

CULTURALLY CONSCIOUS ADHD CARE

Evidence-Based Practices for Clinicians Serving Black and Brown Communities

For psychologists, psychiatrists, primary care providers, PMHNPs, therapists, and all clinicians treating ADHD

WHY CULTURALLY CONSCIOUS PRACTICE IS A CLINICAL IMPERATIVE

ADHD is significantly underdiagnosed and undertreated in Black and Hispanic/Latino communities. The gap is not explained by lower prevalence. It is explained by systemic and clinical factors that every clinician treating ADHD has the power to address.

Medical mistrust is not a patient problem. It is a systems problem with documented roots in historical and ongoing discrimination in healthcare. Culturally conscious clinical practice is not an add-on or an accommodation. It is the standard of care for equitable outcomes. (Cenat et al., 2024; Su-Kubricht et al., 2025)

55% of Black Americans report negative experiences with doctors. (Pew Research Center, 2024)

67.8% of Black Americans and 68.9% of Hispanic Americans report medical mistrust, compared to lower rates in white Americans. (Health Information National Trends Survey, 2022; PubMed, 2025)

26% less likely: non-Hispanic white individuals were approximately 26% more likely to receive an ADHD diagnosis than Black individuals, across 849,281 ADHD patients. (Shalaby, Sengupta and Williams, Scientific Reports, 2024)

79% of the U.S. psychology workforce is white; Black and Hispanic providers account for only 5% and 8% respectively. (American Psychological Association, 2023)

01 Build Trust Before You Build a Treatment Plan

Medical mistrust in Black and brown communities is a rational response to documented histories of medical exploitation, discrimination in clinical settings, and ongoing disparate treatment. A clinician who moves directly to assessment and intervention without first addressing the relational foundation of care will encounter resistance that is frequently misread as non-compliance. (Alang, Health Services Research, 2019)

Cultural humility, defined as an ongoing practice of self-reflection, openness to learning, and willingness to acknowledge the limits of one's own cultural knowledge, is the evidence-supported framework for building that foundation. It differs from cultural competence in that it does not assume mastery. (Su-Kubricht et al., 2025; Cenat et al., 2024)

Implement it:

- **Slow down the first appointment:** Reserve meaningful time in the initial visit for relational groundwork. Ask about the patient's or family's previous experiences with healthcare before asking about symptoms. Naming prior dismissal reduces the unspoken labor of deciding whether to raise it.
- **Ask about prior healthcare experiences explicitly:** Sample language: "Before we talk about what brings you in today, I'd like to understand what your experiences with healthcare have been like. Have there been times when you didn't feel heard or when your concerns were dismissed?"
- **Be transparent about your process:** Explain what you are doing and why at each step of the assessment. Black and brown patients who understand the clinical rationale for each action are more likely to engage fully, ask questions, and return.
- **Follow through on what you say you will do:** For patients whose previous experience has been broken commitments from institutions, consistency communicates safety more powerfully than any single statement.

02 Create Conditions Where Patients and Families Are Genuinely Heard

Being heard requires a clinician who listens without agenda, validates before moving to interpretation, and creates genuine shared decision-making. For Black and brown patients, the experience of being dismissed or corrected

by clinicians is common enough that many enter appointments already managing the expectation that it will happen again.

Shared decision-making, the evidence-based practice of collaborating with patients and families in treatment decisions rather than prescribing unilaterally, is particularly important in BIPOC care. Minority patients report lower rates of shared decision-making, and this disparity is associated with worse engagement and outcomes. (Perez Jolles et al., *Patient Education and Counseling*, 2019)

Implement it:

- **Use open-ended, culturally informed history-taking:** Expand the standard developmental and symptom history to include questions about community context, household structure, stressors, and the patient's or family's own explanation for the concerns they are presenting.
- **Validate before you interpret:** Before offering a clinical frame for what a patient or family describes, reflect what you have heard. Validation is not agreement. It is acknowledgment, and for many Black and brown patients, it is what makes the clinical relationship possible.
- **Involve the family as the patient defines family:** In many Black and Hispanic/Latino families, "family" includes extended relatives, faith community members, and other trusted adults who play active caregiving roles. Excluding key decision-making figures produces fragmented treatment.
- **Offer choices at every stage of treatment:** Shared decision-making is most meaningful when practiced throughout care, not only in the initial conversation about diagnosis. (Perez Jolles et al., *Patient Education and Counseling*, 2019)

03 Address Stigma Directly and Compassionately

Mental health stigma in Black and brown communities operates at multiple levels simultaneously: within families, within faith communities, and internalized by the patient. It is shaped by cultural values around strength, privacy, and self-reliance, by historical experiences of being pathologized by medical and psychiatric systems, and by the real consequences of mental health labels in employment, custody, and immigration contexts.

Implement it:

- **Name stigma early in the conversation:** Do not wait for the patient to raise it. Consider opening with: "Sometimes families have concerns about what an ADHD diagnosis might mean, or about what others might think. I want you to know that this is a safe space to talk about any of that."
- **Reframe ADHD as neurology, not character:** Consistently use brain-based, neurological language: "ADHD is a difference in how the brain manages attention and impulse control. It is not a reflection of intelligence, character, or how someone was raised." This reframe is particularly important in communities where ADHD behaviors have historically been attributed to poor parenting or moral failure.
- **Acknowledge that the label has real-world consequences:** For families with immigration concerns, custody sensitivities, or contexts where a mental health diagnosis could be weaponized, the concern about diagnosis is not irrational. Acknowledge this directly and then address it.
- **Use community and peer narratives where appropriate:** Normalized representations of ADHD in Black and brown communities reduce isolation and stigma more effectively than clinical explanation alone. (Uzoaru et al., *Pediatric Medicine*, 2025)

04 Respect and Integrate Faith and Family as Clinical Assets

Faith is not a barrier to ADHD care in Black and brown communities. For many patients and families, it is the primary meaning-making framework, the primary community of support, and the primary source of resilience. Clinicians who position faith and mental health care as competing forces lose the patient.

Research on Black mental health consistently identifies the Black church and faith community as among the most trusted institutions, often more trusted than healthcare systems. Integrating faith, when the patient welcomes this, is evidence-supported and clinically effective. (Ward et al., *Nursing Research*, 2013; Alang, *Health Services Research*, 2019)

Implement it:

- **Ask about faith as a standard part of the psychosocial history:** Include faith, spirituality, and religious community as routine intake questions, framed without assumption: "Is faith or spirituality an important part of your life or your family's life?"

- **Explore what faith says about the presenting concerns:** For families who understand their child's behavior through a spiritual lens, asking directly what their faith community has communicated about these challenges is both respectful and diagnostically useful.
- **Collaborate with faith leaders when the patient invites it:** With patient consent, collaboration with a pastor, minister, or spiritual leader can be one of the most effective therapeutic levers available. The Society for ADHD and Co-Occurring Conditions has developed resources and training specifically for this faith community bridge.
- **Recognize that prayer and faith practices can coexist with clinical treatment:** Many Black and brown patients do not experience prayer, faith practices, and medication or therapy as mutually exclusive. A clinician who validates this integration reduces the false choice that causes many patients to choose community over care.

05 Examine and Interrupt Implicit Bias in Assessment and Diagnosis

The documented racial disparities in ADHD diagnosis are not explained by prevalence differences. They are substantially explained by clinician bias, conscious and unconscious, in the interpretation of behavior.

Research shows that the same behaviors are more likely to be coded as ADHD in white patients and as conduct disorder or defiance in Black patients. Non-Hispanic Black individuals were approximately 61% more likely to be diagnosed with conduct disorder than white individuals in an 849,281-patient analysis, despite equivalent or higher rates of ADHD symptomatology. (*Shalaby, Sengupta and Williams, Scientific Reports, 2024; Academic Psychiatry, Springer Nature, 2019*)

Implement it:

- **Use standardized, norm-referenced assessment tools for all patients:** Standardized rating scales, structured clinical interviews, and validated cognitive assessments reduce the variability introduced by clinical impression. Validated tools include the Conners 4, the ADHD Rating Scale-5, the Vanderbilt Assessment Scales, and the Adult ADHD Self-Report Scale. (*DuPaul et al., 2016; Conners, 2014*)
- **Gather multi-informant, multi-setting data for every patient:** DSM-5-TR requires evidence of impairment in two or more settings. Gathering input from parents, teachers, and other caregivers is essential. A child who masks effectively in a clinical setting may appear far less impaired than their daily life reflects. (*APA, DSM-5-TR, 2022*)
- **Distinguish culturally normative behavior from clinical symptoms:** Some behaviors that may be flagged as ADHD-related are better understood as culturally normative responses to environment, including hypervigilance and code-switching. Clinical training in culturally responsive assessment reduces misattribution. (*ResearchGate, Culturally Responsive Approaches for ADHD, 2020*)
- **Before concluding "conduct disorder," rule out undiagnosed ADHD:** Given the documented pattern of Black patients receiving conduct disorder diagnoses in place of ADHD, a structured practice of ruling out ADHD before or alongside a conduct disorder or ODD diagnosis is both clinically sound and equity-affirming.

06 Offer Multimodal Care Options That Meet Families Where They Are

Evidence-based treatment for ADHD is multimodal, combining medication, behavioral interventions, psychoeducation, environmental modifications, and family support. For Black and brown families, access to this full array of care is frequently limited by cost, provider availability, transportation, insurance coverage, and language access.

Cultural factors shape medication attitudes in meaningful ways. Concerns about ADHD medication in Black and brown communities are rooted in historical experiences of Black children being disproportionately and inappropriately medicated, in legitimate concerns about side effects, and in cultural values around natural or faith-based approaches to health. (*PMC, Considering Cultural Diversity in ADHD; Rostain and Ramsay, Psychiatrist.com*)

Implement it:

- **Lead with psychoeducation as the first intervention:** For many BIPOC families, understanding what ADHD actually is neurologically is itself transformative and is the prerequisite for engagement with any subsequent treatment. The Society's Resource Library offers free, culturally conscious ADHD psychoeducation materials.

- **Have an explicit conversation about medication:** Ask directly: "What have you heard about medication for ADHD? Do you have any concerns?" Then listen, acknowledge, and provide accurate information without pressure.
- **Offer behavioral and skills-based options explicitly:** Behavioral parent training, CBT for ADHD, executive function coaching, school-based accommodations, and family psychoeducation are all evidence-based and medication-free. These should be offered proactively, not as second-best alternatives. *(Pfiffner and DuPaul, 2015; Barkley, 2015)*
- **Address access barriers as part of the treatment plan:** If a family cannot afford the evaluation, cannot get to the appointment, or cannot take time off work for weekly therapy, the treatment plan will fail regardless of its clinical quality. Sliding-scale referrals, telehealth options, and community health resources are all legitimate clinical tools.
- **Connect patients and families to community and peer support:** Peer support and faith community connection are evidence-informed complements to clinical care, particularly in communities where professional mental health care carries stigma. *(Alang, Health Services Research, 2019; Ward et al., Nursing Research, 2013)*
- **Provide materials in the patient's language:** For Hispanic/Latino patients and families whose primary language is Spanish, providing written materials and assessment instruments in Spanish is not optional for equitable care. Relying on patients to translate clinical information introduces error and reduces the quality of informed consent. *(Rostain and Ramsay, Psychiatrist.com; PMC, Cultural Diversity in Hispanic ADHD)*

A COMMITMENT, NOT A CHECKLIST

Culturally conscious ADHD care for Black and brown communities is not a list of techniques applied to a different category of patient. It is an orientation to clinical practice that recognizes the full humanity, history, cultural context, and community belonging of every patient who sits across from you.

The evidence is clear that these practices improve diagnosis accuracy, treatment engagement, and clinical outcomes for BIPOC patients with ADHD. They are not only the equitable thing to do. They are the clinically effective thing to do. *(Cenat et al., 2024; Perez Jolles et al., Patient Education and Counseling, 2019)*

Culturally conscious care and the faith community: The Society for ADHD and Co-Occurring Conditions is the only ADHD organization in the United States with a dedicated focus on faith-based and marginalized communities. We serve as a bridge between clinicians and the communities they serve, providing culturally conscious education, training, and resources specifically for Black and brown individuals and families living with ADHD.

The Society for ADHD and Co-Occurring Conditions

Empowering Faith-Based and Marginalized Communities with ADHD Education & Advocacy

The only ADHD organization in the United States with a dedicated focus on faith-based and marginalized communities.

- **Refer your patients and families:** The Society's free Resource Library at www.societyforadhd.org/resource-library provides science-backed, culturally conscious ADHD resources for individuals, families, and communities.
- **Access clinician resources:** The Society provides ADHD Clinician Toolkits for Black and Brown Communities, developed specifically to support culturally conscious practice.
- **Request training or a professional development session:** We offer ADHD education and training for clinical teams, community health organizations, and professional associations serving Black and brown communities.
- **Become a Society partner:** Clinicians and practices committed to culturally conscious ADHD care are invited to connect with The Society as community partners.

For clinician resources, referrals, training, or partnership inquiries:

info@societyforadhd.org | www.societyforadhd.org

All content is science-backed and evidence-based.

Key sources: Shalaby, Sengupta and Williams, Scientific Reports (2024); Pew Research Center (2024); Health Information National Trends Survey/PubMed (2022/2025); APA Workforce Data (2023); Su-Kubricht et al. (2025); Cenat et al. (2024); Perez Jolles et al., Patient Education and Counseling (2019); Ward et al., Nursing Research (2013); Alang, Health Services Research (2019); Uzoaru et al., Pediatric Medicine (2025); Rostain and Ramsay, Psychiatrist.com; PMC Cultural Diversity in Hispanic ADHD; ResearchGate Culturally Responsive ADHD Approaches (2020); ADHD Online (2024); Academic Psychiatry, Springer Nature (2019); DuPaul et al. (2016); APA, DSM-5-TR (2022); Barkley (2015); Pfiffner and DuPaul (2015).



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