V.O.I.C.E Neurodiversity

Villages Overcoming Intersections: the Collaborative Empowerment for Neurodiversity

Navigating adversities, disparities, and complexities to promote resilience and agility

V.O.I.C.E. for Neurodiversity's Response to the MAHA Commission's May 23, 2025 Report: Make Our Children Healthy Again: Assessment.

The Make America Healthy Again (MAHA) Commission generated a report on May 23, 2025 titled: "Make Our Children Healthy Again: Assessment." It noted its purpose stating, "***The Executive Order (#14212) establishing the MAHA Commission directed the study of any potential contributing causes to the childhood chronic disease crisis, including medical treatments, and to assess the threat that potential over-utilization of medication pose[s] to children with respect to chronic inflammation or other established mechanisms of disease, using rigorous and transparent data, including international comparisons***."

The report identifies the following as contributing factors for the current childhood chronic disease state: **Poor diet driven by ultra-processed foods (UPFs), the Aggregation of environmental chemicals that children are exposed to, Lack of physical activity and chronic stress, and Overmedicalization** (described as "overprescribing medications to children often driven by conflicts of interest in medical research, regulation, and practice)." While the report advises it is using rigorous and transparent data to support these findings, a major concern is that neither the report or the references cited tell the whole story. At least in the realm of mental health conditions, neurodevelopmental diagnoses, and overall general health of America's children, there's multiple missing pieces. For the sake of clarity, rigorous and transparent data is considered to be the result of experts' diligent work and research on a particular matter that when replicated produces the same or similar results.

While the purpose of this writing is not to pick apart MAHA's report line by line, the intent is to provide a broader lens of contextual contributing factors to consider that explain other critical ***'root causes'*** that were overlooked. Additionally, this writing stands to clarify misconceptions and assumptions about diagnosis and treatment as it relates to neurodiverse conditions (i.e., autism, ADHD, and learning disorders). While I am not a voice of authority on matters such as UPFs and environmental chemicals, my work in the realm of mental health in both the pediatric and adult population is credible and based in years of clinical practice, research, and quality education. The honor yielded from my 20+ year military career and a decade of community-focused research, entailed numerous opportunities to see, assess, and treat many diagnostic conditions. The people I serve and continue to work with consist of Veterans, Service Members, their family members, non-military affiliated adult, adolescent and child populations--across a variety of socioeconomic and sociodemographic statuses, within a diverse range of geographical settings.

As we pursue an explanation on the root causes for medical conditions and mental health disorders, one of the first places to consider is the ecological system a child grows up in. The work of Urie Bronfenbrenner (1978) highlights how a child's immediate family, neighborhood, community, geographical location, and greater systems within society pose contextual and environmental factors beyond that child's control. Aside

from genetics, heritability, and biology imprinting a child's DNA, susceptibility to adverse social determinants and societal systems can also influence DNA structuring. These factors are important as they potentially render a pre-disposition for developmental disorders, elevated stress and health compromises. Evidenced-based research informs conditions such as depression, bipolar, anxiety, ADHD, autism, and others, have a significant heritability rate. Interestingly, for those who have a genetic pre-disposition for these conditions, the cells could be recessive or dormant and actual symptoms never manifest. The same person's ecological system could be centered in an environment that entails exposure to multiple adverse conditions, chronic stress or a major traumatic event. Under those circumstances, recessive genes have a greater probability of expressing, resulting in symptoms of a potentially diagnosable condition such as one of the aforementioned. This is essential in understanding how America's high rates of mental health concerns are in part attributable to the amount of stress people are exposed to, how the human body carries it, and passes it to a forming embryo in the womb.

Return to the concept of the ecological system and take a moment to ponder the role stress ***really*** plays. A child who grows up in a healthy household, safe neighborhood and supportive community may not have to worry about environmental stressors adding to their pre-existent biology. However, that person is still at risk of having a mental health diagnosis because of genetics alone. If that individual and their family has good healthcare benefits and insurance, their mental health and other medical conditions can receive suitable treatments and have a higher likelihood of being well-managed. This is one reason why research is so effective! Doctors and scientists share their lessons learned from engaging patients regularly about these conditions and they're able to determine the best way to treat them. In fact, when these doctors and scientists begin dialoguing with engineers, biologists, and other experts (for example, those working within pharmaceutical companies) they're able to design medications that are very effective in treating an identified condition. Doctors and scientists work with and sometimes within pharmaceutical companies to carry out research studies and clinical trials on the medication formulation being proposed, and make modifications as needed. This process makes sense and highlights how some industry companies and corporations are passionate about particular medical conditions and seek professional relationships with providers, institutions, and patient advocacy groups to collaborate on effective detection, prevention, and/or treatment of the condition. This example is presented so that readers of the MAHA Commission's report are able to see pharmaceutical companies from a lens of value added, rather than a generalization and negative depiction of them. Notably, non-profits championing a specific medical condition conduct various activities to educate the public and raise awareness. At times, they connect with industry organizations that are willing to support their initiatives because funding from government entities can be difficult to obtain, in addition to being restrictive and limited. In fact, as of January 2025, recent executive orders, similar to the one creating the MAHA Commission explicitly denies grants/funding when the requestor is pursuing support on behalf of their work with under-served or marginalized populations. How many people belong to under-served or marginalized populations that benefit from these efforts and could be impacted? Surely, that would've been worthy information to include in the MAHA Commission's report. Before exploring those numbers and statistics, let's finish the discussion related to ecological systems and mental health.

I talked about mental health diagnoses being better managed for a child with a stable ecological system and a family that has good health insurance and medical coverage. However, a child who grows up in an unstable household, or whose neighborhood or community is unsafe deals with more adversities and therefore endures more stress. Sometimes these adversities are occurring at the societal level and across multiple systems. Factor in common variables such as financial distress, limited medical resources, subpar or no health insurance and we have an equation for significant deficits in access to multiple fundamental needs. Lesser quality of food carried by local grocery stores; schools with large classroom sizes, fewer teachers and a reduced education; limited access to specialized providers, preventive measures, and timely identification and treatment of medical/mental health conditions are often referred to as **health disparities and health inequities**. For people who differ from the dominant race, in ethnicity, culture or socioeconomic status, their experiences with adversities are compounded with these intersecting demographic categories that often

carry a negative perception, stigma, and/or historic systemic disadvantages. According to the Congressional Research Service, **11-12% (42 million) of Americans earn below the poverty line** which is estimated at $15,480 for a single individual and $24,230 for a family of three. **Thirteen percent (5.4 million) of children are below the poverty line** and subsequently all of these households are at risk of experiencing at least one type of disparity. Recall how the MAHA report strongly emphasized that poor diet and UPFs are a root cause of the chronic conditions in children and insinuated that families who participate in a government benefit program such as SNAP are opting for UPFs over healthier choices. Yet, the MAHA commission didn't acknowledge the role disparities play in this situation. Grocery prices are higher in local, low-income stores (especially for fresh fruit, vegetables, and meats), and families have to choose between limited, more expensive healthier options versus purchasing cheaper frozen/prepared processed food for the sake of affordability and attempting to budget the food benefit across the month.

The point here is this: families and children encountering health disparities are also at a greater risk for anxiety and/or depression symptoms. This further informs the role of stress on an early developing brain. **Neurodevelopmental disorders can start pervading a once healthy brain's functioning when repeated exposure to stress or trauma occurs** (*Humphreys, K, et al, 2019*). Lack of access to care and unmet basic needs (like healthy food and stability) become stressors that can impact brain development and contribute to adverse mental health outcomes.

The Census Bureau reports America's demographic population as such:

- **White alone (non-Hispanic)**: Approximately **61.6%**
- **Hispanic or Latino (of any race)**: Approximately **19.5%**
- **Black or African American alone**: Approximately **12.3%**
- **Asian alone**: Approximately **3.6%**
- **Two or more races**: Approximately **2.4%**

Nearly 38% (128 million) of America's population consists of people who are either Latino, Black, Asian, mixed, or another diverse ethnicity such as American Indian, Middle Eastern Indian, African or Caribbean descent, etc. Twenty two percent (75 million) of America's total population is between the ages of 1 and 18 and 6.7% (23 million) are between the ages of 19 and 24. Current average family income by ethnicity/race shows:

- **White households**: $74,912,
- **Asian households**: $94,903,
- **Hispanic households**: $55,321
- **Black households**: $45,870

These statistics provide some insight into the frequency and intensity families are likely to experience financial distress, especially single-income homes. Those who differ in ethnicity/race particularly of African and Latino decent have a well-researched American history that highlights persistent, structural societal barriers across major systems (i.e., housing, educational, occupational, and penal domains). These types of obstacles are ever-present and pervasively impact wages, access to resources and overall quality of life. Efforts that have been helpful and a step in the right direction to mitigating distress by improving access to care are currently under attack and targeted for dismantling. Millions of families have benefited from the Affordable Care Act (instilled by former President Obama in 2010) which facilitated the expansion of insurance and medical care to socioeconomically disadvantaged individuals and families. Several reputable reports and sources acknowledge significant improvement in people's medical conditions, their attitudes about getting care, and their consistency in remaining compliant with their healthcare provider's treatment recommendations (*Schmittdiel, J.A., et al, 2017; Kilchenstein D., et al, 2022; Dai, H., et al, 2022, etc.)*. Unfortunately, the MAHA commission's report doesn't acknowledge how improved access to care allowed millions of people with undiagnosed and untreated symptoms and conditions an opportunity for relief and

healing. Included in those millions are children and adults with neurodevelopmental disorders (i.e., autism, ADHD, etc.) and co-occurring conditions (i.e., anxiety, depression, etc.). They are also reflected in the recent increase in over a million diagnoses between 2009 and current. Whether the MAHA commission will admit it or not, **it will cost our nation over $450 billion annually to pay for expenses related to untreated neurodevelopmental conditions than what it will cost to manage it with appropriate care.** These costs are associated with emergency medical care, accidents, additional educational services, loss of productivity, admission to detention centers/prisons, and overall shorter life expectancy. The following is an excerpt from a white paper we released last month:

> "***While neurodevelopmental disorders such as ADHD and Autism Spectrum Disorder (ASD) are well-documented, extensively researched conditions that have been on the Nation's (and overall public's) radar for decades, its impact when untreated or ignored is devastating on the individual and society. Multiple sources cite concerning statistics (see below).***
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> - "In 2015, the total annual cost of untreated autism in the U.S. was estimated at **$268 billion**, including direct services, lost productivity, and family costs." *(Multiple Sources, Autism Speaks, Time)*
> - "The lifetime cost for individuals with Autism can reach up to **$2.4 million**, compared to those without intellectual disabilities incurring around **$1.4 million."** *(Multiple Sources, Very Well Mind, Wang, C. et al)*
> - "In 2018, the annual excess cost of ADHD among adults was approximately $122.8 billion with unemployment and loss of productivity accounting for nearly $96 billion. Direct healthcare costs contributed approximately $14.3 billion." *(jmcp.org), (Zhou, et al, 2023)*
> - "For children aged 5–11 years, the annual societal excess cost of untreated ADHD was estimated at **$19.4 billion**, and for adolescents aged 12–17 years, it was **$13.8 billion**. A significant portion of these costs was attributed to educational expenses." *(PubMed)***,** *(Multiple Sources, Wang, C. et al)*
> - 40% of youth with diagnosable ADHD symptoms don't get treatment (*multiple sources)*
> - "While approximately 9% of white children are diagnosed with ADHD, the diagnosis rate among African American children can be as low as 6-7% due to access to care factors" *(multiple sources, Cénat, J.M., et al., 2022)*
> - "Latino children were 1.5 times less likely to receive an ADHD diagnosis compared to white children" *(multiple sources, Cénat, J.M., et al., 2022)*
> - Higher rates of autism diagnoses are prevalent for BIPOC individuals compared to White children (24.3 per 1,000 aged 8 years). Black children had a prevalence of 29.3, and Latino children had a prevalence of 31.6 per 1,000 *(Benevides. T.W., et al, 2024)*
> - 60% of Children with Autism also have a co-occurring diagnosis of ADHD *(Multiple Sources)*
> - 61% of people with ADHD have chronic financial stress and problems *(R Barkley, 2008)…"*

Given the access to care obstacles discussed earlier, the following excerpt also comes from our white paper and pertains to marginalized, under-resourced adolescents and young adults (especially those of diverse ethnicities and social status, oftentimes BIPOC individuals).

> ***"Too many BIPOC children unsuccessfully navigate untreated neurodiversity across critical developmental life stages and oftentimes reach adulthood with significant executive dysfunction undermining their efforts at emotion management, maintaining relationships, and consistent productivity in their occupational or academic capacity. They are at a disproportionately higher risk for lower socioeconomic status, unhealthy and at-risk coping, impaired/impulsive decision-making,***

compromised mental and physical health, increased probability for involvement in accidents, admission to detention centers/prison, and overall shorter life expectancy."

Hence the applicability of the popular phrase**, "School to Prison Pipeline."** According to recent research, 26% of persons detained in the U.S. prisons have some form of neurodiversity. For detention centers, it's estimated that one out of three adolescents have a diagnosable neurodiversity condition.

According to published statistics from the Bureau of Justice, as of 2023:

U.S. Incarcerated Population

- **Total Prison Population**: Approximately **1.25 million** individuals were incarcerated in state and federal prisons
- **Total Jail Population**: Approximately **664,200** individuals were held in local jails at midyear (2023)

State and Federal Prisons

- **Black or African American**: Approximately **33%** (**412,500)** of the incarcerated population
- **White**: Approximately **30% (375,000)**
- **Hispanic or Latino**: Approximately **23% (287,500)**
- **Other Races**: Approximately **14% (175,000)**

Multiple sources (including *Morris, D. et al, 2020; Rösler, M., et al 2004, etc*.), noted the following statistics related to neurodiversity in incarcerated populations:

- **Attention Deficit Hyperactivity Disorder (ADHD)**: A 2018 meta-analysis estimated that approximately **26.2% (325,000)** of incarcerated individuals have ADHD.
- **Autism Spectrum Disorder (ASD)**: Estimates suggest that individuals with autism are overrepresented in the criminal justice system, though specific prevalence rates vary.
- **Learning Disabilities**: Approximately **30% (375,000)** of incarcerated individuals are reported to have some form of learning disability.

To summarize, the MAHA report was not inclusive of important contributing factors that impact the mental and medical health of American Children. There was an absence of information related to the genetic and biological influences on neurodevelopmental disorders as well as other mental health conditions (i.e., anxiety, depression, etc.). The report did not discuss the role health disparities and health inequities have played in creating access to care obstacles as well as limited access to healthy food and other essential needs. Additionally, the report did not discuss how people are impacted by untreated neurodevelopmental conditions and the costly trajectories our nation is faced with as a result. Our recommendation to Congressional leaders is to insist on accountable reporting from the MAHA Commission to ensure reports and official documents are not absent of critical information. Clinical and scientific experts speak from research that is overseen by Institutional Review Boards who enforce a standard of ethics and truthfulness when it comes to conducting studies and publishing findings. Please make sure those facts make it into these published reports, similarly, facts about the effectiveness of treatment (i.e., medication, therapy, healthy coping strategies, and lifestyle changes collectively are the gold standard; however, for some medication and therapy are matters of personal preference). Secondly, if a doctor or scientist has a conflict of interest in place with an industry corporation or pharmaceutical company, most are acknowledging they receive compensation for the time and consultative knowledge they're providing. Therefore, don't assume that their work together will be biased and not reflect reliable and quality data/outcomes. Third, because preventive measures typically yield better outcomes than reactive ones (particularly as it relates to medical conditions and mental health), lets collaboratively action our efforts towards more preventive strategies (i.e., public awareness and education, enhanced training for providers/educators/legislators, and mental wellness campaigns/initiatives). Fourth, we pray that Congress is ready to restore benefits and entitlements that

have already been striped away from Medicare and Medicaid. We also hope that our Congressional leaders and stakeholders recognize the value in research and restore grants and financial support to efforts aimed at better understanding the diversity of cultural needs and experiences our collective population has. It turns out, making America healthy is more about investing in the wellness and resilience of **ALL of our people** rather than tearing them down by decimating resources or the pillars of their stability.

About Us:
Villages Overcoming Intersections: the Collaborative Empowerment (VOICE) for Neurodiversity (https://VoiceForNeurodiversity.org) is a national non-profit organization based out of Maryland. One major aspect of our mission is to address access to care inequities and disparities via collaborative research and building sustainable infrastructure and networks that connect persons challenged with neurodivergence to resources and relevant information, particularly those whose experiences are compounded by marginalization and lack of privilege or inclusion, because of cultural, ethnic, or other demographic difference. Dr. Brandi Walker, PhD, CEO/founder of VFN is a licensed clinical psychologist, board certified executive leadership coach, cultural humility and cultural competence educator, and organizational consultant on mental wellness and strategic planning. She is a Howard University and University of Maryland alumna and a recently retired Army commissioned officer. She actively conducts research on Neurodiversity, ADHD, and co-occurring conditions.

Call to Action:
If you're a person with neurodiversity or a parent/caretaker of someone with neurodiversity and you feel inspired to share your story, please visit us at: Neurodiversity Speaks (https://VoiceForNeurodiversity.org/neurodiversity-speaks). Your voice matters!

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