editorial

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Developmental disorders come of age

SUMMARY

A review of the presentation and the issues surrounding the management of developmental disorders which, while always part of the remit of child psychiatry and learning disability psychiatry, are relatively new to adult psychiatry.

It is only recently that we have begun to recognise the extent and importance of developmental disorders in adults of otherwise normal ability. This article reviews their impact on psychiatric practice and training.

Child psychiatry developed on the premise that early treatment would eliminate later, adult disorder. Experience has led it to settle for less but it has yet to lose its monopoly on the developmental disorders. True, many people do grow out of their disorder, even if only partially, and others find relief as they escape from the stringent demands of adolescence and school. However, there is no magic transformation at 18 years and, as the tide of persistent disorder surges around adult mental health services, the shortfall shows.

Specific developmental disabilities are ubiquitous and uncounted. Usually mild and immaterial, they can be sufficiently prominent to affect the lives of about 5% of the population. They cluster to form developmental disorders which, genetically based, evolve with age and growth to be shaped by circumstances and experience. Lying on a continuum, the symptoms may be seen as extremes of normal behaviour, crossing some ill-defined threshold to become a disorder when people and their environment are sufficiently out of kilter to produce morbidity. Of most immediate concern are the autism-spectrum disorders, attention-deficit hyperactivity disorder (ADHD), tic disorders (including Tourette syndrome), the epilepsies and various forms of intellectual disability which may range from the specific (notably dyslexia) to the general.

Why might an adult with one of these disorders have any difficulty in finding a suitable service? First are psychiatry's doubts as to whether there is a real need for additional services. In the absence of population surveys, it is difficult to do more than guess as to the prevalence of disorder in adulthood; the starting point of a response to the managerial demand for a business case. The developmental trajectories hinder extrapolation from younger groups for, with increasing age, many will drop below the clinical threshold that divides disorder from trait. Such a shift, however, is dependent on a reasonably stable and sympathetic setting so that some will be destabilised by the upheaval of, say, divorce or unemployment with a re-emergence of their disorder. There is substantial overlap between the groups so that estimates, such as 1.0% of the population might have autism-spectrum disorders and 2% treatable ADHD, cannot be summed. Although there is an element of attrition, many will wait to see the full extent of public demand as it filters through general practice and service commissioners. The generation of children who managed to get their ADHD treated with stimulants has grown up and many want to continue on (or return to) medication (Edwin & McDonald, 2007; Fung, 2007). As public awareness of autism-spectrum disorders has increased, so has the pressure to provide diagnostic services for those individuals who children's services had missed or even told (within the narrower concepts of the time) that they did not have an autistic disorder. For others, the gradual development of neuropsychology is leading to health involvement in areas such as dyslexia and dyspraxia, which previously were dealt with by agencies such as the voluntary sector or occupational psychology.

Next is the very real concern that the demand will swamp overstretched services in the absence of additional resources; the more so as multi-agency models are recommended. Although 'New Ways of Working' (Care Services Improvement Partnership, 2005) does hold out the promise of creating some slack in existing services (but also staff redundancy), it must be acknowledged that it would be difficult to match the relative wealth of supportive educational, social and voluntary services that is available to child psychiatry.

A third factor is the reservation as to whether these disorders really fall within the remit of psychiatry, a point reinforced by the readiness of paediatrics to deal with them in childhood. Like the personality disorders, these might be seen as representing an extreme of normality, which should not be medicalised and for which other agencies, such as social services and education, are better fitted to make provision. This line of thought would see it as more fitting for the neurologist or physician to support the general practitioner in prescribing specialist medication (as in the treatment of

editorial

tics or ADHD). It is an argument which ignores the considerable comorbidity associated with developmental disorders. Anxiety and depression are rife and obsessive–compulsive symptomatology runs through biological psychiatry alongside other problems of control and impulsivity. Bipolar disorder has been linked with ADHD (the more so in the USA) and, although autism-spectrum disorder does not predispose to schizophrenia, neither does it protect. It is only the psychiatrist who has the necessary experience to cope with this porridge of psychopathology.

A fourth factor is that many psychiatrists lack experience and training in the developmental disorders so that they are unwilling to venture into work in an area for which they feel unqualified, particularly in today's climate of formal and legal criticism and complaint. Although experience in developmental psychiatry is now mandatory for membership of the UK Royal College of Psychiatrists, its nature may not equip the trainee sufficiently. For example, a placement in adult learning disability psychiatry may have little of the management of ADHD, whereas child (as against adolescent) psychiatry may not touch on the nature of the diagnosis of autism-spectrum disorder in adults of normal ability.

What might be expected of adult mental health services? We can identify different categories of patient depending on the source of referral and previous experience.

- Those who have been identified and managed by the child and adolescent services but require continued psychiatric input, whether because they continue to be disturbed or because of the nature of treatment. They need a temporary overlap in order to make a smooth transition from adolescent to adult mental health.
- Those who, following diagnosis, have established a stable pattern of life that does not require medical input other than to provide medication. It has been suggested that this group might be managed entirely by primary care. Unfortunately, much of neuro-developmental prescribing falls outside drug licensing and, although it is thought that this difficulty might be resolved by the establishment of shared care agreements, many children's services have found these unexpectedly difficult to implement.
- Those who have not had a previous diagnosis/assessment. A diagnosis is not something to be given lightly for the consequences are far-reaching, thereafter altering the identity of the person, their eligibility for education, employment and benefits, the significance of any other symptoms they have and their management (including the choice of treatment and medication). In addition, the developmental disorders are the secondary consequence of a variety of medical disorders sufficiently often as to require a clinical assessment to identify or exclude such conditions as fragile-X syndrome or a neurocutaneous disorder. Any disability is likely to be only a part of a constellation of disabilities so that diagnosis should only be an element of the wider (diagnostic) assessment in which the psychiatrist is one component of a multi-disciplinary clinical team.
- Those whose comorbid symptomatology requires psychiatric management. Many of these people are going to find themselves engaged with adult mental health anyway but failure to take account of their developmental disorder will limit the success of any therapeutic work.

What then should be psychiatry's business and how should this be determined? Although ruled to some extent by resource allocation and managerial diktat, patient need and personal enthusiasms are still powerful elements in service development. Given these, what form might a neurodevelopmental service take? At the moment, demand and interest are producing clinics dedicated to single disorders such as ADHD (Asherson *et al*, 2007; Verity & Coates, 2007), autism-spectrum disorders (Royal College of Psychiatrists, 2005) or any one of the variety of developmental disorders. Such clinics tend to focus on their disorder as the primary diagnosis and, whether other disorders are recognised or not, they are likely to be of secondary importance. This model means that diagnosis will be weighted by the availability of clinics and the referrers' selection. An alternative approach might be to develop a broader, specialist neurodevelopmental service, perhaps as part of a neuropsychiatric service. However, given the potential numbers and the need for a local service, it might be better to copy the models established in child and adolescent psychiatry and in learning disability psychiatry whereby developmental disorders become part of the everyday work of the mainstream adult community psychiatrist. Such a psychiatrist would be a member of a multidisciplinary adult mental health team which might include a community nurse who monitors and prescribes medication.

Psychiatry has evolved rapidly over the last 50 years, flexibly adapting to new therapies, constructs and fashions, with the College playing a vital part in determining the training required. The developmental disorders are upon us and are pressing for better recognition, but the lack of research means their importance is open to exaggeration or denial. All the same, we must be prepared to respond.

Declaration of interest

Tom Berney acts as a consultant on the developmental disorders to a number of providers in the independent sector.

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editorial

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