Submission to the United Nations Office of the High Commissioner for Human Rights' Report on the Impact of Mental Health Challenges on the Enjoyment of Human Rights by Young People, to be presented at the 63rd session of the Human Rights Council in September 2026

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Submitting Organization:

Youth for Neurodiversity Inc. is a U.S.-based, youth-led 501(c)(3) nonprofit organization and community member of the United Nations Youth Office's flagship initiative on Youth Mental Health and Wellbeing. Founded in 2025, our mission is to break barriers for neurodivergent and differently abled youth globally. We amplify personal stories, champion strengths-based model of neurodiversity, educate and mobilizing neurotypical allies, and push for inclusive policies, spaces, assistive technologies, and equitable access. We center the voices of autistic, ADHD, dyslexic, and other neurodivergent and differently abled youth (ages 13–25), many with intersecting marginalizations (LGBTQIA+, racial/ethnic minorities, low-income, migrants). We advocate that differences are not deficits, inclusivity isn't about "accommodations"—it's about creating culturally-sensitive, true belonging, where youth feel understood, valued, and celebrated for who they are. This submission draws on our direct work with neurodivergent and differently abled youth, their lived experiences, and available data.

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Executive Summary

Mental health challenges among U.S. young people (ages 12–25), particularly neurodivergent youth, stem largely from stigma, ableism, lack of inclusive support, and systemic barriers rather than inherent "deficits." These challenges impede enjoyment of core human rights under the Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights (ICESCR), Convention on the Rights of Persons with Disabilities (CRPD), and Convention on the Rights of the Child (CRC)—including rights to the highest attainable standard of health, education, non-discrimination, participation, and work. Recent federal funding and staffing cuts (2025) impact oversight of special education and transition programs critical to youth mental health. Neurodiversity-affirming, youth-led, strengths-based approaches offer promising solutions. Guided by "nothing about us without us," we recommend meaningful youth co-creation, increased investment in prevention, technological innovation, grassroots community events for dismantling societal and cultural stigma, and international cooperation to scale affirming practices.

1. Key Mental Health Challenges Faced by Young People in the United States and Impact on Human Rights (with focus on neurodivergent, differently abled, and marginalized youth)

Nearly one in three U.S. youth ages 12–17 experienced mental, emotional, developmental, or behavioral concerns in 2022–2023, according to data from the National Survey of Children's Health

(NSCH).[1] Furthermore, 40% of high school students reported persistent feelings of sadness or hopelessness, and 20% reported that they had seriously considered attempting suicide.[2] Suicide remains one of the leading causes of death among young people ages 10–24 in the United States.[2]

Neurodivergent youth face disproportionately high rates of bullying and isolation. Autism prevalence in the United States is currently estimated at approximately 1 in 36 children, and ADHD affects approximately 1 in 10 children.[1] Autistic youth experienced bullying victimization at rates between 64.1% and 68.9%, ADHD youth between 43.5% and 57.4%, and AuDHD youth up to 71.7%, compared to 22.7% - 29.6% among peers without these conditions.[3] Bullying was significantly associated with increased anxiety and depression, with stronger associations observed among autistic and ADHD youth relative to non-autistic, non-ADHD peers.[4] Autistic youth also suffer higher rates of depression compared to neurotypical peers, with some national estimates approximating nearly one in five.[3,5]

Bullying, isolation, stigma, and social misunderstandings significantly impact education of students with learning differences. National Center for Learning Disabilities reports indicate that students with learning and attention differences face higher risks of academic disengagement and dropout relative to their peers.[3,6] Approximately 70% of those in college choose not to disclose their disability status, potentially limiting access to accommodations to which they are legally entitled.[3,6] One-third of educators report that learning or attention differences are sometimes mistaken for laziness, and 43% of parents report reluctance to disclose a child's learning disability due to fear of social stigma.[3,5]

Marginalized youth face inequities of access to healthcare and eligibility testing for special education and accommodations. Racial and ethnic minority youth, low-income youth, rural youth, migrant youth, and LGBTQIA+ youth report greater exposure to stigma, discrimination, access barriers to mental health and education services.[6] Structural barriers to youth mental health care include cost barriers, lack of specialized providers, proximity, and transportation.[7]

Human rights impact: Young people with mental health challenges face discrimination in school, sports, communities, and workplaces. They become socially isolated. These barriers violate the Convention on the Rights of Persons with Disabilities (CRPD), including Articles 5 (equality and non-discrimination), 24 (education), and 27 (work and employment), as well as Article 23 of the Convention on the Rights of the Child (CRC). Stigma and labelling young people only by a diagnosis further undermines dignity and equality, violating Article 1 of the Universal Declaration of Human Rights (UDHR). Access barriers to mental health care violate Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).

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[1] National Survey of Children's Health (2022–2023 data). U.S. Health Resources & Services Administration. https://www.childhealthdata.org/learn-about-the-nsch/NSCH

[2] Centers for Disease Control and Prevention (CDC). *Youth Risk Behavior Survey Data Summary & Trends Report: 2013–2023.* 2024. https://www.cdc.gov/yrbs/dstr/pdf/YRBS-2023-Data-Summary-Trend-Report.pdf

[3] Cortiella, Candace, and Sheldon H. Horowitz, *The State of Learning Disabilities: Facts, Trends and Emerging Issues*, 3rd ed., National Center for Learning Disabilities, 2014, www.advocacyinstitute.org/resources/2014StateofLD.pdf; Horowitz, Sheldon H., et al., *The State of Learning Disabilities: Understanding the 1 in 5*, National Center for Learning Disabilities, 2017, tinyurl.com/2017-sld-report.

[4] Accardo, Amy L., et al., "Bullying Victimization Is Associated with Heightened Rates of Anxiety and Depression Among Autistic and ADHD Youth: National Survey of Children's Health 2016–2020," *Journal of Autism and Developmental Disorders*, 2024, pmc.ncbi.nlm.nih.gov/articles/PMC12476435/.

[5] "Mental Health Challenges Faced by Neurodivergent Teens," *Newport Academy*, 5 Aug. 2025, www.newportacademy.com/resources/mental-health/neurodivergent-teens.

[6] Maenner, Matthew J., et al. "Racial, Ethnic, and Sociodemographic Disparities in Diagnosis of Children with Autism Spectrum Disorder." 2021. https://pmc.ncbi.nlm.nih.gov/articles/PMC8500365/

[7] Mental Health America. *The State of Mental Health in America 2025.* https://mhanational.org/the-state-of-mental-health-in-america

2. Steps the U.S. Government Is Taking to Address Root Causes and Ensure Human Rights

The United States has enacted several federal measures to expand youth mental health protections. The Mental Health Parity and Addiction Equity Act (MHPAEA) requires many insurers to cover mental health services,[8] and the Affordable Care Act (ACA) designates mental health and substance use treatment as essential health benefits.[9] In education, the Individuals with Disabilities Education Act (IDEA) guarantees students with learning differences a Free and Appropriate Public Education (FAPE) and Individualized Education Plan (IEP). Furthermore, Section 504 allows for accommodations with individualized supports.[10] Federal programs administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) provide funding for community-based and school-based mental health services.[11] Following the COVID-19 pandemic, the Bipartisan Safer Communities Act (BSCA) included increased investments in school mental health services,[12] and the Centers for Disease Control and Prevention (CDC) expanded youth mental health surveillance and public awareness initiatives.[13] The Trump Administration launched The Make America Healthy Again (MAHA) initiative to emphasize prevention, mental health, and early intervention for youth.[14]

3. Main Barriers to the Right to Mental Health and Impacts on Human Rights

Despite significant steps taken by the government, young people, especially neurodivergent and differently abled youth still face significant barriers to mental health care which impacts their ability to live a happy, healthy, and successful life. These barriers are grouped by the international framework of acceptability, availability, accessibility, and quality.

- **Acceptability:** Stigma and ableism in health care remain pervasive. The traditional medical model treats differences as “disorders” and “abnormalities.” Although the strengths-based model and cultural sensitivity is gaining traction among some healthcare providers, advocacy nonprofits, and academia, the traditional model remains pervasive. The concept that there is a "normal" and those who are different are not normal has isolated many youth, forcing many to "mask," feeling excluded and isolated. [15]
- **Availability:** There is a severe shortage of mental health providers trained in child and adolescent care, particularly those knowledgeable about neurodiversity. Fewer than 1% of graduate medical education (GME) slots are allocated to child and adolescent psychiatry, contributing to long waitlists.[16] Furthermore, as youth transition from high school to college, special education accommodations and disability services are not seamlessly transferable to colleges.[17]

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[8] Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343. https://www.congress.gov/bill/110th-congress/house-bill/1424

[9] Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010). https://www.healthcare.gov/glossary/affordable-care-act/

[10] Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1400 (2004, as amended). https://sites.ed.gov/idea/

[11] Substance Abuse and Mental Health Services Administration (SAMHSA). https://www.samhsa.gov

[12] Bipartisan Safer Communities Act, Pub. L. No. 117-159 (2022). https://www.congress.gov/bill/117th-congress/senate-bill/2938

[13] Centers for Disease Control and Prevention (CDC), Youth Mental Health Initiatives. https://www.cdc.gov/healthyyouth/mental-health

[14] Make America Healthy Again Commission. Make Our Children Healthy Again: Strategy and Assessment. The White House, 2025, www.whitehouse.gov/wp-content/uploads/2025/09/The-MAHA-Strategy-WH.pdf.

[15] Neurodiversity 101, *Youth for Neurodiversity*, https://www.youthfornd.org/neurodiversity-101

[16] Mental Health America, *The State of Mental Health in America 2025*, Table on workforce shortages. https://mhanational.org/the-state-of-mental-health-in-america

[17] Support the RISE Act, https://ncld.quorum.us/campaign/rise25/

- **Accessibility:** Even with mental health parity laws, costs remain prohibitive for many neurodivergent and marginalized youth; insurance gaps, transportation challenges, and geographic disparities, further limit access.[18] 28.7% of youth ages 12-17 did not have a preventive health visit in 2024. [19] Recent federal funding disruptions, layoffs, and uncertainty stemming from decentralizing federal education responsibilities back to the states add to barriers, disproportionately affecting low-income, rural, migrant, and marginalized youth.[20]
- **Quality:** Mental health services rarely accommodate sensory needs, executive function differences, or strengths-based approaches. Misdiagnosis is common, and fragmented systems often fail to provide continuity of care.

4. Laws, Policies, and Programs Concerning Youth Mental Health

Key federal frameworks supporting youth mental health include:

- **Individuals with Disabilities Education Act (IDEA, 2004, as amended)**: Guarantee a free, appropriate public education with accommodations for disabilities, including neurodevelopmental differences.[10]
- **Mental Health Parity and Addiction Equity Act (MHPAEA, 2008) & Affordable Care Act (ACA, 2010)**: Require insurance coverage and designate mental health and substance use services as essential benefits.[8,9]
- **Substance Abuse and Mental Health Services Administration (SAMHSA) Programs**: Block Grants and *Healthy Transitions* initiatives fund state services for youth with emotional disturbances.[11]
- **School-Based Programs**: The *Bipartisan Safer Communities Act (BSCA)* provided grants for mental health services in schools, though affected due to cuts in 2025.[12] State-level programs vary widely.[13]
- **National Hotline**: 988 Suicide & Crisis Lifeline, a free, confidential mental health hotline available 24/7 for support to U.S. youth.[21]

Many states and local communities run programs such as school-based counseling,peer support, early screening, and prevention campaigns.[13] Nonprofits like **Mental Health America** partner with schools and communities to provide youth leadership councils, public education, and resources on depression, anxiety, and neurodiversity.[7] These programs aim to increase access, reduce stigma, and promote strengths-based approaches, though funding and access vary widely across regions, leaving gaps for rural, low-income, and marginalized youth.[15]

5. Proportion of Public Expenditure Allocated to Youth Mental Health Services

In the U.S., national data on youth mental health services is fragmented and hard to consolidate. For 2025-26, out of the total projected healthcare spending ($5.6 trillion), approximately $280–300 billion (~5–6%) is for mental health and substance use management services.[11] For youth

[18] Interagency Autism Coordinating Committee, *2022 Report to Congress on Supportive Services for Individuals with Autism*, Washington, DC: U.S. Department of Health and Human Services, 2022, https://iacc.hhs.gov/publications/report-to-congress/2022/report_to_congress_2022.pdf.

[19] Mental Health America, *The State of Mental Health in America 2025*, Youth Access to Care Section. https://mhanational.org/the-state-of-mental-health-in-ame

[20] Teen Opinions Matter. "Urgent Action Needed to Reverse Layoffs at OSEP and RSA to Protect 7.5 Million Neurodivergent Students." November 21, 2025. https://teenopinions.org/urgent-action-needed-to-reverse-layoffs-at-osep-and-rsa-to-protect-7-5-million-neurodivergent-students.

[21] 988 Suicide & Crisis Lifeline, https://www.fcc.gov/988-suicide-and-crisis-lifeline.

specifically (ages 6–17), behavioral health expenditures totaled $41.8 billion in 2022, representing 40.2% of all pediatric health care spending, up from 22.4% in 2011.[3]

Key funding includes SAMHSA's Community Mental Health Services Block Grant (~$319 million for FY 2026 youth-focused services)[4], the Children's Mental Health Services Program (~$130–180 million), Medicaid coverage via Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandates for youth under age 21, and school-based programs (IDEA and BSCA grants).[5,6]

Families' out-of-pocket spending reached $2.9 billion in 2022, growing at 6.4% annually, and those with at least one child using behavioral health services were 40–60% more likely to face high or extreme financial burden.[3] Underinvestment disproportionately affects low-income, marginalized families.

6. Call to Action for Youth Mental Health & Wellbeing: "Nothing About Us Without Us"

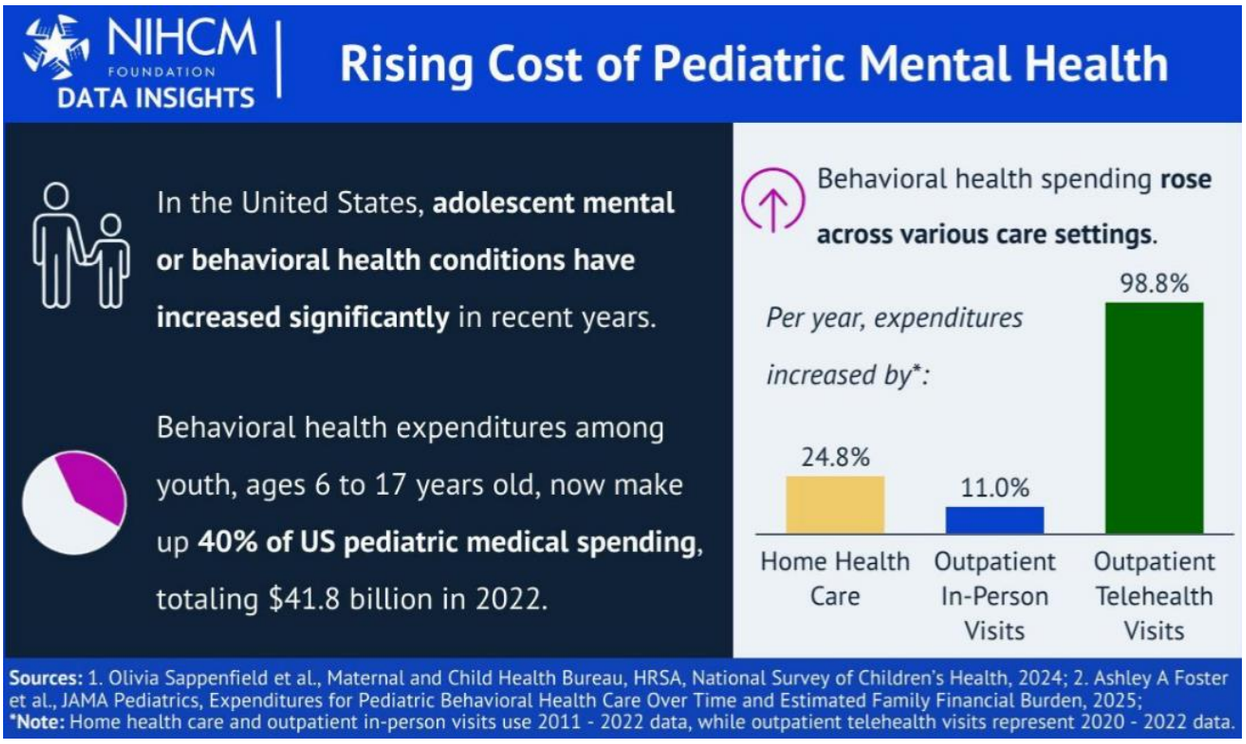
- **Youth input and agency are critical** for States to deliver effective mental health care. Healthcare providers, academic institutions, and community programs must adopt neurodiversity-affirming, strengths-based approaches. They must involve youth advisory councils for co-design and decision-making.
- **The medical model must evolve** from using stigma-inducing labels such as "disorders" and "abnormalities" to "differences" and culturally sensitive treatments for empowerment (not compliance).
- **States must prioritize funding for culturally sensitive, easily accessible** preventive and mental health care, sensory spaces, and universal design in all youth spaces (schools, colleges, libraries, pharmacies, community centers).
- **States must invest in technology innovation, gamified learning with youth co-design.** Novel AI-based, individualized assistive technologies for education and emotional regulation, gamified neurodiversity education such as one developed by Youth for Neurodiversity Inc. for the Presidential AI Challenge.[22]
- **States must dismantle societal and cultural stigma** by celebrating global events such as the Neurodiversity Celebration Week (March 17-23) for solidarity and awareness.[23] All academic institutions must be mandated to have clubs for neurodiversity, disability rights, culture immersion, and mental health & wellness.
- **Equitable access must not be an afterthought.** States must invest in data collection to assess and deliver affordable and easy access for youth mental health services by low-income, marginalized, neurodiverse, LGBTQIA+, rural, and migrant families.
- **States must share best practices with each other.** International cooperation is vital for human rights for youth worldwide. Outcomes and learnings from youth-facing investments and programs should be disseminated in a language accessible to youth.

Mental health challenges among U.S. youth, especially neurodivergent, differently abled, and marginalized populations, reflect systemic barriers. By centering youth voices, empowering them with agency for decision-making, co-designing solutions, restoring funding, and crowdsourcing innovation, the U.S. can champion human rights and model global progress. Youth for Neurodiversity Inc. stands ready to contribute stories, evidence, and policy guidance to inform OHCHR studies for the HRC 63rd session (2026).

[22] *Youth for Neurodiversity,* "Ally in Training™" (video), YouTube, https://www.youtube.com/watch?v=Y2NEecNIC-A

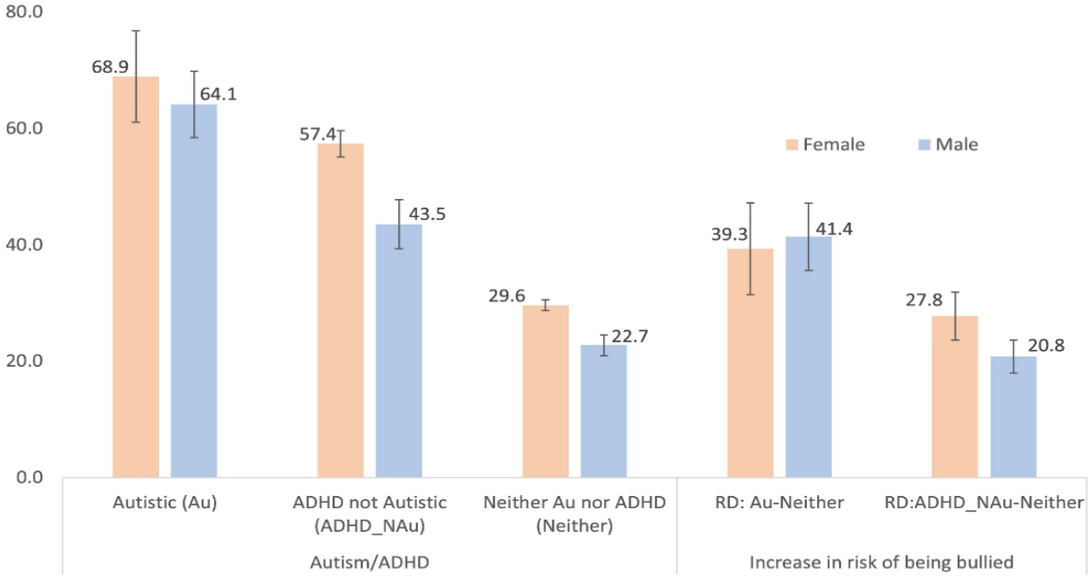
[23] *Neurodiversity Celebration Week,* https://www.neurodiversityweek.com/

Appendix



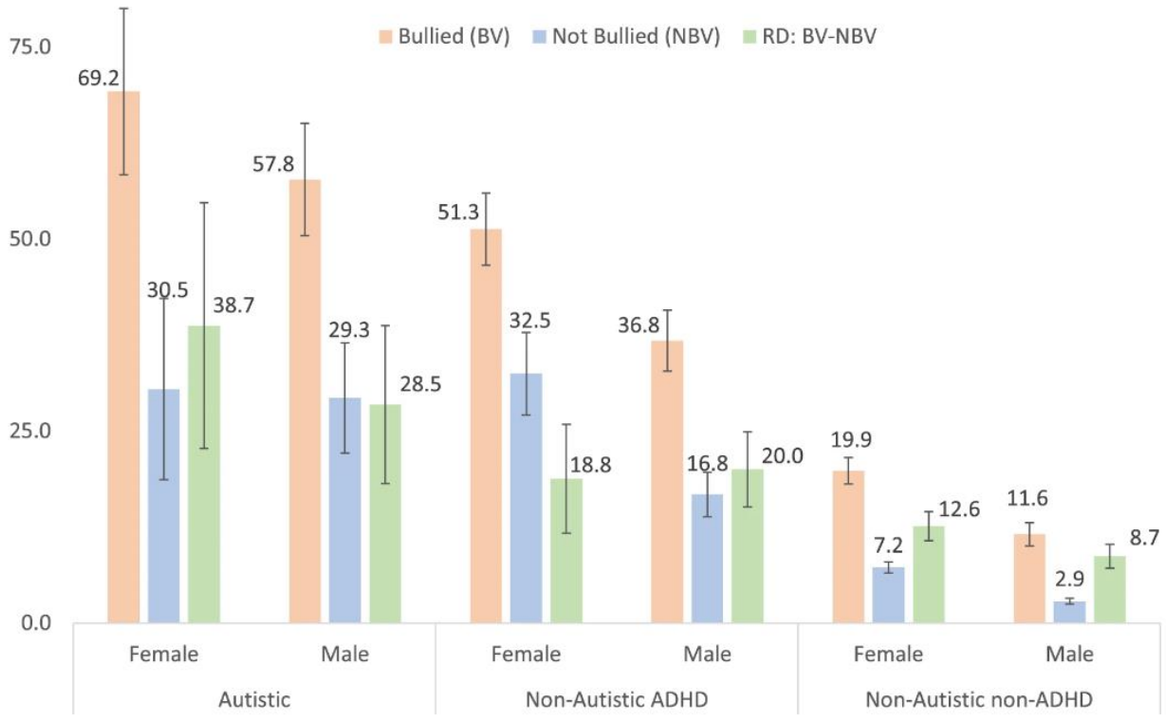
Source: NICHM

From: Bullying Victimization is Associated with Heightened Rates of Anxiety and Depression Among Autistic and ADHD Youth: National Survey of Children's Health 2016–2020



Average Marginal Percentage of US Youth 12–17 years who were Bullied Stratified by Autism/ADHD and Sex (RD = Percentage Increase in Bullying Victimization Associated with Autism/ADHD Stratified by Sex

Source: NSCH



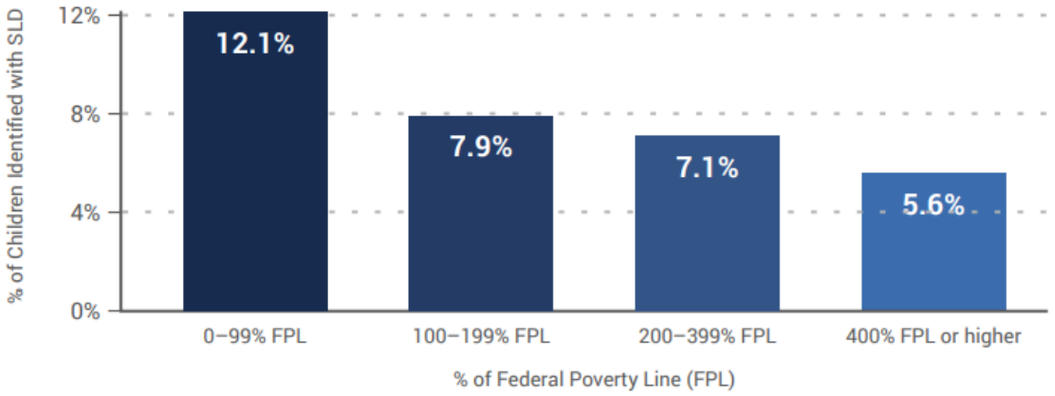
Average Marginal Percentage of Anxiety in US Youth 12–17 years Stratified by Autism/ADHD, Sex, and Bullying Victimization (RD = Percentage Increase in Anxiety Associated with Bullying Victimization Stratified by Autism/ADHD and Sex)

Source: NSCH

DISPARITIES IN SPECIAL EDUCATION IDENTIFICATION

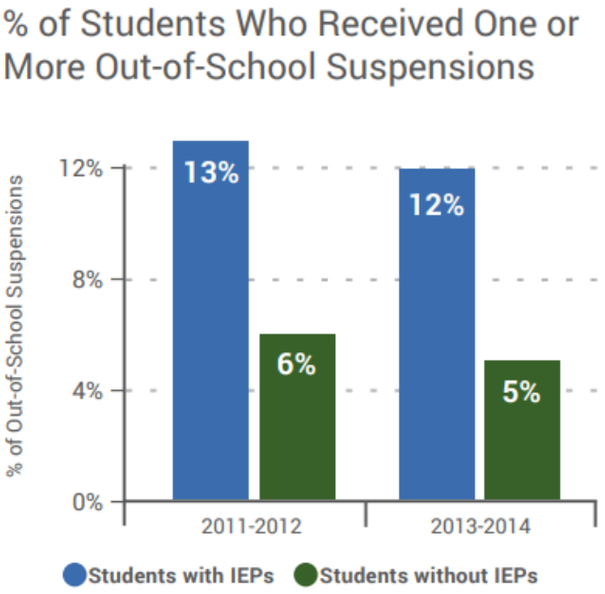
Learning and attention issues affect children from all income levels and across all races and ethnicities. Yet low-income children, students of color and English language learners are more likely to be identified as having specific learning disabilities (SLD). Bias plays a key role in over- and underrepresentation.

SLD Identification by Income Level



DISCIPLINE

Students with disabilities are more than twice as likely to be suspended as students without disabilities, and the loss of instructional time increases the risk of repeating a grade and dropping out. In 2013–2014, 65% of all special education disciplinary removals involved students with SLD or OHI. Many removals are made at the discretion of school officials.



LACK OF DISCLOSURE

Stigma and other factors deter many undergraduates from accessing key resources in college, where only one-fourth of students with learning disabilities disclose that they have a disability. Reasons for low disclosure rates may include:

- Wanting to establish an identity independent of disability status
- Shame or fear of being perceived as lazy or unintelligent
- Underestimating how important accommodations are to their academic success
- Not knowing what kinds of disability services are available in college or not having the paperwork needed to access them

24% of students with learning disabilities informed their college they have a learning disability

7% did not inform their college even though they still considered themselves to have a learning disability

69% did not inform their college because they no longer considered themselves to have a learning disability (even though people don't "grow out" of learning disabilities)

Source: State of Learning Disabilities: Understanding 1 in 5