

The Empowerment Project - Stronger Voices for Fairer Futures

The Royal College of Psychiatrists Paper - Our Reflections

3 March 2026

Key Takeaways

- We welcome the strong emphasis in the Royal College’s Paper on the need for adequate levels of assessment and support for neurodivergent people in Scotland, along with its recommendation to explore how to expand the availability of ADHD treatment. However, we do not consider this need to have been “unforeseen”.
- A needs-based approach and society-wide response may require legislative reform, and will require an improvement to the mechanisms for holding local authorities and health boards to account.
- The current framework for disability benefits requires the applicant to provide supporting information from professionals involved in their care about their disability. It is unrealistic to expect all neurodivergent children to get the benefits they need without involvement from medical or clinical services, particularly given the lack of detailed-record keeping within education services.
- We need professionals to lead by example when it comes to use of appropriate terminology, and services should avoid setting thresholds for assessment which necessitate consideration of “functional impairment”.
- We are keen to explore the questions of health care regulation in the UK, and seek further details of the evidence base for the concerns being raised about private ADHD assessment.
- Research and evidence that is used to form the basis of policy recommendations should be proactively published if it is to be relied upon by policy-makers.

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Introduction

One of the themes of discussion during the Committee's Evidence Session on 17 February was the Royal College of Psychiatrist's Paper on [Multi-system solutions for meeting the needs of autistic people and people with ADHD in Scotland](#) (the "**Paper**").

The work that has gone into the Paper is clearly intensive, and it demonstrates a real commitment from psychiatrists in Scotland to make life better for neurodivergent people. We are grateful for their work on this, and their obvious efforts to raise awareness amongst policy-makers of the need to improve access to assessment, diagnosis, medication and support for neurodivergent people. We value their prioritisation of this issue, particularly in the context of the significant challenges those working in NHS psychiatry services currently face.

In particular, we welcome the Royal College's suggestion that the workstreams recommended in the Paper are developed with the input of people with lived experience. We intend to write directly to the Royal College with more detailed comments and questions in order to ensure that, as an organisation run by and representing those with lived experience, we are in a position to provide a meaningful contribution at the appropriate stage of policy development.

In the meantime, there are some initial observations that we have made which we consider might be useful for the Committee's considerations as part of the Inquiry. We hope that these comments can assist the Committee and, in turn, whoever is implementing any of the Royal College's recommendations as set out in the Paper.

The Foreseeable Impact

We are grateful that the Royal College is highlighting the impact of the ongoing lack of dedicated, standardised pathways for neurodevelopmental conditions. However, we are surprised at the characterisation of this as "*unforeseen*".

Mental Health Strategy (2012)

For example, the [Scottish Government](#) recognised the importance of developing specialist services for ADHD as far back as 2012. In particular, the "[Mental Health Strategy for Scotland: 2012 to 2015](#)" (the "**2012 Strategy**") stated:

“...there is work needed to improve diagnosis of and response to Attention Deficit Hyperactivity Disorder (ADHD). Work within NHS Lothian has established that people with ADHD are increasingly presenting to adult mental health services, but there are inconsistencies within mental health services in how this is responded to.”

It goes on to make a commitment that the Scottish Government *“will undertake work to develop appropriate specialist capability in respect of developmental disorders as well as improving awareness in general settings”*.

This demonstrates that the Scottish Government had already recognised the increasing demand 14 years ago, and had committed to improve their response to this.

Royal College Guidelines (2017)

Further, the Royal College highlighted this unfulfilled commitment from the 2012 Strategy in their [Good Practice Guidelines in 2017](#) (the **“2017 Guidelines”**). The Royal College stated:

*“Commitment 33 of the Mental Health Strategy for Scotland 2012–2015 (Scottish Government, 2012) undertakes to develop specialist capability with respect to those with neurodevelopmental disorders (NDDs), including ADHD, in adults. **Scottish health boards therefore need to address this emergent clinical and educational need**”* (emphasis added).

Under-diagnosis of ADHD

They went on to explain that levels of adult diagnosis of and treatment for ADHD in Scotland is *“well below expected”*, and that *“ADHD continues to be underestimated in the Scottish school-age population”*. They cited Healthcare Improvement Scotland when stating that there was a *“dearth of services”* for adults with ADHD in Scotland, in contrast to the *“expanding situation in England and Wales”*.

“Predictable increase in need”

The 2017 Guidelines also gave advice on suggested service models, highlighting the underdiagnosis rates which were reported by NHS Quality Improvement Scotland as far back as 2008 and stating:

“As awareness and diagnostic rates increase, an increased demand on adult services is likely to follow. Health boards should develop proactive strategies to meet the predictable increase in need for this adult group, in line with recommendations (Scottish Government, 2012)” (emphasis added).

Characterisation of issue as “unforeseen”

We therefore find it frustrating that the rising demand, and failure to meet that demand, is being characterised as “unforeseen” [by the Scottish Government](#).

To the extent that it was unforeseen, we would suggest that this observation is not particularly relevant, and is not a helpful thing for neurodivergent children and their families to hear from the politicians who are charged with that area of responsibility. We already feel “unseen” as it is, and we are acutely aware that, historically, our needs have been ignored or dismissed.

Context and “lessons-learned”

It is not our intention to attribute “blame” to any particular organisation or decision maker, or provide commentary on decisions that have been made in the past, and we do not think it would be a good use of our volunteers’ time and energy to do so. However, the predictability of the situation is an important context for policy-makers when allocating resources or when conducting reflective “lessons learned” exercises, especially because it highlights the systemic lack of recognition or respect for the needs of neurodivergent children in Scotland.

Importance of Diagnosis

We welcome the Royal College’s recognition of how important timely diagnosis is in order to reduce risks that are faced by neurodivergent people, to improve their quality of life, to prevent secondary mental illness, and increase life expectancy. We are reassured to see that recognition of the importance of diagnosis is balanced with recognition of the need to ensure that support is available even when a person does not have one.

Social Security Benefits

In particular, we agree with the Royal College that people should have access to social security benefits notwithstanding the lack of a diagnosis. In the case of devolved benefits administered by Social Security

Scotland, such as Child Disability Payment and Carer Support Payment, we still see that lack of diagnosis can be a barrier.

The first workstream recommended by the Royal College relates to support being available for those who need it without diagnosis, and specifically states that:

“Those who require support... from the social security benefits system should be able to access this based on self-recognition of traits (and without the need for a formal diagnosis).”

It also states that:

“There is a need for clarity that legally, DWP benefits should be awarded according to needs, rather than requiring diagnosis.”

We are not sure exactly what is meant by the reference to a “*need for clarity*”, but we do support the idea that benefits should be awarded according to needs, and we think it is important to consider whether the current regime for disability benefits is compatible with the suggested “*needs-based approach*”.

We caution against inadvertently raising expectations amongst neurodivergent children and their families about the level of social security assistance to which they are entitled as a matter of law. In other words, we need to make sure that the message of “*you do not need a diagnosis to get disability benefits*” is not translated to “*you can get disability benefits even if you are not disabled*” in the minds of those receiving that message.

Devolved disability benefits

Child Disability Payment¹ is a devolved benefit which was introduced by the Scottish Government using powers under the [section 31](#) of the [Social Security \(Scotland\) Act 2018](#) (the “**2018 Act**”). the 2018 Act currently provides for disability assistance to be given to an individual on account of that individual “*having a disability arising from a physical or mental impairment*”² that has a “*significant and not*

¹ We support neurodivergent children and their families so have focussed on Child Disability Payment but note that Adult Disability Payment is also a form of disability assistance under section 31 of the Social Security (Scotland) Act 2018 (“2018 Act”).

² Noting that there is also provision in section 31(1)(b) of the 2018 Act for disability assistance to be given to an individual with a terminal illness.

short-term adverse effect on the individual’s ability to carry out normal day-to-day activities, or otherwise gives rise to a significant and not short-term need”³.

This is very different from the current legal framework for additional support for learning, which gives children rights to have additional support needs met, regardless of whether those needs arise from a disability arising from a *“physical or mental impairment”*.

“Severely Disabled”

Specifically, for a [child to be eligible](#) for the “care component” of Child Disability Payment (“CDP”), the law requires them to be “**severely**” disabled.

Therefore, children who identify or present as having “traits” of neurodivergence will not currently meet the criteria for social security benefits unless it could be established on the balance of probabilities that they are “severely disabled”.

“Backwards and Forwards Tests”

Additionally, for the “severely disabled” child to qualify for CDP, what’s referred to by Social Security Scotland as the “backwards and forwards tests” must be satisfied. This is a [legal requirement](#) that the needs arising from the *“physical or mental impairment”* must have been present for at least 13 weeks prior to the date of application, and must be likely to continue for at least 26 weeks following that date.⁴

These “backwards and forward tests” pose a particular challenge for applicants of CDP, given the different ways that the needs of neurodivergent children may present, and the differing presentations in different environments or different stages of development. Without an underlying diagnosis it is difficult for parents and carers to persuasively demonstrate the likelihood of needs persisting over time, and/or the likelihood that other needs might arise even if the existing needs may not persist.

Supporting Information from Professionals

Aside from the eligibility thresholds set for CDP, another contributing factor to the issues faced by neurodivergent children when accessing disability benefits is the requirement to provide a document⁵ by way of “supporting information” to accompany an application. In particular, the fact that supporting

³ See section 31 as read with Schedule 5 to the 2018 Act.

⁴ Note the different tests for CDP awarded in cases of terminal illness.

⁵ The [Scottish Government’s website](#) states: “When you apply for Child Disability Payment, you need to provide a document from a professional that confirms the child’s conditions, disability or needs. It does not need to include a diagnosis.”

information must be provided from a professional or organisation that falls within the one of the following categories:

- *“have been involved in the individual’s care, treatment, or everyday life for a period that would allow them to be familiar with their needs*
- *have carried out an assessment of the individual’s condition, disability or needs*
- *have the professional knowledge and access to records to provide an informed opinion on the individual’s condition, disability or needs.”*

In the absence of evidence that a child is on a diagnostic assessment pathway it is often the case that such documents do not exist. It may be that there simply is no professional involved in the child’s care that falls within one of the categories mentioned above, or it may be that no documentation exists which contains the supporting information necessary to corroborate the applicant’s description of the child’s needs. This risk is exacerbated by poor or inaccurate record keeping by schools and education authorities.

Even when documentation from a professional does exist, it may not be sufficient. The [Social Security Scotland’s Decision Making Guidance](#) states that supporting information for an application for CDP may provide details on:

- *“a diagnosis*
- *a treatment being received, such as medication or physiotherapy*
- *how an individual’s condition or disability impacts their life*
- *steps taken to find out about the individual’s condition and make a diagnosis*
- *aids and equipment that an individual uses to manage daily life*
- *support that the individual needs at school or in a club they attend although this information is more likely to be found in additional supporting information.”*

While the Guidance states that *“the lack of a diagnosis does not prevent an individual from being awarded CDP”*, it goes on to explain that documents which amount to *“supporting information from professional sources”* consist of:

- “official documents“ such as “a report from a specialist doctor based on their interaction with the individual and medical records” ,or
- “a prescription list of the individual’s medications”.

By citing these as the main examples, applicants may not realise that they can still apply even without medical supporting information, and many will not bother to apply in the first place.

“Legal clarity”

Therefore, it will be important to confirm with their intended meaning when the Royal College uses the term “legal clarity”, and when they state the benefits “should” be awarded according to needs: Do they mean that there is a need for public awareness that the disability benefits must, as a matter of existing law, be awarded on the basis of need? Or do they mean that the law on social security benefits should be reformed so that children with neurodivergent traits should be awarded benefits on the basis of any need arising from that, regardless of whether or not those traits amount to a “disability”?

If legislative reform is required then this would not be a solution in the immediate-term, although it would be a welcome longer-term goal. .

Society Wide Response

We welcome the Royal College’s recognition that an urgent society-wide response will help, and we hope that the Royal College’s suggestions will contribute to achieving it. That said, we are alert to the risk that it is used (either deliberately or inadvertently) by health boards to justify a failure to provide appropriate levels of diagnostic assessment and, where appropriate, treatment.

Medication

It will be important to bear in mind that only health care providers can prescribe medication, for example ADHD medication, melatonin, or other medication used in co-occurring mental health conditions. This is particularly important given that mental health issues often arise as a result of, or are exacerbated by, the lack of medical or other support for neurodivergent people. We worry that neurodivergent people who may benefit from medical input will be expected to seek support for their needs elsewhere.

Reasonable Adjustments

As part of a society-wide approach, the Royal College recommends that guidance is given to service providers and employers about how to provide reasonable adjustments. Of course, we welcome this and it will definitely help improve things to a certain extent. However, we must be careful not to conflate the duty to make reasonable adjustments with other duties, such as the duties of health boards to provide healthcare and the duties of education authorities to provide education. We cannot and should not rely on the duty to make reasonable adjustments to ensure that neurodivergent children get the access to healthcare and education to which they are entitled.

Another area of caution is around the recommendation that “reasonable adjustments” should be made for people with “neurodivergent traits”. There is a [duty to provide reasonable adjustments for disabled people](#) under the Equality Act 2010, but that duty does not extend to people who have “neurodivergent traits” but do not meet the [Act’s definition of disability](#).

Accountability and Enforceability

A society-wide response will only work if there is a workable, realistic mechanism to hold the relevant bodies, service providers and employers to account. Unfortunately, we do not feel confident that we are anywhere near a stage in societal progression that will mean that rights and support will not be easier to enforce and obtain if a child has a diagnosis, or has evidence of being on a diagnostic assessment pathway. Even the current legal frameworks are not properly enforced, or do not provide the legal protection that is required.

The Perspective of Lived Experience

We are mindful that the Paper has been produced by and on behalf of the medical profession, and not necessarily for or on behalf of people with lived experience, or for consumption by the general public. The Royal College has rightly highlighted the need for lived experience to be involved in the development of the workstreams in future, and we have therefore shared some reflections on the contents of the Paper which the Committee may wish to consider before publishing its own report.

The “Wicked Problem”

We suggest that the Committee avoids using terminology such as “*wicked*”, or making comparisons with societal issues such as “*knife crime*”, when communicating its conclusions, unless it is absolutely necessary to make a point. It is easy for words like “wicked” to be taken out of context, and comparisons with societal harms such as knife-crime are unfortunate in the context of the prevalent societal stigma that neurodivergent children and their families already face.

NAIT Definitions

We welcome the Paper’s note on language use, and the fact it draws attention to the benefits of adhering to the [National Autism Implementation Team’s definitions](#). However, the fact that even the Royal College have struggled to use that terminology consistently and accurately⁶ in the Paper is evidence that we are far away from the societal understanding which we all strive to achieve. Similarly, some witnesses at the Committee’s evidence sessions, when appearing in their capacity as professionals who have particular knowledge or expertise in the subject matter of the Inquiry, have also demonstrated a failure to properly understand or use terms such as “*neurodiverse*” and “*neurodivergent*” correctly⁷. If we are aiming for increased awareness and acceptance of neurodivergent children, then professionals in positions of authority and influence must lead the way.

Reference to functional impairment

We are surprised at the Paper’s use of concepts such as “functional disability” and “functional impairment”, particularly in the context of thresholds for diagnostic assessment. For example, the Paper states:

“Where functional impairment remains significant despite initial adjustments having been made, then referral to clinical teams for a diagnostic assessment would be indicated.”

We would be extremely disappointed if the Committee were to endorse this approach.

⁶ A particularly unfortunate example of this includes: “*This may mimic or worsen the symptoms of neurodiversity.*” (p12). The references to “symptoms” being “worsened”, and the use of the word “neurodiversity” instead of “neurodivergence”, are things which we hope that the Committee does not replicate in its Report, notwithstanding the need to give due consideration and deference to the Royal College in relation to their expertise and experience in a clinical context.

⁷ We do not wish to highlight specific individuals from the evidence sessions in this Paper but assume and hope that the Committee members noticed the examples to which we refer, and we are happy to provide follow up on this if required.

Lifestyle Factors & Neurodivergent Children

The Paper contains examples such as screen time, social media, caffeine and sleep as lifestyle factors which adversely affect concentration and attention in a way that “*may mimic or worsen the symptoms of neurodiversity*” (sic). The Paper recommends that guidance and self-help resources for these areas should be commissioned.

We defer to scientists and professional experts when it comes to analysis of current research in this area, but wish to flag that recommendations such as this can contribute to the feelings of self-blame that we often feel as parents and carers. They can also be weaponised by those who explicitly and/or implicitly blame parents and carers for the struggles of their neurodivergent children. Any messaging around this recommendation should be crafted with this in mind.

Screen-time

It is often difficult for parents and carers of neurodivergent children to avoid screens, especially when they are used for so many things these days, including at school. Some neurodivergent children rely on electronic devices for use of alternative communication technology, and yet we still hear of schools refusing to accommodate this. Any guidance that is issued on screen-time must take into account the reality of the situation for families, and must include specific caveats when it comes to the use of communication devices to be used in classrooms.

Sleep

Many neurodivergent children (and therefore also their parents and carers!) have extreme challenges with sleep, yet children are being denied access to melatonin if they don't have a diagnosis. Some children have a diagnosis and are prescribed melatonin tablets which they cannot take because of sensory issues, but many doctors refuse to prescribe liquid melatonin instead.

Realistic and achievable goals

It is not always realistic for parents and carers to implement lifestyle changes or environmental modifications when they are juggling the stresses of caring for a disabled child, particularly when that child is not getting the support they need at school or perhaps not getting medication that they need. It

can be even harder when, as is often the case, the parents or carers are neurodivergent themselves, often with woefully inadequate support or recognition, or being unmedicated for ADHD.

Stigma and Blame

The last thing the families of neurodivergent children need is any more fuel to the fire when it comes to parent-blaming. While this does not negate the significance of any emerging evidence about the impact of lifestyle factors, it needs to be borne in mind by those allocating resources to the development of online self-help guidance about this.

If any evidence does show significant links with lifestyle factors, the onus has to be placed on public bodies to solve the problem, and it has to be communicated in a way that takes active steps to clarify this. We would not want anything to risk undermining the message that, if a child is neurodivergent, it is not as a result of something a parent or carer has done.

Importance of Treating ADHD

A really positive aspect of the Paper is the recommendation to expand the types of professionals who can diagnose and treat ADHD, and the general focus on the importance of early intervention, diagnosis and treatment to reduce the risks associated with unmanaged ADHD.

Primary health care

We also support the idea that primary care teams should be involved in the treatment of ADHD. This is what we believe should already be happening.

Independent Health Care Providers

An area of the Paper where we are less convinced is the discussion in “Section 6 - Private Providers, clinical standards and oversight”.

It is extremely concerning to read of potential risks involved in the diagnosis and treatment of ADHD, whether it is a private provider or not. For example, the [recent decision report from the SPSO](#) in relation to the quality of CAMHS services for neurodevelopmental assessment in NHS Tayside causes us great concern. However, we have not yet been provided with evidence to substantiate the risks, or to reassure us that these risk are appropriately weighed against the risks of inadequate access to diagnosis and

assessment (such as the risks highlighted by the Royal College, including suicide rates, drug misuse and lower life expectancy).

Inconsistency re Shared Care

The Royal College recommends that there should be *“collaboration, training and investment with primary care colleagues to support consistent access to shared care arrangements for ADHD medication prescribing”*. We very much welcome this, provided of course that the consistent approach is not to extend the blanket bans which are implemented by some GP practices on a Scotland-wide basis. We support consistent access to medication as part of shared care agreements, not consistent lack of access.

Regulation of Health Care

We would appreciate more information from the Royal College about their concern that there is a lack of regulation when it comes to private providers. We are confused by the assertion that a “loophole” exists, at least to the extent that it would be unmanageable to mitigate the risks of any such loophole.

Online Providers

The loophole described by the Royal College relates to online providers who are not based in Scotland. Of course, there is always a possibility that a GP would be asked to enter into a shared care arrangement with a clinician who is prescribing medication from outwith the UK via online services. That is not what the families we support are asking for. They are asking for shared care with providers who are based in the UK, and therefore subject to regulation by Healthcare Improvement Scotland or the equivalent regulator in one of the other three nations of the UK. The prescribing clinician would also be regulated by the GMC or equivalent professional regulator. We are therefore surprised by the statement on page 16 that a provider is *“not subject to any scrutiny”* simply because it is not based in Scotland.

The NHS

If HIS cannot be relied upon to regulate independent health care providers and agencies, we are unsure why they can be relied upon to carry out adequate inspections of NHS facilities. Psychiatrists in both sectors are regulated by the GMC, and providers in both sectors are regulated by the HIS or equivalent in England, Wales or Northern Ireland (who also work together on a cross-border basis via Memorandums of Understanding). Therefore, if these concerns are so great that GP practices cannot be

reassured that the diagnosis and treatment plan are reliable, this suggests systemic issues across the health care system in the entire UK.

NICE and SIGN Guidelines

We note the concerns expressed about NICE and SIGN Guidelines, but we do not understand why these concerns are restricted to shared care agreements with private providers rather than NHS providers too, since the NICE and SIGN guidelines are applicable in both contexts.

Single Condition Assessments

We also note the concerns about Single Condition Assessments, but again do not understand why these concerns would be restricted to shared care with private providers only given that health boards also still provide single condition assessments.

BBC Panorama

The Paper mentions that they have evidence from investigations “*such as*” the BBC Panorama documentary. We would welcome information from the Royal College about the other investigations they have used as evidence here.

We are surprised that a BBC Panorama documentary is the primary example being cited as evidence for concerns about private providers. It is difficult to understand why it would carry evidentiary weight to the extent that it is capable of undermining confidence in the system for regulating health professionals and health care providers (including the NHS) across the UK.

Independent ADHD Taskforce

We note with interest the [Report of the Independent ADHD Taskforce](#). The Taskforce was commissioned by NHS England in 2024. The evidence of low-quality ADHD assessment and inaccurate diagnosis was described by the Taskforce as “*anecdotal*”. The report also raised the issue that mistrust about the quality of diagnosis poses further challenges for people with ADHD, including disbelief from others about the authenticity of their diagnosis and having to seek additional assessments.

It is against this background that they advise that nationally accepted commissioning standards for ADHD are developed. The reasoning was that it is important for *“addressing ADHD stigma and perceptions of some about the lack of rigour of ADHD diagnosis and low quality of providers”*.

Evidentiary insufficiency and stigma

We would not complain about higher standards of quality assurance being met, and we welcome any improvement that can be achieved without having a corresponding negative impact on the rights of neurodivergent children. However, it seems that its purpose in this case may be to mitigate the impact of stigma and prejudice, rather than to prevent patients from risk of medical harm.

Person-centred care and distress

As a charity run by and supporting those with lived experience, we feel that the current situation leaves us between a rock and hard place - if we accept the inconsistent concerns raised about the private providers, we risk leaving our ADHD children open to the risks of being unmedicated. If we do not accept the concerns, then we worry that we risk medicating our ADHD children even when it is not the best clinical decision to do so. How can we trust the medical profession when some GP practices are criticising the approach of other GP practices to enter into the shared care agreements. Which GP practices should we trust?

The GP practices who implement blanket bans on shared care due to concerns about quality assurance should be expected to actively engage in a meaningful dialogue with patients and families, and be willing to explain the basis on which they are criticising private providers in a way which causes such distress and alarm.

STAND's Message

Ultimately, STAND welcomes the Royal College of Psychiatrists' comprehensive Paper and appreciates the vital focus on improving services for autistic people and people with ADHD in Scotland. However, our core message is that all solutions must be grounded in the reality of lived experience to be truly effective, and be properly evidence-based. This means acknowledging the historical failure to meet predictable demand, ensuring policy recommendations are compatible with current legal frameworks (especially concerning social security benefits and the duty to make reasonable adjustments),

consistently challenging stigma and parent-blaming, ensuring transparency in decision making, and proactively publishing all research and evidence that is being relied on.

We also urge the Committee to ensure that the necessary urgency of a society-wide response does not inadvertently allow public bodies to further abdicate their core duties to provide timely diagnosis, healthcare, and education.