HEALTH ORGANIZATION, 2022).

Finally, knowledge production requires the meaningful participation of neurodivergent people themselves in defining research priorities, methods, and outcomes considered relevant. Research conducted without accessibility measures may reproduce the exclusion it seeks to describe. Equitable care emerges from an ongoing process of institutional review in which scientific evidence, rights, and lived experience are brought together without automatically privileging one over the others (FLETCHER-WATSON et al., 2019; PELLICANO; DEN HOUTING, 2022).

4 CONCLUSION

Developing equitable mental health care for neurodivergent populations requires recognizing that organizational, communication-related, and sensory barriers can generate inequalities as significant as the shortage of specialized resources. A humanized approach integrates individualized clinical assessment, reasonable accommodations, stigma-free care, respect for autonomy, and continuity of follow-up. Recognizing neurodiversity does not mean overlooking psychological distress or therapeutic needs; rather, it means improving how these needs are identified and addressed.

In practical terms, accessibility should be incorporated into management processes, continuing professional development, flexible protocols, and participatory service evaluation. The main limitation of this essay stems from its reflective and nonsystematic nature, which does not allow conclusions to be drawn regarding the comparative effectiveness of the interventions discussed. Future studies should assess outcomes reported by neurodivergent people themselves

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and identify which institutional changes sustainably improve access, safety, quality, and the overall care experience.

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