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Guest Editorial

Separating neurodevelopmental and psychiatric services: clinical hazard?

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Summary

Neurodevelopmental and psychiatric disorders differ in onset and course but comorbidity between groupings is high. Diagnostically siloed services risk fragmented care, misdiagnosis, inefficiency and clinical risk. Such services also deskill clinicians and intensify waiting list pressures and budget competition. We propose more person-centric systems to reduce risk and improve outcomes.

Keywords

Autistic spectrum disorder; attention-deficit hyperactivity disorder; psychiatric disorder; neurodevelopmental disorders; service development.

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Neurodevelopmental and psychiatric disorders are distinguished both conceptually and diagnostically in DSM-5(TR) and ICD-11. In recent years, many clinical services have separated services for these two disorder groups. We argue that, despite their conceptual differences, siloing of neurodevelopmental and psychiatric disorder service provision is inefficient and may amplify risk to patients. For this article, the term 'disorders' will be used, in line with terminology in current diagnostic manuals.

Characteristics of neurodevelopmental disorders versus psychiatric disorders

In DSM-5(TR) and ICD-11, neurodevelopmental disorders include autism, attention-deficit hyperactivity disorder (ADHD), intellectual disability, specific learning difficulties, communication disorders, motor disorders such as developmental coordination disorder and (only in DSM-5 (TR)) also tic disorders including Tourette syndrome.

There is a rationale for grouping neurodevelopmental disorders given their shared features.[1] Each is strongly heritable, shares familial and genetic liability and originates early in development. Although manifestation and impairment vary with maturation and context, neurodevelopmental disorders generally have a steady course. They often co-occur with each other and tend to show gender differences in how they manifest clinically.

We note that 'neurodiversity' and 'neurodivergence' are increasingly used as umbrella labels to refer to neurodevelopmental traits, although neurodiversity refers to diversity in a group rather than at the individual level. These non-clinical terms[2] have their origin in a social justice movement for autism. Their increasing use reflects a wider societal shift in the perception of neurodevelopmental identities towards a positive model of differences that should be accepted, accommodated and supported, rather than a restricted 'medical model' that views neurodevelopmental traits as deficits.

By contrast, psychiatric disorders such as mood and psychotic disorders typically arise in adolescence or early adult life, although some may have their onset in childhood.[3] A conceptual difference from neurodevelopmental disorders is that these are not typically considered as a core aspect of self in the way that a neurodivergent identity is considered by some. Unlike neurodevelopmental disorders, psychiatric disorders can often relapse and remit, with periods of time where individuals are unaffected. Unlike some neurodevelopmental disorders (except ADHD or tic disorders), symptoms can often be effectively eliminated or substantially reduced by psychological interventions and/or medication.

Evidence that challenges clear-cut separation

Several factors, however, challenge this conceptual separation between the two groups of disorders.

Risk factors cross diagnostic groupings

Psychiatric disorders share risk factors, including familial and genetic liability,[4] with neurodevelopmental disorders, and the genetic overlap between neurodevelopmental and psychiatric disorders is much more marked than with physical health conditions, including neurological ones. Other shared risks include early pre-, peri- and postnatal risk factors (e.g. preterm birth). However, because neurodevelopmental disorders onset early, later adversities such as victimisation, stressful life events and substance misuse – that have been implicated as risk factors for psychiatric disorders – may in some cases be consequences rather than causes of neurodevelopmental disorders.[5]

Comorbidity is the rule rather than the exception

A key challenge to the conceptual separation is that comorbidity is very common between, as well as within, the neurodevelopmental and psychiatric disorder groupings. This is especially the case for autism, ADHD and intellectual disability, that show prominent comorbidity with virtually every psychiatric disorder. For example, it is estimated that around 70–80% of those with ADHD will develop a psychiatric disorder.[5]

Comorbidity can be explained by shared risk factors, although some disorders, including substance misuse, anxiety and depression, may arise as a direct result of an unrecognised or suboptimally supported neurodevelopmental disorder. In the case of ADHD, treatment can reduce the risk of many associated risks.[6]

Notably, comorbidity of neurodevelopmental and psychiatric disorders is an important marker of additional impairment and risk (e.g. suicide), as well as an indicator of poor outcomes.[5]

Hazards of diagnostic siloes

Separation into specialist neurodevelopmental and mental health services, starting around a decade ago in the UK, was well intentioned. It followed an increasing awareness of neurodevelopmental disorders and their conceptual separation from psychiatric disorders; it also was consistent with the introduction of a pathways-based approach to define consistent, high-quality care in other

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areas of mental health (e.g. early psychosis services) in the face of increasing demand.[7] It may be more acceptable for those with neurodevelopmental symptoms to access support through a service specifically set up to assess neurodevelopmental disorders. Also, access to or direct involvement of multidisciplinary team members such as speech and language therapists may be facilitated within a neurodevelopmental disorder service. However, in our view, service separation by diagnoses is problematic for several reasons.

First, the very high levels of neurodevelopmental and psychiatric comorbidity mean that those with both types of disorder (the majority), and who are at highest risk, experience fragmented rather than comprehensive person-centric care. This was not problematic when mental health services provided care across the full spectrum of conditions. Those with a neurodevelopmental disorder who present to mental health services now may fail to have their neurodevelopmental disorder identified, and those who present to a neurodevelopmental service may not have a comorbid psychiatric disorder identified. This could be due to clinicians not being allowed to assess comorbidities that fall outside a service's 'remit', or because staff are not actually trained to recognise/assess a broader range of disorders. Even when comorbidity is recognised or at least suspected, inefficient crosstalk between services and a lack of a single front door can adversely affect timely access to relevant assessment and treatment.

Second, the complete splitting of services, compounded by long waiting lists, leads to both system and time inefficiencies. The presence of two waiting lists creates frustration for patients, their families and clinicians. This is especially relevant when neurodevelopmental assessment is hindered by mental health concerns, or when an apparently psychiatric presentation is better explained by a neurodevelopmental disorder. Notably, there are substantial overlaps between the components of a full neurodevelopmental and a full psychiatric assessment. Thus, continuing with the other assessment within the same service requires less time and resources than starting again in another service – avoiding duplication and unnecessary financial costs.

Third, increased service siloing and subspecialisation leave clinicians less skilled in recognising, assessing and treating neurodevelopmental and psychiatric disorders, formulating differential diagnoses and identifying comorbidities. This risks misdiagnosis, inappropriate treatment and adverse outcomes. Also, many clinicians highlight that the Child and Adolescent Mental Health Services (CAMHS) workforce has become less experienced and well trained, and has recruited fewer qualified staff as it has increased in size. This generates challenges around both the availability of diagnosticians and sufficient supervision.

Fourth, lack of timely access to relevant assessment and treatment can increase clinical risk, including the potential for self-harm and suicidality. For example, a young person with ADHD or autism who develops comorbid depression while on the waiting list for neurodevelopmental assessment could attempt suicide prior to assessment. There are also safety concerns when patients who develop comorbid psychiatric disorders are 'case-held' by neurodevelopmental services that are not set up to comprehensively manage and treat psychiatric risk and emergencies, while they await an appointment with mental health services – leaving both patients and clinicians vulnerable. Conversely, there may be individuals being assessed and treated in mental health services for whom it is evident that an ADHD diagnosis and medication would be a key intervention to ameliorate psychiatric symptoms and reduce potentially life-threatening risk, e.g. a young person with untreated ADHD who develops comorbid depression and who becomes suicidal as a consequence of ADHD. Current service models may not always support thorough, holistic assessment of complex presentations, with pressures to prioritise throughput and rapid assessment potentially compromising quality.

Finally, we believe that the siloing of budgets can lead to unhelpful competition for funding and resources from the highest level (e.g. government officials) to locality (e.g. National Health Service (NHS) Trusts). Let us take the real-life example of a mental health service where the treating clinicians face the restriction and ethical challenge of not being able to diagnose ADHD – and prescribe accordingly – because of the constraints of service models and spending allowed from siloed budgets. Most agree that resources and clinical care should follow the patient and that budget lines should not matter, but that often does not happen. Also, the existence of siloed pathways and constrained subspecialist service remits, in an era of unprecedented demand, may lead a variety of services to impose very stringent access criteria. This may mean that some of the most clinically complex and risky patients are passed between services, rather than being able to access the multidisciplinary help they need.

How can we move forward?

We present several alternatives to inefficient and potentially harmful siloed pathways that could be considered as pilot projects.

A first option is to move back to a more generalist model where everyone in mental health services is trained to diagnose and possibly treat neurodevelopmental disorders, at least less complex cases. For this, more diagnosticians are needed in the workforce and this needs to be underpinned by upskilling clinicians during their training, with the most experienced staff focusing on training and supervision. At the very least, given the high rates of co-occurrence, there is a strong rationale for resourcing routine screening of mental health service users for neurodevelopmental disorders and evaluating whether this reduces misdiagnosis and diagnostic overshadowing.

Second, the assessment and treatment of a psychiatric disorder within existing neurodevelopmental services may be more challenging where these are paediatrics-led and possess no capacity to treat psychiatric conditions or manage risk. One option is for paediatrics-led neurodevelopmental services to be jointly resourced and fully integrated with CAMHS, which is not currently the case in many areas. An additional service model is the integrated youth service that spans ages 11/12–25 years[8,9] and that has been adopted and evaluated across many different countries. These services are co-developed with young people and include professionals with expertise in mental health and encompass psychiatrists, substance misuse, criminal justice, physical health, education and careers, and are needs- rather than diagnosis-led. These appear to be effective for integrating support across different services (e.g. education, work, mental and physical health) and provide rapid access to support and treatment for young people.

Third, we suggest that all neurodevelopmental and psychiatric service staff routinely consider neurodevelopmental and psychiatric differential diagnoses and have the skills to conduct assessment and formulation to avoid assessment duplication. Furthermore, seamless, rapid access with a horizontal referral and consultation system between neurodevelopmental and psychiatric services would mean that those affected do not have to wait on two separate waiting lists. Physical co-location of services' bases would help with facilitating advice and referral between services.

Finally, ADHD and autism are especially commonly associated with intellectual disability, substance misuse, criminality (thereby presenting to a forensic psychiatrist) and eating disorders that often have subspecialist services. It is our opinion that expertise in

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assessing and treating neurodevelopmental disorders, and the resources to do so, must be embedded in these services.

Although from a conceptual perspective neurodevelopmental and psychiatric disorders can be separated, research shows that our diagnostic criteria and groupings are imperfect and co-occurrence levels high. Thus, siloing services by diagnosis and superspecialisation in psychiatry has serious limitations and can create hazards.

We suggest a few different alternative models that could be tested, while recognising that other successful models may exist locally or internationally.

Finally, regardless of model, we urge providers to ensure that budgets, planning and service provision across neurodevelopmental and mental health services are seamless and joined up. Also, proper comprehensive training of all staff in both neurodevelopmental and psychiatric disorders represents a crucial priority. In this era of extremely high demand for services and ever-increasing clinical complexity, the current situation is unsustainable and changes are imperative.

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Author contributions

A.T. and S.C. conceived the manuscript. A.T. conceptualised the key points of the paper and led the writing of the first draft. All authors contributed to drafting and editing of the paper, considering different service models.

Declaration of interest

A.T. receives royalties from Wiley for *Rutter's Textbook of Child and Adolescent Psychology and Psychiatry*; was Chair of the NHS England-commissioned independent ADHD Taskforce; has served on the Welsh Government Adult ADHD Task and Finish Group; and previously was co-chair on the Welsh Government Neurodivergence Ministerial Advisory Group and on the Welsh government clinical advisory group for ADHD assessment and support. All roles have been unfunded. M.C. is a consultant child and adolescent psychiatrist at Clinical Partners. She has spoken about the Cwm Taf Morgannwg Neurodevelopmental Service at conferences hosted by Takeda (formerly Shire) and Flynn Pharma. These talks were not related to the content of this article, and she did not receive personal payment. S.C. has declared reimbursement for travel and accommodation expenses from the Association for Child and Adolescent Central Health (ACAMH) in relation to lectures delivered for ACAMH, the Canadian AADHD Alliance Resource, the British Association of Psychopharmacology, Healthcare Convention and CCM Group team for educational activity on ADHD; and has received honoraria from Medice.

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