ND-Safe Triage & First Contact Framework

A guide for emotionally safe, low-threat communication with neurodivergent patients.

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Important note

This resource is intended to support understanding and good practice in neuro-inclusive workplace design. It provides general guidance and does not constitute legal, medical, or clinical advice. Organisations should apply the principles in line with their own policies, regulatory obligations, and professional judgement.

A clear orientation (for healthcare and support services)

This is not a diagnostic protocol.
It is not a risk-screening substitute.
It is not a script for controlling behaviour or accelerating throughput.

This framework exists because **first contact and triage are high-threat moments** for many neurodivergent (ND) patients… particularly those with ADHD, autism, AuDHD, trauma histories, or prior negative healthcare experiences. When early interactions increase threat, services often see:

- incomplete or distorted information
- shutdown, distress, or disengagement
- missed risk signals
- repeated presentations and escalation

ND-safe triage focuses on **how information is gathered**, not whether it is gathered. The aim is to **reduce nervous-system threat so accurate assessment becomes possible**.

This framework should be used to **change communication and conditions**, not to require patients to self-regulate under pressure.

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1. Core reframe: triage is a nervous-system event

Traditional triage treats first contact as a cognitive task: ask questions, gather facts, assign priority.

For many ND patients, first contact is first experienced as:

- evaluation under power imbalance
- time pressure with unclear rules
- sensory and emotional overload
- fear of being dismissed or misunderstood

Before a patient can answer accurately, their nervous system asks:

- *Am I safe here?*
- *Will I be believed?*
- *Will this make things worse?*

If the answer feels like “no,” information quality drops.

Regulation precedes accuracy.

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2. Why standard triage often fails ND patients

Common triage features that increase threat:

- rapid-fire questioning
- interruptions or rushing
- vague or abstract questions
- forced verbal processing
- emphasis on “severity” without context
- minimisation (“That’s common”)
- ambiguous tone or implied judgement

ND patients may respond by:

- over- or under-reporting symptoms
- masking distress
- shutting down or dissociating
- becoming emotionally escalated
- abandoning contact entirely

These are not “communication problems.”
They are **predictable nervous-system responses**.

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3. ND-safe triage principles (non-negotiable)

1. **Safety before efficiency**
   A small investment in safety saves time later.
2. **Clarity over speed**
   Clear framing reduces re-asking and misinterpretation.
3. **Choice reduces threat**
   Even small choices restore agency.
4. **Neutral tone protects dignity**
   Avoid emotional amplification or minimisation.
5. **Information ≠ evaluation**
   Gathering data must not feel like judgement.

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4. Preparing the first contact (before the interaction)

Environmental and procedural considerations

Where possible:

- reduce background noise
- avoid crowded or public settings

- allow seated, grounded posture
- minimise sensory distractions

Procedurally:

- avoid “quick questions” with no context
- allow slightly longer slots where feasible
- ensure privacy and confidentiality are explicit

Small adjustments here significantly reduce downstream escalation.

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5. Opening the interaction: setting safety conditions

The opening moments matter disproportionately.

ND-safe opening elements

- **Name the purpose**
  “I’m going to ask some questions to understand what support you need.”
- **Name the structure**
  “I’ll ask a few things, then we can pause.”
- **Name choice and control**
  “You can ask me to slow down or repeat anything.”
- **Name non-penalty**
  “There’s no right or wrong answer.”

Avoid:

- abrupt questioning
- humour that downplays distress
- reassurance that dismisses (“You’ll be fine”)

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6. Question design: reducing cognitive and emotional load

6.1 Use concrete, present-focused questions

Avoid abstract prompts like:

- “How are you coping overall?”
- “How severe is it?”

Prefer:

- “What’s been hardest today?”
- “What changed that made you seek help now?”

Concrete questions anchor processing.

6.2 One question at a time

Bundled questions overwhelm working memory.

Avoid:

“When did this start, how often does it happen, and how bad is it?”

Use:

“When did this start?” *(pause)*
“How often is it happening?” *(pause)*

Pauses are access.

6.3 Allow non-linear responses

ND patients may answer in:

- detail before summary
- examples before labels
- emotion before timeline

Do not interrupt to “correct the order.”
Gently guide after listening.

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7. Managing time pressure without escalating threat

Time constraints are real… but pressure can be managed.

Helpful strategies:

- name time boundaries explicitly
  “We have about ten minutes.”
- prioritise essential information first
- offer follow-up or written continuation

Avoid:

- visible impatience
- rushing speech
- cutting off responses mid-thought

Pressure degrades accuracy more than it saves time.

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8. Tone and language: what reduces threat

Use:

- neutral, steady tone
- plain language
- short sentences
- explicit reassurance of purpose

Avoid:

- clinical jargon without explanation
- evaluative phrases (“That’s not serious”)
- comparison (“Others have it worse”)
- disbelief cues (“Really?”)

ND-safe tone is **calm and precise**, not overly warm or detached.

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9. Responding to emotional escalation or shutdown

If a patient becomes distressed, tearful, angry, or quiet:

Do:

- pause questioning
- lower your voice
- name safety
  “We can slow this down.”
- reduce demand
  “You don’t need to answer right now.”

Do not:

- push for completion
- interpret behaviour as hostility
- threaten delay or withdrawal of care

Stabilisation first. Assessment second.

10. Offering choice without burden

Choice restores agency… but too many options overwhelm.

ND-safe choices are:

- binary or limited
- time-bounded
- non-consequential

Examples:

- “Would you like to continue now or pause for a minute?”
- “Is it easier to answer verbally or write a note?”

Avoid open-ended demands for self-advocacy.

11. Handling risk and safeguarding sensitively

Risk assessment is essential… but how it’s done matters.

ND-safe risk questioning:

- explains *why* questions are asked
- uses direct, non-euphemistic language
- avoids alarmist tone
- reassures about next steps

Example:

“I need to ask about safety so we can support you properly. These questions don’t mean you’re in trouble.”

Never surprise patients with risk escalation.

12. Closing the interaction: preventing drop-off

Endings shape whether patients re-engage.

ND-safe closing includes:

- summarising what was heard

- stating next steps clearly
- naming timelines
- confirming how to get help if things change

Example:

“Based on what you’ve told me, the next step is X. You’ll hear from us by Y. If things worsen, you can contact Z.”

Ambiguous endings increase anxiety and re-presentation.

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13. Written follow-up (where possible)

Written summaries:

- reduce memory load
- prevent misinterpretation
- support continuity

Even brief written confirmation is protective:

- key points
- next steps
- contact details

This is not bureaucracy.
It is **access**.

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14. Common mistakes to avoid

Avoid:

- framing calm as compliance
- equating verbosity with exaggeration
- assuming distress equals low credibility
- interpreting shutdown as lack of need
- expecting self-regulation under threat

These patterns disproportionately harm ND patients.

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15. What good ND-safe triage enables

When first contact is ND-safe, services often see:

- clearer histories
- earlier risk disclosure
- reduced escalation
- fewer repeat contacts
- improved trust and engagement

These outcomes come from **reduced threat**, not extended questioning.

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16. Organisational guardrails (non-negotiable)

This framework must not be used to:

- delay care
- deny access
- assess “communication ability”
- require disclosure of diagnosis
- shift responsibility onto patients

If patients must perform calmness to receive care, the system is unsafe.

A closing note for services

ND patients are not “hard to triage.”

They are **hard to triage safely in systems built on speed, ambiguity, and pressure**.

When first contact is:

- calm instead of rushed
- clear instead of vague
- choice-based instead of coercive

patients do not become “easier.”

They become **more accurate, more forthcoming, and safer**.

ND-safe triage is not an extra.

It is how good assessment actually works.