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Workplace experiences of neurodivergent nurses: a scoping review

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Abstract

Background

Despite the recognised benefits of a diverse nursing workforce and severe global shortages, little is known about the workplace experiences of neurodivergent nurses. A recent scoping review synthesised neurodivergent nurses' workplace experiences but did not disaggregate findings by neurocognitive profile. This scoping review aimed to map and synthesise the literature reporting the workplace experiences of neurodivergent nurses, including their strengths, challenges, learning preferences, and workplace supports and accommodations, and to delineate findings by neurocognitive profile (autism, attention-deficit/hyperactivity disorder, dyslexia, dyspraxia, and dyscalculia).

Methods

Scoping review with reflexive thematic analysis, informed by a strengths-based, social-relational framework. CINAHL, Embase, MEDLINE and APA PsycInfo were searched in February 2025 and updated in October 2025; the protocol was prospectively registered with the Open Science Framework. Records were screened against pre-set criteria, charted using a piloted proforma, and synthesised using reflexive thematic analysis.

Results

Searching yielded 1,790 records, of which twelve sources met the inclusion criteria and five themes were generated. Across profiles, nurses described meaningful strengths alongside cumulative sensory, cognitive and organisational load. Effective support was contingent on disclosure, and disclosure was perceived as professionally risky.

Conclusions

Neurodivergent nurses bring valuable strengths to nursing practice yet frequently work in environments poorly matched to their needs, producing intensive adaptive labour and elevated attrition risk. Addressing this involves a shift from individual coping toward strengths-based, setting-sensitive accommodations embedded in workplace design, management and education.

Background

The benefits of nursing workforce diversity, including enhanced patient satisfaction and quality of care, are well documented [1, 2]. Nurses comprise the largest professional group within the health workforce [3]. While all nurses should work in an environment that is safe, inclusive, and free from stigma and discrimination, evidence of neurodivergent nurses' experiences in health services remains limited [4, 5].

'Neurodiversity' describes the natural variations in neurocognition amongst the human population [6, 7]. Within these variations, 'neurodivergent' describes individuals whose neurocognitive functioning diverges from dominant social ideas of what is generally considered typical [1, 8, 9]. Neurodivergence encompasses differences in *"kinds of minds"* [10, p. 7], shaping how individuals experience and interact with the world [8, 11, 12]. While formal diagnosis is not a requirement for self-identification of neurodivergence, common diagnoses include, but are not limited to, autism, attention-deficit/hyperactivity disorder, and dyslexia [12, 13]. Population prevalence estimates of neurodivergence are 15–20% [1, 13, 14]. Rates of neurodivergent diagnoses and identification are increasing, particularly in adult populations and people assigned female at birth. This likely reflects improvements in understanding and recognition of neurodivergent presentations amongst diverse groups [4, 15].

Research identifies challenges for neurodivergent healthcare workers [1, 16], including sensory processing challenges triggered by socio-environmental factors [17] and episodes of significant overwhelm [4]. Less commonly, neurodivergent healthcare worker strengths are reported, including creative insight, intuition, and pattern recognition [13, 18, 19]. Despite nurses representing the largest healthcare workforce, research focused on neurodivergent nurses remains limited. Population prevalence estimates indicate that up to one-fifth of nurses could be neurodivergent, representing a significant minority group in this essential workforce [1, 5, 20]. However, formal prevalence data for neurodivergence are currently not available, and the true prevalence of neurodivergence in nursing would likely be obscured by barriers to diagnosis and disclosure, including stigma and discrimination [9].

Stigma and discrimination are not only barriers to identification but also impact neurodivergent nurses' confidence and perceived competence to provide nursing care [21, 22], with implications for job satisfaction and burnout [23–25]. A recent scoping review by Pohlmann and Hill [5] synthesised neurodivergent nurses' workplace experiences, which highlighted stigma and disclosure barriers, and pointed to the benefits of targeted workplace accommodations for supporting this workforce. However, this review did not disaggregate findings by neurocognitive profile, that is, the distinctive pattern of cognitive, sensory, and social processing characteristics associated with a given neurotype rather than the diagnostic label itself. This restricted a detailed understanding of neurodivergent nurses' experiences, as different neurotypes are associated with distinct cognitive, sensory, and social processing differences that produce meaningfully different workplace experiences and support needs [1, 13, 19].

Understanding nurses' experiences and needs is critical for developing policies that promote inclusion, safety, and retention of this group within the health workforce. Challenges faced by neurodivergent nurses intersect with a global nursing shortage [26] and high staff turnover, resulting in significant financial and non-economic costs [25, 27]. Downstream consequences of nursing shortages include reduced quality of patient care, high rates of attrition [20, 25], work dissatisfaction and burnout [23, 25]. While burnout antecedents and the protective role of social support are well documented [23, 24, 26], neurodivergence-specific nursing experiences, needs, and retention strategies are rarely reported [4, 5, 14, 28].

Building on the foundation established by Pohlmann and Hill [5], this study used a scoping review methodology to capture a broad range of contemporary published sources [29, 30]. It synthesised and analysed published literature across neurocognitive profiles, then delineated findings by neurocognitive profile within each theme. Furthermore, it included lived experience perspective pieces authored by neurodivergent nurses [21, 28, 31]. Inclusion of lived experience perspective pieces strengthened the analysis and interpretation of neurodivergent nurses' experiences [7, 32, 33].

Aims

This scoping review aimed to map and synthesise the literature reporting the workplace experiences of neurodivergent nurses. It specifically aimed to describe the reported strengths, challenges, learning preferences, workplace supports and accommodations of neurodivergent nurses, and to consolidate and delineate findings by neurocognitive profile (autism, attention-deficit/hyperactivity disorder, dyslexia, dyspraxia, and dyscalculia), while also noting experiences of nurses with co-occurring profiles.

Positionality Statement

The lead author is a neurodivergent nurse with ten years' nursing experience. A co-author also identifies as neurodivergent and has a background in psychology and neurodivergent health research. Other authors do not identify as neurodivergent, and have backgrounds in mental health, disability, public health, and nursing scholarship. We recognise that lived experience-led research has a critical role in challenging medicalised and ableist narratives of neurodivergence [7, 11, 32]. The lead author's positionality as a neurodivergent nurse was considered a valuable analytic resource, as lived experience involvement supported nuanced engagement with the topic and informed the sensitivity of data interpretation and reporting in reviews [33]. Regular team dialogue – comprising scheduled reflexive discussions at team meetings – enhanced reflexivity, providing a structured forum to challenge assumptions, enhance conceptual clarity, and support interpretation as a collaborative, accountable process [33, 34].

Research concerning neurodivergent populations requires a commitment to ethical practices and non-ableist language [7, 8, 11, 35]. Therefore, this review employs identity-first and neuro-affirming terminology, such as 'autistic person', reflecting preferences within neurodivergent communities [8, 15, 35].

Methods

This scoping review was conducted and reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for scoping reviews (PRISMA-ScR) [36] (Additional file 1). A scoping review methodology was chosen to capture the breadth and depth of evidence on neurodivergent nurses' workplace experiences [29, 30, 37, 38]. As scoping reviews do not exclude sources based on methodological quality, this allowed inclusion of diverse evidence types [37], which was essential given the scarcity of primary studies on this topic. Stages one to five of the Arksey and O'Malley [29] framework guided the review process, incorporating recommendations by Levac et al. [30]. The sixth stage of this framework, consultation with stakeholders, is being completed as a separate, follow-up study [29, 30].

Search Methods

The guiding review question was: *'What are the workplace experiences of neurodivergent nurses?'* Four online databases (CINAHL, Embase, MEDLINE, and APA PsycInfo) were searched in February 2025, with an updated search conducted in October 2025. The search strategy combined MeSH terms, key words, truncation, and Boolean and adjacency operators, and included the concepts: nursing, neurodivergence, and experiences/perspectives. A search validation was conducted with a university librarian to ensure known and relevant literature on neurodivergent nurses was returned. Following librarian consultation, the terms for 'experience' (and related terms) were omitted from the final strategy, as preliminary results demonstrated adequate coverage of this concept without them. This represented a deviation from the registered search strategy. The final search terms included: *"nurs* with" adj4 AND (neurodiver* or neuroatypical or neurodevelopmental disorder* or autis* or aspergers or ADHD or attention deficit hyperactivity disorder* or attention deficit disorder with hyperactivity or dyslexi* or dyspraxi* or dyscalculia)*, adapted as needed for individual database search functionality (Additional file 2).

Inclusion and Exclusion Criteria

Sources were excluded if they reported on pre-registration nursing students, healthcare workers in professions other than nursing, or post-graduate nurses operating purely within an academic context. The exclusion of post-graduate nurses in the academic context was added following protocol registration to improve the precision of the review's clinical focus.

Conversely, published sources were included if they reported on one or more of the specified neurocognitive profiles (autism, attention-deficit/hyperactivity disorder, dyslexia, dyspraxia, and dyscalculia) among practising nurses and were published in English. Literature types for

inclusion were primary studies (quantitative, qualitative, or mixed methods), lived experience perspective pieces, editorials, and discussion papers. These literature types reflect modifications from the registered protocol and were included to fully capture the available evidence base. Lived experience perspective pieces were defined as published first-person reflective accounts authored by neurodivergent nurses. While these accounts, alongside editorials, are not peer-reviewed primary research, their inclusion is consistent with scoping review methodology, which does not exclude sources on the basis of methodological quality [36, 37]. This provided contextual and interpretive insight where empirical research on neurodivergent nurses remains scarce.

Search Outcome

Database search results were uploaded into Covidence [39], where duplicates were removed. Titles and abstracts were manually screened against pre-determined inclusion/exclusion criteria. Full-text reports were screened by the lead author and independently checked by a second author. Reference lists of the remaining reports were hand-searched to identify any additional relevant publications for inclusion.

Quality Appraisal

In keeping with scoping review methodology, the review mapped the breadth and nature of the available evidence and did not undertake a formal critical appraisal of the methodological quality of the included sources.

Data Extraction

Data extraction was carried out by the lead author using a pro-forma template in Excel, developed iteratively by the review team to ensure suitability across heterogeneous sources. Items for data extraction included citation information (author(s), year), geographical location/context where the research was conducted or location of the author(s) (country, as applicable), study design (where relevant), participant characteristics and demographics (if applicable). Key data relevant to the review question and aims were also extracted. This included relevant quantitative and qualitative data (numerical data, statistics, and/or direct quotes as applicable). Two authors validated the extracted data for completeness and consistency, and to support reflexive interpretation of the dataset.

Synthesis

Given the heterogeneity of the included sources, we adopted Braun and Clarke's [34, 40, 41] approach to reflexive thematic analysis. This approach facilitated the translation of diverse data into interpretive themes through six phases: 1) familiarising yourself with the dataset; 2) coding; 3) generating initial themes; 4) developing and reviewing themes; 5) refining, defining and naming themes; and 6) writing up [41, 42]. While reflexive thematic analysis is typical for primary qualitative research, its emphasis on reflexive engagement and meaning making across diverse data rendered it appropriate for synthesising the heterogeneous body of sources in this review, including primary studies, editorials, and lived experience accounts [34, 43]. Our team engaged in deep reflection on each source to understand nuanced perspectives before inductively generating codes [34, 43]. We then constructed themes and sub-themes by clustering codes where patterns of shared meaning were identified. In line with the reflexive nature of this method, we moved back and forth between phases to ensure internal coherence and accurate reflection of the broader dataset, attending to recommended quality practice for reflexive thematic analysis throughout [34, 42–44].

The analysis was also theoretically informed by a strengths-based perspective on neurodivergence [13, 19] and a social-relational understanding of disability [15], which supported a focus on the structural and relational context impacting neurodivergent nurses' experiences. This approach allowed us to move beyond simple descriptive domains to provide an account of the interaction between individual characteristics and broader workplace relations, structures and environments [13, 15, 19]. The final themes were agreed by all authors. This scoping review did not require ethics approval as it synthesises data from previously published sources.

Results

Included Sources

The initial database searches yielded 1,790 records. 959 duplicates were removed, leaving 831 records for title and abstract screening. During this title and abstract screening stage, 763 records were excluded. Full-text screening of the remaining 68 records resulted in the exclusion of a further 56 records, most of which focused on undergraduate nursing students (n = 43). Additional exclusions included sources with insufficient relevant data (n = 5), legal or ethical discussions concerning neurodivergent populations (n = 3), neurodivergent patient populations (n = 2), neurodivergent nurses' experiences of post-graduate study (n = 2), and duplicate study data (n = 1). Reference lists of remaining reports were hand-searched, and no additional eligible sources were identified. Twelve sources were included in the final review, as shown in Fig. 1.

Characteristics of Included Sources

Of the twelve included sources reporting on neurodivergent nurses' workplace experiences, most sources originated from the United Kingdom (n = 6), with the remaining sources from Sweden (n = 3), the United States of America (n = 1), Guernsey (n = 1), and unknown geographical origin (n = 1). Five sources (42%) reported primary research data, comprising three qualitative studies (interviews and/or focus groups), one quantitative study

(online survey), and one mixed-methods study (online survey including both qualitative and quantitative data collection). The remaining sources comprised discussion papers (n = 4; two of which also presented lived experience perspectives), editorials (n = 2), and a standalone lived experience perspective piece (n = 1). Several sources (n = 5) explicitly identified lived experience involvement amongst the authorship, while the remaining sources (n = 7) did not report authors' positionality in terms of lived experience or neurocognitive profile.

Across the included sources, reported neurocognitive profiles included dyslexia (n = 5), autism (n = 2), co-occurring autism and attention-deficit/hyperactivity disorder (n = 2), and attention-deficit/hyperactivity disorder (n = 1). Two sources discussed neurodivergence without specifying a neurocognitive profile of focus. No eligible sources reported the workplace experiences of nurses with dyscalculia or dyspraxia.

All sources reported on post-registration nurses or discussed the nursing profession more broadly. One primary study reported qualitative data from nurses (n = 5) and healthcare assistants (n = 2). Some sources (n = 3) used the specific title 'registered nurse' to describe the participants or author(s), whereas most (n = 9) used the term 'nurse' without specifying registration status. The characteristics and key findings of the twelve included sources are summarised in Table 1.

Table 1
Characteristics and key findings of twelve included sources

Author, year	*Title*	Country	Aim	Sample/ demographic and neurocognitive profile	Source type, and/or study design	Key relevant findings	Inclusion of neurodivergent researchers
Azar & Taha 2025 [14]	*Embracing Neurodiversity in the Nursing Workforce*	USA	Advocate for embracing neurodiversity in nursing; advancing diversity, equity and inclusion in nursing workplaces	Conceptual focus on neurodivergent (registered) nurses	Secondary discussion paper	ND[a] nurses contribute problem-solving, pattern recognition, and attention to detail. Inclusive work environments enable these strengths to improve patient care and team dynamics.	Not stated
Butler 2024 [21]	*Nurses with Dyslexia: Overcoming Challenges and Thriving in the Profession*	England	Describe workplace experiences of dyslexic (registered) nurses; identify challenges and strategies	Dyslexic (registered) nurses; author's reflective account of their lived experience	Secondary discussion paper and lived experience perspective	Dyslexic (registered) nurses face literacy-related hurdles amplified by busy environments. Tailored accommodations and personalised strategies improve confidence, care quality, and job satisfaction; call for dyslexia-aware training design and supportive culture.	Author is a dyslexic (registered) nurse
Hedlund & Jordal 2025 [48]	*What About Neurodiversity Among Nurses? A Cross-Sectional Exploration of Work Environment and Health Among Nurses with ADHD[b] and/or Autism*	Sweden	Examine associations between work environment, perceived health/satisfaction, and care quality	99 (registered) nurses: autism (n = 9), ADHD (n = 75), autism and ADHD (n = 15); survey	Primary study; quantitative (cross-sectional survey)	ND nurses reported workplace and health challenges, high mental health burden, and elevated intentions to leave the profession. Despite this, they reported high satisfaction with the care they deliver.	One author (ÅH) is an autistic (registered) nurse
Hedlund & Jordal 2024 [4]	*Feeling Like an Untapped Resource. Experiences of Working Life Among Nurses with ADHD and/or Autism: An Interview Study*	Sweden	Describe how (registered) nurses with ADHD and/or autism experience working life	17 (registered) nurses: autism (n = 3), ADHD (n = 11), and combined autism and ADHD (n = 3); interviews	Primary study; qualitative (semi-structured interviews)	ND nurses report distinct strengths alongside barriers linked to sensory/organisational conditions and limited organisational support; targeted accommodations and role/setting fit are critical for function and retention.	One author (ÅH) is an autistic (registered) nurse
Hedlund 2023 [28]	*Autistic Nurses: Do They Exist?*	Sweden	Explore current understanding of autistic (registered) nurses; identify support needs and useful adaptive strategies	Autistic (registered) nurses; author's reflective account of their lived experience	Secondary discussion paper and lived experience perspective	Autistic nurses are likely under-recognised; research is scarce. Reports nurses' need for clear step-by-step instruction, extra time and repetition, reduced sensory load or quiet space, and tailored accommodations; calls for targeted research.	Author is an autistic (registered) nurse
Illingworth 2005 [45]	*The Effects of Dyslexia on the Work of Nurses and*	England	Explore how dyslexia affects the working lives of dyslexic (registered) nurses	7 dyslexic (registered) nurses (n = 5) and nursing	Primary study; qualitative (semi-	Dyslexia impacts individuals uniquely; reading/writing and documentation pose challenges, worsened	Not stated

[a] ND = neurodivergent; [b] ADHD = Attention-deficit/hyperactivity disorder

Author, year	*Title*	Country	Aim	Sample/ demographic and neurocognitive profile	Source type, and/or study design	Key relevant findings	Inclusion of neurodivergent researchers
	Healthcare Assistants		and nursing assistants	assistants (n = 2); interviews	structured interviews)	by distractions. Safety strategies include paper calculations, colleague double-checking, and slowed pace. Documentation aids include drafting, spell-checkers, word/phrase notebooks, and avoiding uncertain words. Stigma limits disclosure; some colleagues *"quick to judge"*. Collaborative and mentored learning viewed as helpful.	
Layzell 2024 [31]	*'As a Nurse with ADHD, I had Always Felt Different From my Colleagues'*	Wales	Describe the impact of ADHD on clinical practice and self-understanding	One (registered) nurse with ADHD's reflective account of their lived experience	Lived experience perspective piece	Late ADHD diagnosis reframed prior difficulties and enabled disclosure and support. Reports strengths (quick-thinking, complex problem-solving, high empathy, calm under pressure). Role fit matters: *"blunt"* communication can strain relationships; structured breaks and stimulation help manage restlessness and improve focus.	Author is a (registered) nurse with ADHD
Major 2019 [46]	*'We Can't Afford Not to Support Registered Nurses with Dyslexia'*	Guernsey	Increase awareness of dyslexia among registered nurses to improve workplace support	Commentary on dyslexic registered nurses	Editorial	Stigma and misconceptions hinder disclosure; supportive, non-judgemental cultures and reasonable adjustments are essential. Notes no evidence that dyslexia increases medication-error risk. Lack of support drives masking, avoidance, stress, burnout, and potential for attrition.	Not stated
Major & Tetley 2019 [22]	*Effects of Dyslexia on Registered Nurses in Practice*	Great Britain, Guernsey	Report the experiences of dyslexic registered nurses	14 dyslexic registered nurses; interviews	Primary study; qualitative (semi-structured interviews)	Dyslexic nurses employ adaptive strategies to protect safety; stigma and misconceptions deter disclosure; informal support can be mistimed or inappropriate; reduced confidence and hesitancy about further study can limit progression.	Not stated
Moore 2021 [12]	*Diversity in Nursing: Why it's Time to Think Neurodiversity*	United Kingdom	Explore recognition and support of neurodiversity in nursing	Conceptual focus on neurodivergent (registered) nurses	Secondary discussion paper	ND nurses contribute strengths; stereotypes and limited accommodations impede inclusion; calls for neuro-affirming culture, training, and reasonable adjustments.	Not stated

[a] ND = neurodivergent; [b] ADHD = Attention-deficit/hyperactivity disorder

Author, year	*Title*	Country	Aim	Sample/ demographic and neurocognitive profile	Source type, and/or study design	Key relevant findings	Inclusion of neurodivergent researchers
Morris & Turnbull 2007 [47]	*A Survey-Based Exploration of the Impact of Dyslexia on Career Progression of UK Registered Nurses*	United Kingdom	Explore the influence of dyslexia on clinical practice and career progression of dyslexic registered nurses	116 dyslexic registered nurses; survey	Primary study; mixed methodology (survey collecting quantitative and qualitative data)	Dyslexia affects day-to-day practice; nurses deploy individualised adaptive strategies; progression is possible but often slower than neurotypical peers; underscored the need for supportive accommodations.	Not stated
Wallis 2012 [49]	*'They Said I Was Rude'*	Unknown	Describe workplace challenges faced by autistic (registered) nurses	Two autistic (registered) nurses; interviews	Editorial; journalist-reported interviews	Autistic nurses often face interpersonal misinterpretations, hierarchy-related conflict, and ostracism; appropriate supports and reasonable adjustments are needed but inconsistently provided.	Not stated

[a] ND = neurodivergent; [b] ADHD = Attention-deficit/hyperactivity disorder

Identified Themes

Five themes were identified: 1) *"Strengths and talents to use in working life"*; 2) *"I just can't work one more second"*; 3) *"Understand[ing] what I need and what I don't need"*; 4) *"I need to understand it, to over-learn it"*; and 5) *"The required adjustments were not put in place"*.

The first theme, *"Strengths and talents to use in working life"*, captures the strengths and context-dependent clinical assets neurodivergent nurses bring to the workplace. *"I just can't work one more second"* describes the workplace challenges neurodivergent nurses face, including cumulative sensory, cognitive, and organisational loads. *"Understand[ing] what I need and what I don't need"* recounts the adaptive strategies neurodivergent nurses employ to manage these workplace challenges. *"I need to understand it, to over-learn it"* captures neurodivergent nurses' learning preferences and requirements for effective skill acquisition and knowledge consolidation. Finally, *"The required adjustments were not put in place"* describes how workplace culture and accommodations influence neurodivergent nurses' experiences, including disclosure, support, and career progression. Theme titles use verbatim quotations from included sources to centre neurodivergent nurses' voices and lived experience perspectives. In this section, we first present a synthesis of findings across all included sources, before delineating experiences by neurocognitive profile.

Strengths and talents to use in working life

Nine sources reported traits neurodivergent nurses perceived as strengths and beneficial to clinical practice. These included creative problem-solving and intuition [14, 21, 22, 45], pattern recognition and attention to detail [14, 46, 47], creativity [4, 12, 21, 22], and one author described their *"unusually good memory for numbers"* [28, p. 213].

Two studies [4, 22] and two lived experience perspective pieces [28, 31] described neurodivergent nurses' empathy as pronounced and grounded in lived experience. Neurodivergent nurses' empathy was described as *"unusually strong"* [4, p. 4] and *"overwhelming"* [28, p. 213] and linked to resilience in emotionally demanding situations [22, 31]. These findings stood in contrast to perceptions that autistic people lacked empathy, reported by one author's colleague in one source [28].

Across the included sources, accounts of neurodivergent nurses' strengths were not only viewed as positive and valuable individual attributes, but also as context-dependent clinical assets [4, 22]. In other words, expression, recognition, and utilisation of neurodivergent nurses' strengths were often contingent on workplace conditions, including support and relational safety [4, 22, 45].

I just can't work one more second

Nine sources reported workplace challenges that neurodivergent nurses experience. These included cumulative strain from sensory load related to regular alarms and frequent interruptions [4, 28, 48], and cognitive and organisational load related to complex clinical systems and competing priorities [22, 45, 47]. These sensory, cognitive, and organisational loads were reported to undermine nurses' concentration and pace [4, 45, 46, 48]. This effect was particularly pronounced for tasks involving reading or writing, or tasks that required recalling large volumes of clinical information

such as clinical handover [4, 45, 46, 48]. Differences in communication style and persistent stigma were identified as compounding factors that intensified these pressures [4, 22, 47, 49].

Across sources, the challenges nurses faced were framed as a mismatch between neurodivergent nurses' needs, role demands, and workplace design rather than as individual deficits [4, 21, 22]. Collectively, these accounts positioned the cumulative load on neurodivergent nurses as an organisationally produced strain – a strain that became unsustainable when meaningful support was contingent on open disclosure, inconsistently provided, or absent [4, 22, 45, 47].

Understand[ing] what I need and what I don't need

Six sources reported individually developed adaptive strategies through which neurodivergent nurses managed workplace challenges and optimised their clinical practice. These findings were further delineated into two categories: 1) masking strategies to mitigate stigma [22, 46, 47], and 2) safety- or quality-enhancing practices that optimised clinical performance [21, 22, 45, 47].

Individual adaptive strategies – Masking and avoidance

Masking strategies included avoiding certain clinical areas or duties (for example, medication administration rounds, clinical handover, and busy ward rotations) and public tasks requiring literacy skills. These strategies were perceived as protective in avoiding potential stigma and discrimination in the workplace [4, 22, 46, 47]. However, neurodivergent nurses reported that these strategies often resulted in extended task time, reduced confidence, increased stress, and risk of burnout [4, 22, 46, 47].

Individual adaptive strategies – Safety- and quality-enhancing

Neurodivergent nurses indicated that they relied on personal adaptive efforts to ensure accuracy and completeness of work tasks [4, 21, 22, 47]. Safety- or quality-enhancing strategies included pace modulation, paper-based calculations, iterative drafting of notes, and colleague double-checks during high-risk tasks [22, 45, 47].

Structured documentation tools, including the development of templates and prior documentation examples [46], assistive technologies (speech-to-text, spell-checkers), and routinised workflows were also identified as beneficial as they minimised distractions and reduced cognitive load [4, 21, 22, 45, 46].

While the importance of neurodivergent nurses' self-awareness in tailoring accommodations was emphasised across the included sources, neurodivergent nurses also required organisational support, which was reported to be inconsistent due to limited organisational understanding and concerns about sustainability and burden-shifting to other staff [4, 21, 22, 47, 48]. Effective formal accommodations for neurodivergent nurses included predictable breaks, protected documentation time, modified duties (for example, exemption from student supervision or from carrying the 'sick call' phone), strategic use of sick leave, and access to quiet space [4, 22, 28, 46, 47, 49]. However, these were typically contingent on open disclosure within the workplace.

Even when support was forthcoming, accommodations were frequently reported as ad hoc, impractical in context, or inconsistently implemented [4, 22, 45]. The failure of formalised accommodations in practice stemmed from organisations implementing strategies without adequate consultation with the nurse in question, resulting in accommodations that were either redundant or failed to address the nurse's specific requirements [4, 22]. In addition, personal costs for neurodivergent nurses accumulate when organisations and systems do not assume primary responsibility for workplace accessibility and tailored support [22, 47].

I need to understand it, to over-learn it

Seven sources reported neurodivergent nurses' learning preferences, including requirements for effective skill acquisition and knowledge consolidation [4, 12, 21, 22, 28, 45, 47]. Verbal, fast-paced, single-modality delivery of information was reported as inadequate for learning across many sources [4, 12, 21, 22, 45]. Instead, learning was perceived to improve with clear step-by-step instruction [4, 12, 28, 45], multimodal materials (written/visual plus demonstration), extended practice time, and hands-on repetition to *"over-learn"* [22, p. 10] clinical procedures [4, 12, 45].

Collaborative learning formats, such as study groups, peer discussion, and mentorship, were also reported to support development of tailored instruction and to provide opportunities for clarification and practice in lower-distraction settings [12, 21, 22, 45]. Additionally, practical workplace supports that were reported to be beneficial for consolidating practice included checklists, cue cards, templates, and protected time, as these reduced cognitive load during documentation and clinical procedures [21, 22, 45–47]. When training was not adapted, neurodivergent nurses bore the costs, describing lower retention, confidence, and in some cases, increased risk of error [22, 28, 45, 47].

The required adjustments were not put in place

All twelve included sources reported the influence of workplace culture and accommodations on neurodivergent nurses' experiences, including professional relationships, learning opportunities, role choice, and career progression. Five studies [4, 22, 45, 47, 48], four discussion papers [12, 14, 21, 28], two editorials [46, 49], and a lived experience perspective piece [31] explored experiences and needs regarding formal adjustments. These experiences are presented as three sub-themes: *'Meaningful support subject to open disclosure', 'Barriers to disclosure and support'*, and *'Impacts of a lack of support'*.

Meaningful support subject to open disclosure

Three studies [22, 45, 47] and a lived experience perspective piece [31] reported that effective support for neurodivergent nurses was facilitated by open disclosure within psychologically safe teams. Psychologically safe team contexts were characterised by non-judgmental responses from managers and colleagues, and disclosure often occurred gradually and informally as nurses developed relational trust within their teams, rather than as a single formal event [22, 45, 47].

However, disclosure was described as *"easier … if you have credibility"* (Dom, Adult Specialist Nurse) [22, p. 9], with established clinical standing perceived as improving the likelihood of a positive response [22, 47]. In addition to disclosure, meaningful support was reported to be contingent on self-advocacy [4, 22, 45, 47]. This required neurodivergent nurses to selectively identify trusted colleagues and managers with whom to raise specific needs and to actively negotiate adjustments that were not proactively offered [22, 45, 47].

Following disclosure, neurodivergent nurses described more frequent and spontaneous offers of support from colleagues [22, 31, 45]. This included proofreading of notes and presentations, assistance with spelling and grammar, reminders for key tasks, and tailored mentorship with clearer alignment between strengths and role requirements [21, 22, 31, 45, 47]. Supportive contexts were more likely to positively shape neurodivergent nurses' self-perception, where they described themselves as *"bright and committed"* (autistic nurse) [49, p. 24], *"quick-thinking, good at solving complex problems and* [having] *high levels of empathy"* (attention-deficit/hyperactivity disorder nurse) [31, p. 15], and *"a good nurse"* (dyslexic nurse) [47, p. 102].

Barriers to disclosure and support

Four studies [4, 22, 45, 47] and one editorial [46] identified barriers to open disclosure of neurodivergence. These included stigma and prejudice, fear of judgement and reputational harm, and organisational responses to disclosure shaped by stereotypes or misconceptions about neurodivergence [4, 22, 45, 47]. One nurse with co-occurring autism and attention-deficit/hyperactivity disorder noted *"people have their prejudices"* [4, p. 5].

Neurodivergent nurses also reported reduced likelihood of disclosure as they progressed towards senior roles. As careers advanced, the professional stakes of being perceived as less competent, or of having one's neurodivergence viewed as incompatible with leadership, became a more significant barrier to disclosure [22, 45]. In the absence of disclosure, neurodivergent-associated behaviours visible to colleagues were frequently misattributed to incompetence or poor professional conduct rather than neurodivergence. Colleagues were described as *"quick to judge …* [and] *… keen to pull you up"* (participant C, dyslexic nurse) [45, p. 43], and nurses who were perceived as *"something different"* (Ms Bishop, autistic nurse) [49, p. 25] described experiencing ostracism and hierarchy-related conflict in response.

Impacts of a lack of support

In the absence of formalised support, neurodivergent nurses described escalating self-directed adaptive strategies, reduced confidence, and consideration of role change or leaving the profession [4, 14, 22, 45, 47, 48]. These escalating strategies included increasing the frequency of self-checks, extending documentation time after shifts have concluded, and increasingly restricting clinical duties to those perceived as lower risk [22, 47].

To manage the lack of support, neurodivergent nurses also engaged in strategic selection of roles with lower sensory or cognitive load or more supportive cultures [4, 14, 22, 31, 46, 49]. However, where health or function was too compromised, an increased likelihood of neurodivergent nurses leaving the profession was reported across sources [4, 14, 22, 31, 46, 49].

Experiences by Neurocognitive Profile

The five themes above reflect experiences common across all neurodivergent nurses. However, participants also described meaningful differences in specific workplace experiences, learning preferences, and organisational responses according to their neurocognitive profile. A cross-source synthesis necessarily foregrounds shared patterns. Explicitly acknowledging profile-specific experiences is therefore important, as neurodivergent nurses are not a homogeneous group and support needs differ across neurotypes. A summary of these experiences is provided in 'Table 2: *Specific workplace experiences by neurocognitive profile*'.

Table 2
Specific workplace experiences by neurocognitive profile

Theme Title and Description	Autism	ADHD[a]	Dyslexia
"Strengths and talents to use in working life" Traits nurses associated with neurodivergence they considered beneficial to nursing practice	• Heightened sensory sensitivity could support physical assessment skills • Pattern recognition could enable early detection of subtle changes in patient status • Sustained hyperfocus could support safety and accuracy	• Direct and vocal communication could enhance ability to question unclear decisions • Rapid problem-solving could support nurses' ability to act under pressure and remain calm in high-stress contexts • High empathy supported perceived care quality	• High strength as educators/teachers, informed by lived experience of learning challenges • Creative problem-solving and intuition supported quality practice • Lived experience informed empathy and patient care
"I just can't work one more second" Unique challenges neurodivergent nurses encounter in the workplace	• Impacted by sensory overload (alarms/interruptions/touch) • Phone communication could be perceived as harder to manage due to limited social cues • Communication style could be misread • Directness could be perceived as rude or trigger exclusion and bullying	• Systems complexity could impair documentation/communication • Noise and distraction could affect concentration and reading/writing skills • Directness and pace of communication could be a mismatch with other staff and strain relationships • Distractions and competing demands could undermine focus	• Reading could take longer and distraction could worsen literacy performance • Fatigue and stress could affect emotional regulation and working memory • Competing priorities and verbal instructions could be experienced as overwhelming
"Understand[ing] what I need and what I don't need" Adaptive strategies neurodivergent nurses employed to either enhance clinical practice or conceal neurodivergence	• Could require explicit instructions and structured routines for attention/memory/task management • Reports of selecting settings to fit neurocognitive needs; for example, acute wards may be perceived as less suitable due to sensory load	• Preferred fast-paced and varied roles with structure • Used medication, movement, and stimulation to counter boredom and improve focus • Manager-prompted breaks and part-time employment may be perceived as helpful but could also create guilt	• Safety was perceived as being supported by slowing down, minimising distraction, and using paper calculations and colleague double-checks • Preference for documentation scaffolds (templates and drafts), and spelling supports • Reports that supportive environments and assistive technologies (organisation; speech-to-text tools) could be supportive
	Nurses with combined autism and ADHD identified: • Formal accommodations could be supportive, including not being required to supervise nursing students or manage the ward phone • Engagement could be supported by fatigue management, as well as prompting and memory supports • Occasional use of sick leave could also be considered a supportive accommodation		
"I need to understand it, to over-learn it" Neurodivergent nurses' preferred learning styles and experiences with clinical education and training opportunities	• Learning could improve with step-by-step instruction and explicit learning accommodations • Lack of accommodation increases error risk	• The included literature did not contain data specifically relevant to ADHD nurses within this theme	• Supported by collaborative learning, tailored mentoring, and group discussion • Tailored accommodations and learning strategies could improve knowledge retention and skill consolidation
"The required adjustments were not put in place" Influence of workplace culture, colleagues' perceptions, and stigma on neurodivergent nurses' decision to disclose and career trajectory	• Self-advocacy could challenge informal hierarchies • Lack of support could drive role change or attrition, or harm individual wellbeing and career opportunities	• Distractions and competing demands could undermine focus • Stigma could discourage disclosure and limited support could reduce confidence and energy • Mismatch between individual characteristics and work setting could impact perceived competence	• Stigma, misconceptions and fear of blame or discrimination could deter disclosure • Informal support could be perceived as mistimed or inappropriate • Accommodations could be misread as lack of competence by colleagues • Reduced help-seeking with seniority noted

[a] *ADHD = Attention-deficit/hyperactivity disorder*

Theme Title and Description	Autism	ADHD[a]	Dyslexia
			• Hesitancy to engage in further education could limit career progression

[a] *ADHD = Attention-deficit/hyperactivity disorder*

Discussion

This scoping review and thematic analysis identified the workplace experiences of neurodivergent nurses. Our application of a strengths-based, social-relational model of disability to inform interpretation of the data is a novel analytic contribution within the current evidence base [13, 15, 19], identifying individual strengths and challenges alongside organisational and structural barriers.

The identification of *"strengths and talents to use in working life"* [4, p. 4], including problem-solving, intuition, and pattern recognition, aligns with neurodiversity-affirming literature and frameworks that position neurodivergent traits as context-dependent clinical assets rather than individual deficits [12, 13, 18, 19]. Our scoping review extends previous findings by identifying how specific neurodivergent traits, including hyperfocus, pattern recognition, and empathy grounded in lived experience, translated into observable clinical strengths in practice, such as early detection of patient deterioration, high-quality care in complex clinical contexts, and peer education informed by first-hand learning challenges [4, 22, 31].

These findings challenge traditional framings whereby neurodivergence has been constructed as a patient safety risk within a medicalised and deficit-oriented framework [16, 50]. In addition, our findings differed from established assumptions within the existing literature, including misconceptions that depict neurodivergent people, and autistic people in particular, as lacking empathy, social competence, or intelligence [11]. Neurodivergent nurses across multiple sources described their empathy as pronounced and grounded in lived experience [4, 22, 28, 31], suggesting that lived experience of neurodivergence may enhance rather than diminish capacity for patient-centred care. Our review supports a reorientation towards a strengths-based workforce framework that identifies and draws on neurodivergent strengths in clinical team design, including empathy grounded in lived experience, pattern recognition, and innovative problem-solving, to improve patient care [1, 12, 14].

Our findings also highlight how the difficulties faced by neurodivergent nurses are largely related to structural and relational workplace conditions rather than individual deficits [4, 21, 22, 47]. This marks a notable departure from literature that has tended to frame neurodivergent people's difficulties in individualised or medicalised terms [16, 50], and from approaches that emphasise personal adaptation and resilience as solutions to systemic failures. Our review provides empirical support for this departure by documenting how challenges were consistently attributed to workplace design, documentation demands, disclosure cultures, and management practices – conditions external to the individual – across all included neurocognitive profiles. Across the included sources, sensory environments, documentation systems, training design, disclosure cultures, and accommodation practices were considered structurally produced conditions that generated disproportionate disadvantage for neurodivergent nurses [4, 21, 22, 46, 47]. This pattern of systemic disadvantage was reinforced by diagnostic and disclosure barriers that limit safe access to meaningful workplace support [9].

Pervasive stigma and fear of professional repercussions were identified as primary barriers to disclosure of neurodivergence, which in turn restricted access to meaningful workplace support [4, 21, 22, 47]. This is consistent with Pohlmann and Hill's [5] findings and other literature highlighting organisational and structural barriers for neurodivergent health professionals [12, 13, 19, 51]. Extending previous findings, our review indicates a disclosure paradox. Meaningful support was contingent on open disclosure and self-advocacy, yet disclosure was repeatedly described as professionally risky in contexts shaped by stigma, fear of judgement, and organisational responses that reflected stereotypes or misconceptions about neurodivergence [4, 21, 22, 45, 47, 51]. Furthermore, the disclosure paradox may be more pronounced for senior nurses. Professional seniority was identified as a barrier to disclosure and meaningful support, as the professional stakes associated with being perceived as less competent increased with career progression, discouraging disclosure at the career stage where influence over workplace culture may be greatest [22, 45].

In the absence of system accountability for support, the burden of adaptation fell on the individual nurse, with little evidence of proactive supports for neurodivergent workers. A consistent finding across neurocognitive profiles was the substantial, often invisible adaptive labour such as extra checking, slowing pace in high-risk tasks, drafting notes, and heightened self-monitoring [4, 21, 22, 45, 47]. These strategies supported accuracy and safety, yet extended task time and eroded confidence, particularly where formal supports were absent or inconsistent [4, 22, 45]. These dynamics triggered masking and avoidance strategies that reduced immediate social risk but carried longer-term costs to wellbeing and professional sustainability [4, 22, 46, 47]. Where adaptive efforts were relied on, an organisational silence was produced. Support needs were left unspoken, and the risks associated with inaccessible workplace design remained unaddressed by the organisation [21, 22, 45, 46].

This structural dynamic extended to clinical education environments, where learning opportunities were poorly matched to neurodivergent nurses' needs, placing the cost of inaccessible design on the individual [21, 22, 28, 45, 47]. Effective learning was often constructed through systematic prioritisation of controlled pacing, clarity of instruction, and appropriate environmental conditions rather than being contingent on individual capacity alone [4, 12, 22, 28]. Individual adaptive labour was reported by neurodivergent nurses to function as both a practice for reducing stigma and a means of improving the safety and quality of care [4, 22, 47]. Collectively, these findings position individual adaptive labour not as a personal

coping response but as a predictable consequence of systems that have not assumed responsibility for accessibility, reinforcing the argument that the burden of adaptation is structurally misplaced. These structural barriers may reflect global trends impacting a significant proportion of the nursing workforce [1, 14]. Our findings show that high cognitive, sensory, and clinical loads, alongside low support, intensify pressure on neurodivergent nurses within complex clinical workplaces, resulting in personal costs including burnout, reduced confidence, heightened anxiety, and escalating considerations of role change or leaving the profession [4, 23, 26, 48].

A novel contribution of this review was the disaggregation of findings by neurocognitive profile, an approach not previously undertaken in existing reviews [5]. While experiences of stigma, disclosure risk, and inadequate accommodations were common across neurocognitive profiles, delineation by individual profile identified meaningful differences in the nature and origin of workplace challenges.

Autistic nurses described challenges with sensory overload, misinterpretation of their communication style, and conflict arising from self- and patient-advocacy in hierarchical workplace structures [28, 49]. Nurses with attention-deficit/hyperactivity disorder identified complex digital systems and documentation-heavy workflows as primary sources of strain, with a mismatch between individual pace and relational expectations contributing to interpersonal and workplace stress [4, 31]. Nurses with co-occurring autism and attention-deficit/hyperactivity disorder described a complex interplay of sensory and cognitive loads, with findings suggesting that combined presentations may compound the challenges associated with each individual profile [4, 48]. Dyslexic nurses reported literacy-dependent clinical demands as disproportionately burdensome, compounded by stigma and misconceptions about competence [21, 22, 45, 47].

Additionally, autistic nurses and nurses with ADHD reported high levels of satisfaction with the care they delivered despite significant workplace strain and elevated intentions to leave the profession [48]. This suggests that satisfaction with care quality alone is an insufficient indicator of workforce wellbeing or retention risk. That neurodivergent nurses remained satisfied with the care they delivered while simultaneously experiencing strain severe enough to prompt thoughts of leaving the profession suggests that their elevated intention to leave reflected unsupportive working conditions rather than disengagement from their work [48]. Collectively, these findings challenge deficit-oriented assumptions and illuminate the complex interaction between professional identity, clinical commitment, and the systemic barriers facing neurodivergent nurses.

The identification of profile-specific differences suggests that neurodivergent-inclusive clinical settings require individualised accommodations rather than generalised strategies – a finding consistent with calls for tailored approaches to neurodivergent workforce inclusion in healthcare [4, 12, 14]. However, there were notable absences of data on the workplace experiences of nurses with dyspraxia or dyscalculia, representing an important gap in the evidence base. This evidence gap is further compounded by the concentration of primary studies in the United Kingdom, Sweden, Guernsey, and the United States of America, with an absence of empirical data on the Australian nursing context, reflecting a geographic bias in the existing evidence base.

Study Implications

The findings of this review support a shift away from reliance on nurses' individual coping and ad hoc adjustments, towards systematic, setting-sensitive accommodations embedded in workplace design, management practice, and clinical education [4, 21, 22, 47]. Review findings indicate that neurodivergent nurses do not feel safe to disclose without fear of professional or reputational consequences, nor confident that requests for effective, tailored accommodations will be addressed without shame or backlash [4, 22, 45, 47]. Achieving this level of safety would require system-level approaches to neurodiversity-informed management and workplace design rather than continued reliance on individual adaptive labour [4, 12, 14].

Our findings highlight the need for recognition of psychological safety within healthcare teams as a structural precondition for inclusion, as it directly addresses the stigma that currently discourages disclosure and self-advocacy [46, 49]. Inclusive teaching methods such as collaborative learning, tailored mentoring, and multimodal delivery represent an underexplored opportunity for workforce development that may also contribute to shifting unsupportive workplace cultures [12, 21, 22, 45]. Transformation of healthcare workplaces would arguably require neurodiversity awareness to be embedded within educational programs, management processes, and workforce policies [12, 14].

Building on the gaps identified by this review, priority research areas include the workplace experiences of nurses with dyspraxia and dyscalculia, the Australian and broader non-Western nursing context, longitudinal outcomes of neurodivergent nurses' workforce participation, and robust prevalence data [5, 20]. Addressing these gaps is essential to building a more comprehensive, inclusive, and internationally representative evidence base for neurodivergent nursing workforce policy and practice.

Relevance for clinical practice

Nurses across all clinical settings are likely to work alongside neurodivergent colleagues whose strengths and support needs remain inadequately recognised in practice. This review highlights three priorities for nursing practice: (1) recognising neurodivergent nurses' empathy, pattern recognition, and creative problem-solving as clinical assets; (2) embedding psychologically safe, low-stigma cultures in which disclosure is not a precondition for support; and (3) replacing ad hoc adjustments with setting-sensitive, individualised accommodations co-designed with the nurse.

Limitations

This scoping review is primarily limited by the scarcity of the evidence base concerning the workplace experiences of neurodivergent nurses. Only twelve eligible sources were identified, and these were geographically concentrated within Western healthcare contexts including the United Kingdom, Sweden, the United States of America, and Guernsey. Given the substantial variation in settings, staffing models, and disability frameworks across global health systems, the transferability of findings to underrepresented contexts remains uncertain. The absence of sources addressing dyspraxia or dyscalculia constrained neurocognitive profile-delineated synthesis and may reflect cultural or profile-specific research priorities rather than an absence of need or opportunity.

The included sources were largely qualitative and commonly involved small, self-selecting samples, limiting the extent to which patterns can be interpreted as stable across clinical specialties or career stages and precluding claims regarding prevalence or effect size [4, 22, 45, 47]. Samples were often heterogeneous. For example, in the most recent quantitative study by Hedlund and Jordal [48], participants with an autism-only neurocognitive profile comprised approximately 9% of the sample, hindering the generalisability of findings for that specific group.

Inclusion criteria in several studies implicitly required both a formal diagnosis and a willingness to disclose experiences [4, 22, 45, 47]. Given the prominent reporting of stigma, bullying, and misconceptions across the literature, disclosure risks may have suppressed broader involvement, contributing to an underrepresentation of nurses who are undiagnosed, non-disclosing, or precariously employed [9, 24]. The available evidence may therefore reflect experiences most visible within research-accessible groups rather than the full diversity of the neurodivergent nursing workforce.

Nonetheless, the scoping review method enabled the inclusion of a broad range of sources, including lived experience perspective pieces and editorials, which strengthened interpretive depth in a sparse field [32, 33]. However, this heterogeneity limited comparability across sources and required an interpretive synthesis that prioritised patterns of shared meaning over direct cross-source equivalence. Consistent with the purpose of scoping reviews, formal critical appraisal was not undertaken [29, 38]. Findings should therefore be interpreted as indicative patterns within a mapped literature rather than definitive conclusions about causation. Restricting the search to English-language publications across four databases may also have excluded relevant non-English or grey literature.

Conclusions

This scoping review indicates that neurodivergent nurses bring unique strengths and contributions to the healthcare system. However, their participation and career sustainability are frequently undermined by structural barriers, including stigma and inaccessible workplace designs and processes. A persistent disclosure paradox, where meaningful support is contingent on disclosure, yet disclosure is perceived as professionally risky, represents a significant barrier to workplace support. This dynamic intersects with high cumulative sensory, cognitive, and organisational load to produce unsustainable working conditions, intensive adaptive labour, and heightened risk of role change or attrition.

Addressing these barriers would arguably require a fundamental transition away from deficit-based assumptions and towards a strengths-based, social-relational approach. This means embedding neurodiversity literacy and setting-sensitive accommodations into healthcare systems, management practices, clinical education, and workforce policy. Such an approach redistributes responsibility for inclusion from individual coping and resilience to deliberate, accessible systems design. In a global context defined by critical nursing workforce shortages and the substantial costs of staff attrition, the absence of proactive, systemic inclusion strategies represents a significant and addressable risk to workforce sustainability. The capacity of neurodivergent nurses to meaningfully contribute to healthcare services is not in question; what remains to be resolved is the healthcare system's commitment to creating the conditions in which that contribution can be sustained.

Abbreviations

ADHD
Attention-deficit/hyperactivity disorder
CINAHL
Cumulative Index to Nursing and Allied Health Literature
MeSH
Medical Subject Headings
ND
Neurodivergent
PRISMA-ScR
Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews
UK
United Kingdom
USA
United States of America

Declarations

Ethics approval and consent to participate

Not applicable. As a scoping review of publicly available published literature, institutional human research ethics committee approval was not required.

Consent for publication

Not applicable.

Availability of data and materials

Data sharing is not applicable to this article as no new data were created or analysed in this study. The scoping review protocol is registered with the Open Science Framework (https://doi.org/10.17605/OSF.IO/FCH3E), and the search strategy is provided in Additional file 2.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

JS: Conceptualization; Methodology; Investigation; Formal analysis; Data curation; Writing – original draft. RG: Investigation; Formal analysis; Writing – review & editing. JA: Investigation; Formal analysis; Writing – review & editing. River: Conceptualization; Methodology; Formal analysis; Supervision; Writing – review & editing. All authors read and approved the final manuscript.

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Figures

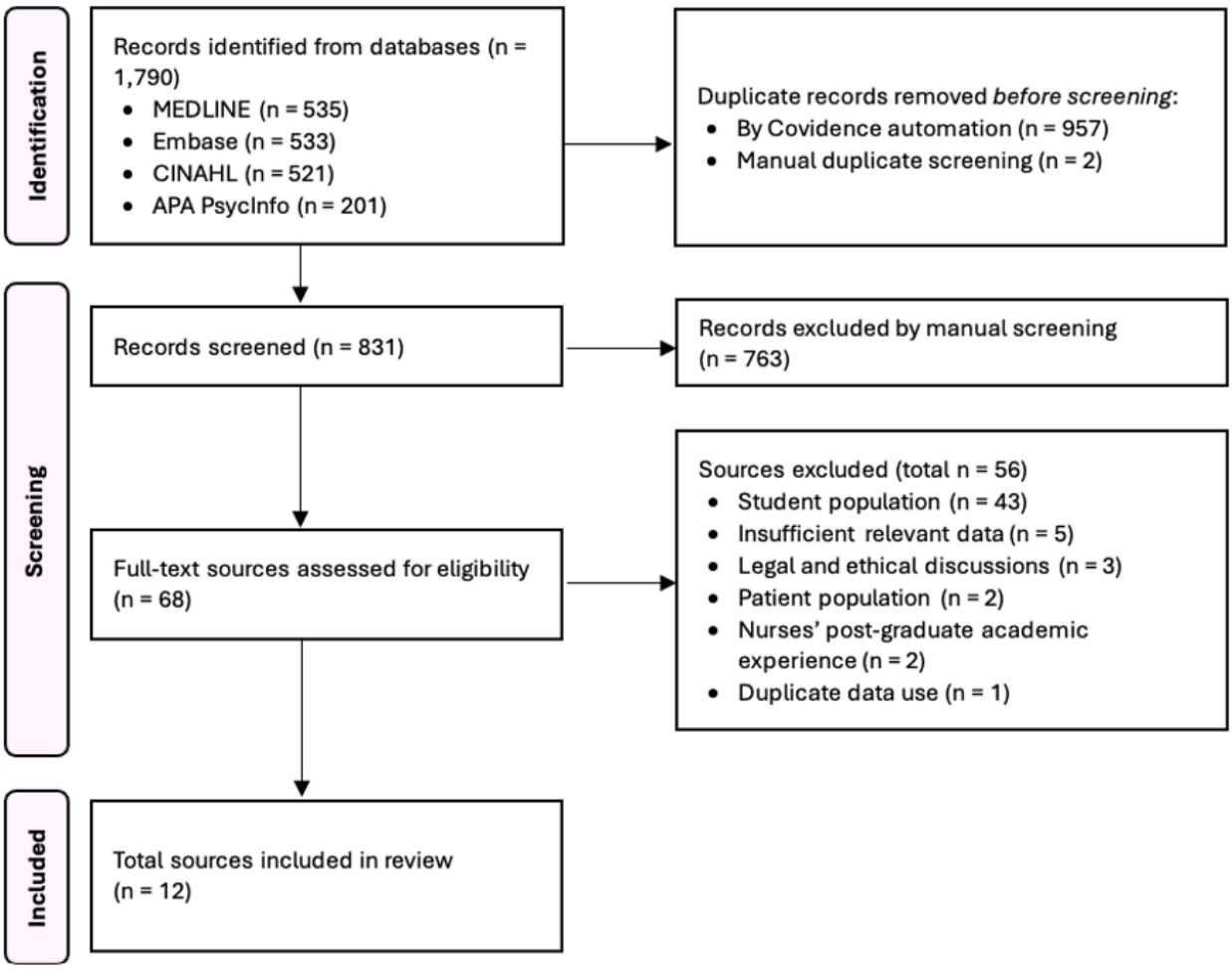


Figure 1

PRISMA-ScR flow diagram of the screening of sources of evidence

Supplementary Files

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- 20261009Additionalfile1PRISMAScRchecklist.docx
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