ST VINCENT'S
Better and fairer care. Always.

Autism and co-occurring mental disorders

Presented by Victorian Dual Disability Service

Better and fairer care. Always.

Acknowledgement of Country

The Victorian Dual Disability Service would like to recognise the traditional owners of the country where we live, work and meet. We recognise and celebrate the diversity of Indigenous people and their enduring cultures and connections to the land and waters of Victoria. We pay our respects to elders; past and present, and recognise the Indigenous people that contribute immensely to mental health and disabilities services.

Artwork by Mandy Nicholson

Acknowledgement of Lived Experience

We would also like to acknowledge the immeasurable contributions of people with a lived and living experience of mental illness, psychological distress, alcohol and other drugs, and disability, as well as those who love, have loved and care for them.

We acknowledge that each person's experience is unique and valued. We recognise their adverse experience of stigma, but also their strength and resilience. We respect and value their generous contributions which teach us, and guide us to continually shape, reflect upon and deliver quality care, from a lived experience perspective.

Artwork by Zeva Mirankar

Victorian Dual Disability Service (VDDS)

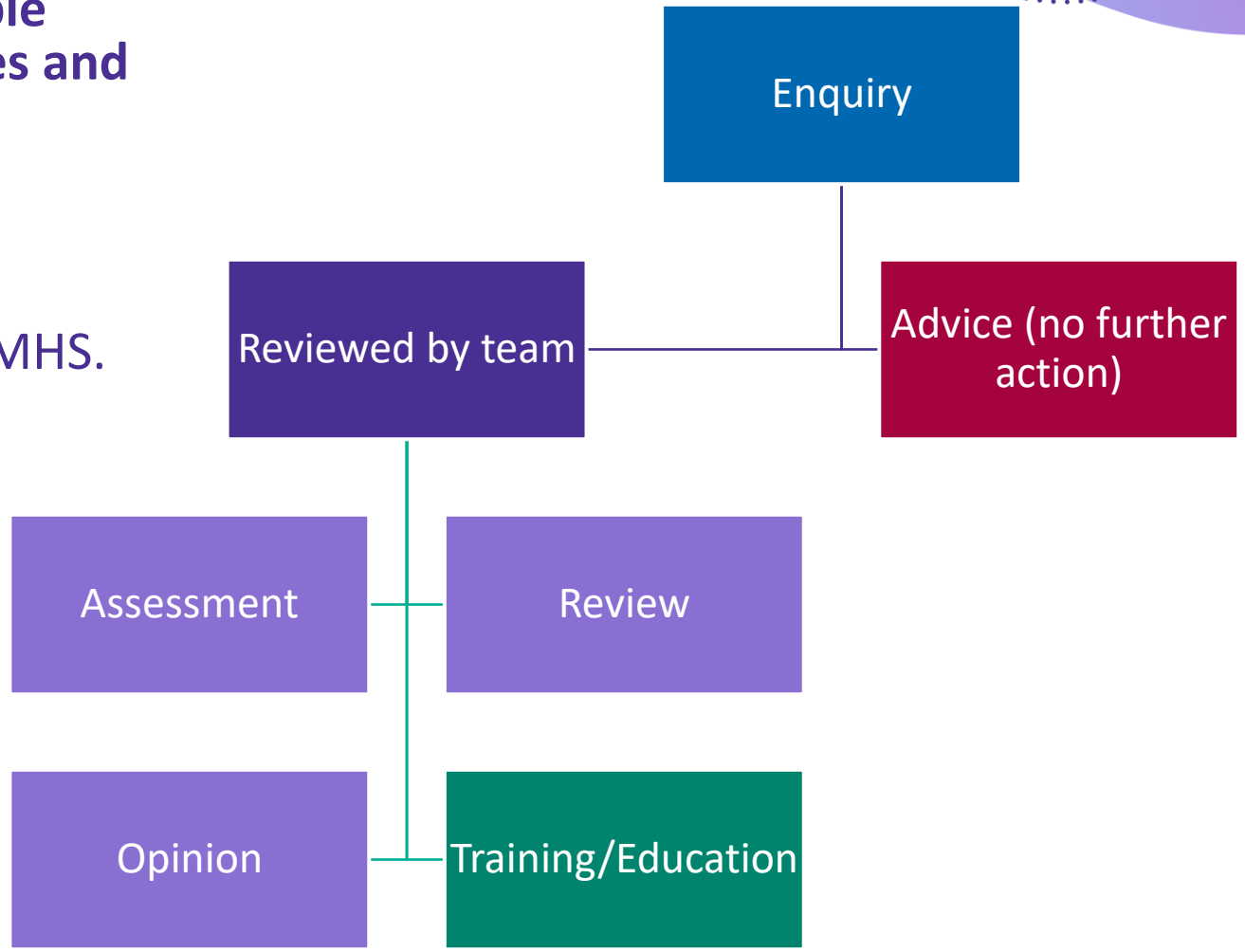
State-wide mental health service for people with co-occurring mental health challenges and a developmental disability.

What does VDDS do?

- Telephone consultation to anyone.
- Assessment & consultation for public AMHS.
- Assessment & consultation for NDIS participants
- Education & Training
- Service Development

How to make a referral or request training:

- *Telephone Referral: (03) 9231 1988*
- *Email: vdds@svha.org.au*

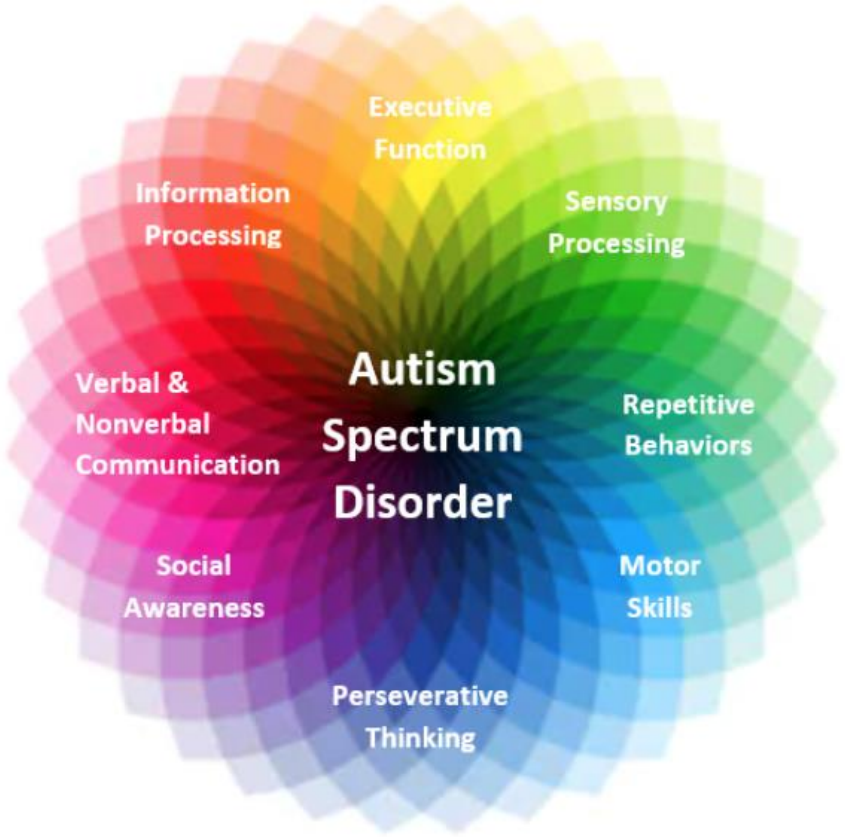


Outline

1. Review – What is Autism?
2. Autism & Mental Health
3. Review – What is Autism?
4. Autism & Mental Health
5. Barriers to Mental Health Care
6. Brief overview of specific disorders & issues
   - Anxiety disorders including OCD
   - Mood disorders
   - Psychotic disorders
   - Personality disorders
   - Catatonia
   - Suicide

What is Autism?

- Autism Spectrum Disorder (ASD)
- Lifelong neuro-developmental disability.
- Multiple causes (genetic / environmental)
- Wide variation in presentation and support needs.
- Core features
  - Social communication challenges
  - Repetitive and restricted interests and/or behaviours.
- Common strengths
  - Recall of facts
  - Attention to detail
  - Following rules
  - Visual skills
- Increasingly common (1:68 children, 1:100 adults)
- High rates of other developmental dx (ID ~ 50%, ADHD ~ 40%)

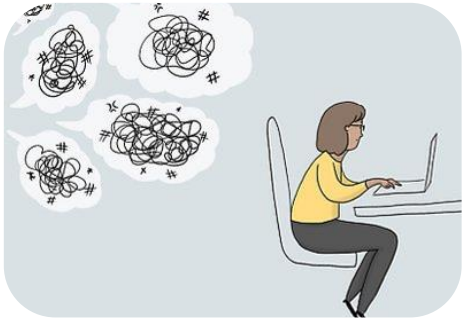


DSM-5 CRITERIA

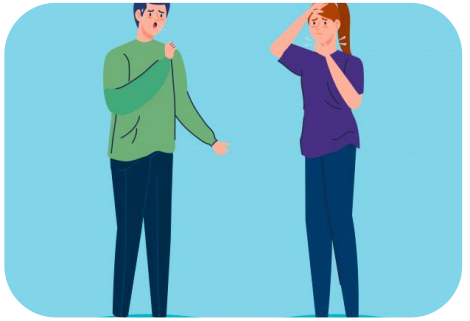
1. Persistent deficits in social communication & interaction across multiple contexts.
2. Restricted, repetitive patterns of behavior, interests or activities.
3. Must be present in the early developmental period.
4. Cause significant impairment in functioning.
5. Not better explained by intellectual disability.

CORE FEATURES

Social Communication



Aloof



Passive

Active, but cold

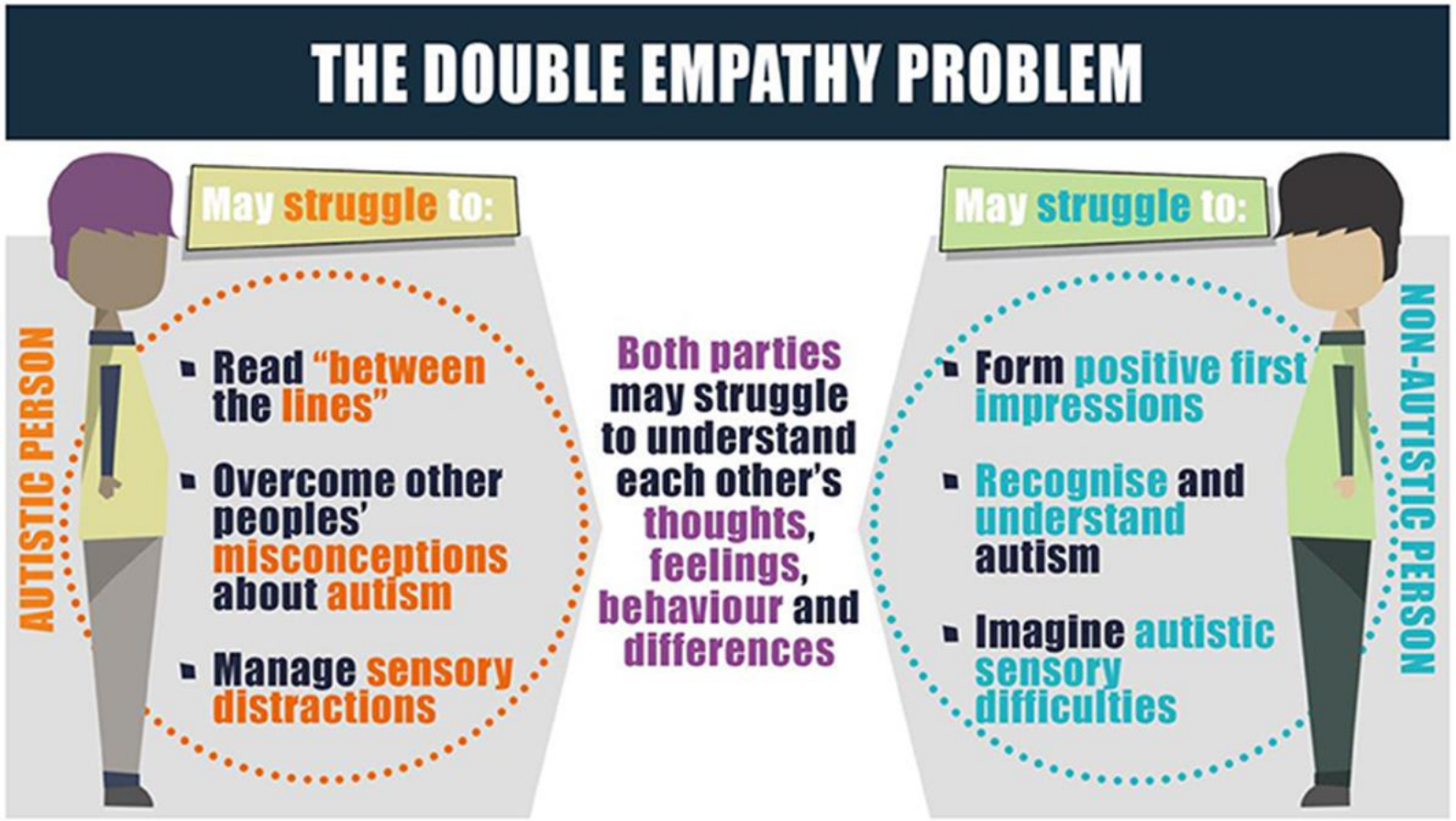
Overly formal

Social Communication

Difficulties in:

- Reciprocal social interaction.
- Non-verbal elements of communication.
- Initiating & maintaining relationships (friendships)
- Sociable with 1 person – problems with groups.
- Understanding beliefs, desires, intentions & emotions of self and others (social imagination).

Double Empathy Problem



CORE FEATURES

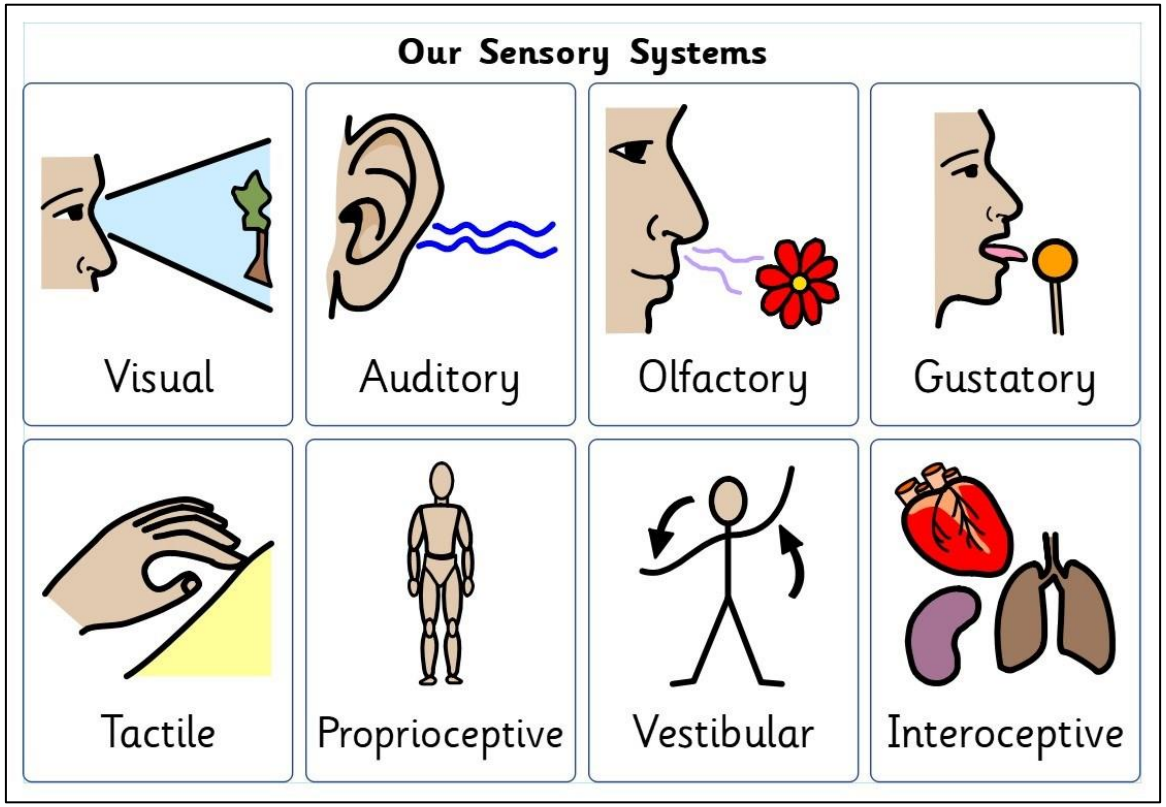
Restricted, repetitive patterns of behavior, interests or activities

- Desire for sameness & predictability
- Rigid adherence to routines, inflexible
- Difficulty in tolerating change.
- Excessive interest in highly specific topics.

CORE FEATURES

Sensory Sensitivities: Registration and Response

- Everyone has sensory preferences.
- Many Autistic people experience sensory sensitivities.
- This may affect them in a variety of different ways, from being distracted, unable to concentrate and having mild discomfort, to symptoms of acute ‘pain’ and deterioration in functioning.
- Consider the environment & make adjustments



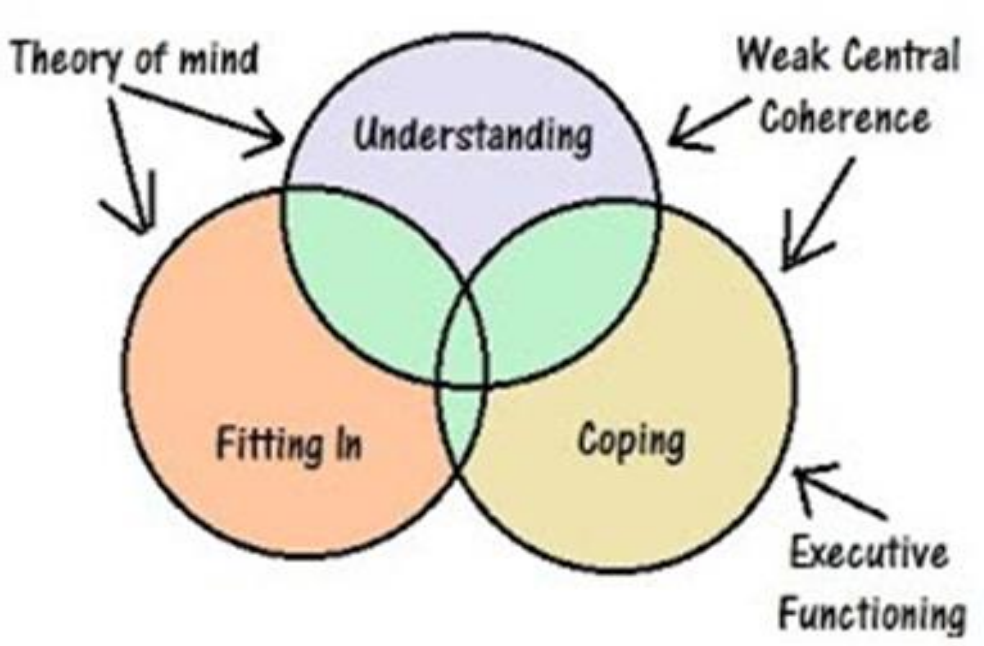
CORE FEATURES

Sensory Sensitivities: Registration and Response – Hyper / Hypo

Sensory domain	Arousing	Calming
Visual	Florescent lighting Clutter Colour Eye contact	Natural light Empty space Colour
Vestibular	Sudden movements	Rhythmic motion
Touch/Proprioception	Slopes, Stairs, light touch	Flat surfaces, pressure, hugging, water
Odour	Perfume, paint, petrol	Vanilla, banana
Auditory	Loud sudden, chatter	Music, soft voices
Temperature	Sudden changes	Natural warmth

ASSOCIATED CHALLENGES

- Concrete thinking, rules based, explicit learning.
- Focus on detail (weak central coherence).
- Inability to prioritise the relevance of details.
- Sticky attention / Distractibility.
- Difficulty combining ideas.
- Problems organising or sequencing.
- Difficulty generalizing.

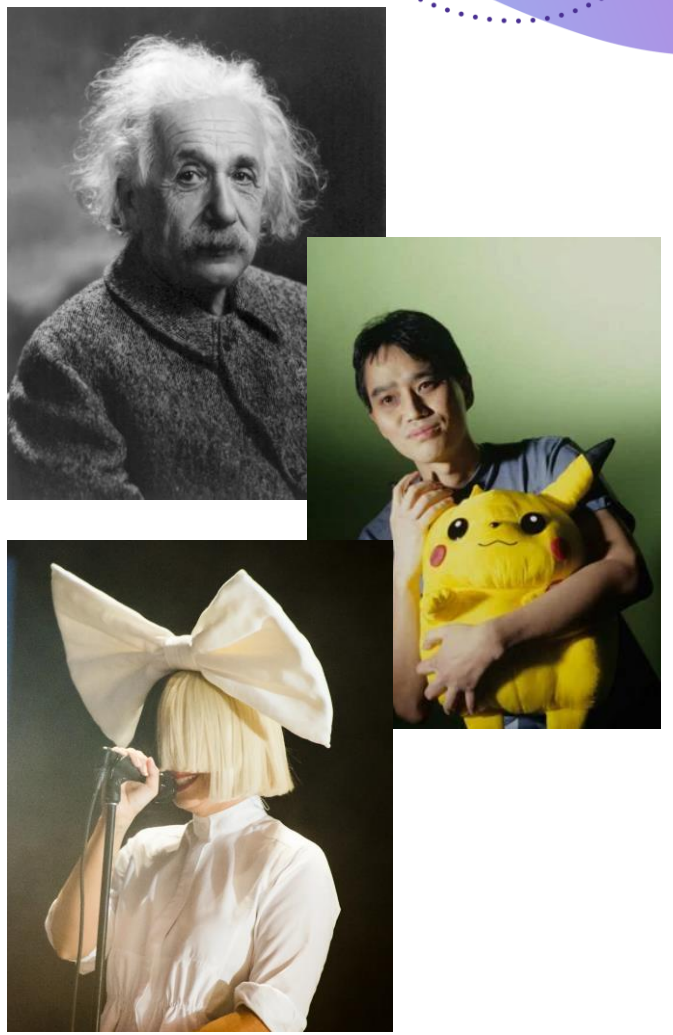


Associated problems

- Sleep
- Activity levels
- Food intake
- Emotional regulation
- Epilepsy
- Anxiety, meltdowns (overwhelmed)

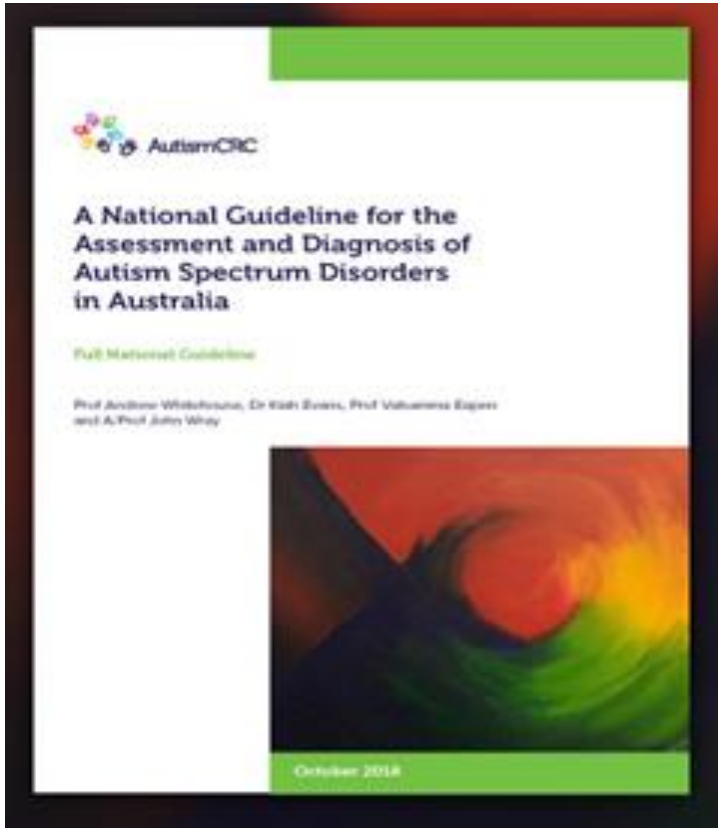
COMMON STRENGTHS

- Attention to detail
- Depth of specific knowledge
- Ability to recognise patterns
- Honesty
- Strong visual skills
- Excellent memory
- Increased sensory awareness
- Strong work ethic
- Correlation with giftedness, prodigy and savant
- Superior logic
- Lateral thinking
- Following rules and instructions



A National Guideline for the Assessment and Diagnosis of Autism Spectrum Disorders in Australia 2018

- A range of mental health conditions are common
- Single clinician or multidisciplinary diagnostic assessment.
- Mental Health symptomatology should be evaluated by a clinician with expertise in both ASD **AND** Mental Health.
- Include suicide risk assessment
- Include physical health assessment
- Assessment of functioning



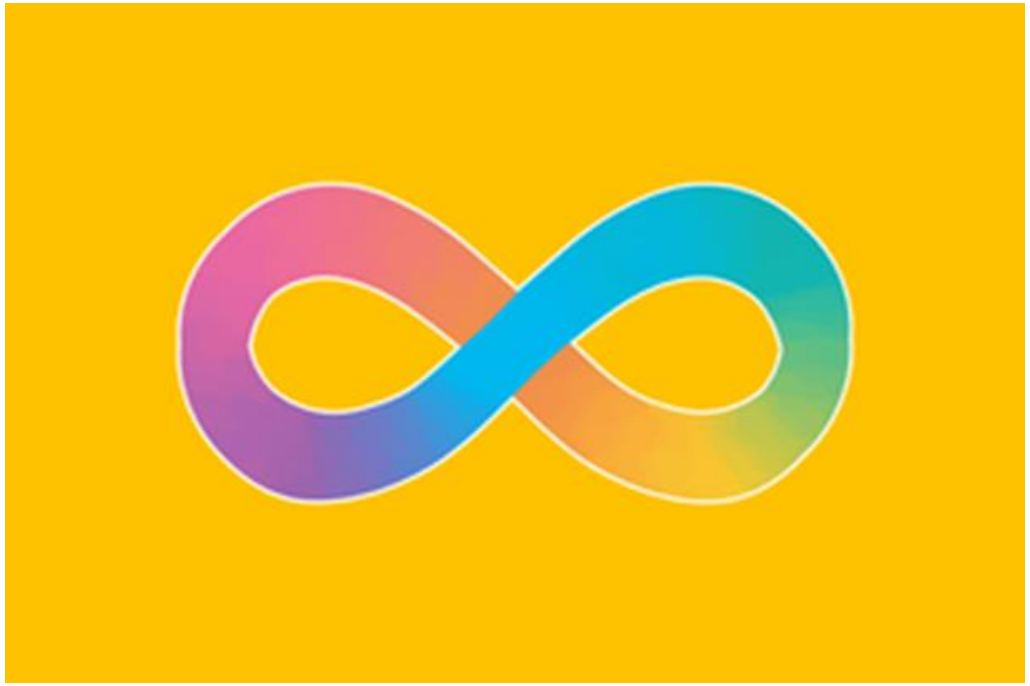
NICE Clinical Guideline: Autism spectrum disorder in adults: diagnosis and management 2012 (updated)

- Take into account & assess for coexisting mental disorders.
- Comprehensive assessment essential.
- Obtain a second opinion & specialist advice.
- Clinicians should have an understanding of core features of autism & their possible impact on the presentation and treatment of coexisting mental disorders.
- Psychosocial interventions - existing guidance for that disorder with reasonable adjustments.
- Pharmacological – existing guidance for that disorder but exercise caution due to increased sensitivity to side effects & unusual responses.
- Offer families, partners & carers of autistic adults an assessment & support.

Autism and Co-occurring Conditions

Neurodevelopmental Disorders

- People with Autism have high rates of other neurodevelopmental disorders.
- 25% to 40 % of people with ID have Autism, 40 to 70% of people with Autism have ID (borderline IQ also common).
- 40 % of children with ASD have ADHD and 22% of children with ADHD have ASD.
- Specific learning disorders increased.
- Each neurodevelopmental disorder increases the risk of psychopathology.



Autism and Co-occurring Conditions

Mental Health Disorders

Autistic individuals experience the full range of co-morbidity

Anxiety disorders: 40 to 50 % in clinical settings.

Problem Behaviours: The lower the IQ ,the higher the risk (higher IQ can make specific diagnosis).

Catatonia: 15-20 % people with ASD affected.

Psychosis: Prevalence unclear but higher rates than general population

Mood disorders: Depression ~20%, BPAD ~5%

Personality disorders: Overlap in symptoms and prevalence unclear

Autism and Co-occurring Conditions

Mental Health Disorders - Assessment

- Use the standard mental health assessment = History & MSE (+ physical ax)
- Increased emphasis on developmental history.
- To confirm diagnosis of autism (? met criteria in developmental period)
- To establish usual (optimum) level of function and identify change.
- Identify significant life events, trauma & experiences.
- Establish issues with current environment, routine & expectations (? change)
- Collateral history essential (informant and previous assessments)

General Principles for Assessment

Establish baseline

Establish diagnostic hypothesis and treatment target.

Assess for medical problems but may be difficult to undertake investigations and decision based on clinical need.

Person-centered approach taking into account individual preferences and needs.

- Use standard criteria if possible and acknowledge if modified DSM 5 and ICD 10)
- Generally applicable to IQ of 50 and above
- Alternative classification systems for PWID (ICD-10, DMID)
- Often lack of certainty about diagnosis
- Will need to manage the autism well (largely ecological measures)

Barriers to Mental Health Care

Difficulty in Assessment

- Some people with autism may not present with any more difficulties than the rest of the population.
- Able to provide history and report mental state.
- Able to inform interviewer of any difficulties they may have and how to account for these.
- Will vary with IQ and ability to communicate.
- Diverse, heterogenous group.

Difficulty in Assessment

Personal Factors

Social and Communication Differences

- Difficulty in understanding questions, expression and non verbal communication.
- Inability to understand assessors needs, lack of interest in ‘sharing information’.
- Acquiescence or resistance esp. with unfamiliar people and odd presentation.

Sensory and fixed repetitive patterns of interest

- Sensory sensitivities (fluorescent lights, noise, movement, smell).
- Pre-occupation with special interests.
- Anxiety (unfamiliar situation, disruption to usual routine).

Associated Difficulties

- Cognitive functioning (consent, recognising symptoms).
- Impaired executive function and cognitive style (concrete, difficulty with uncertainty, ambiguity, nuance).
- Difficulties with ‘autobiographical’ memory (connecting events, thoughts, feelings, behaviours).

Professional and System Barriers to Assessment

Lack of exposure to and training about Autism.

Lack of focus on developmental history.

Classification issues (*i.e. relationship between ASD and PD, symptom overlap*).

Diagnostic overshadowing & behaviour attribution (*it's behavioural, its due to the Autism*)

Stigma, discrimination

Inability to manage Autism

Lack of policy (*role and responsibilities of services unclear*)

Lack of resources (*rationing of services*)

Lack of service models (*inpatient models, therapeutic models*)

Lack of renumeration (*inability to pay gap fees, informant interview, review of previous assessments*)

Modifications to Assessment

FIRST

- Most of an assessment based on informant history and previous reports.
- Interview the person to establish their mental state, their understanding of problem and to get consent to observe behaviour and interactions.
- The person may not be able to give their own consent, so sometimes a guardian will need to give consent on their behalf.
- You should involve the client/consumer in the assessment process wherever possible/practicable.

Modifications to Assessment

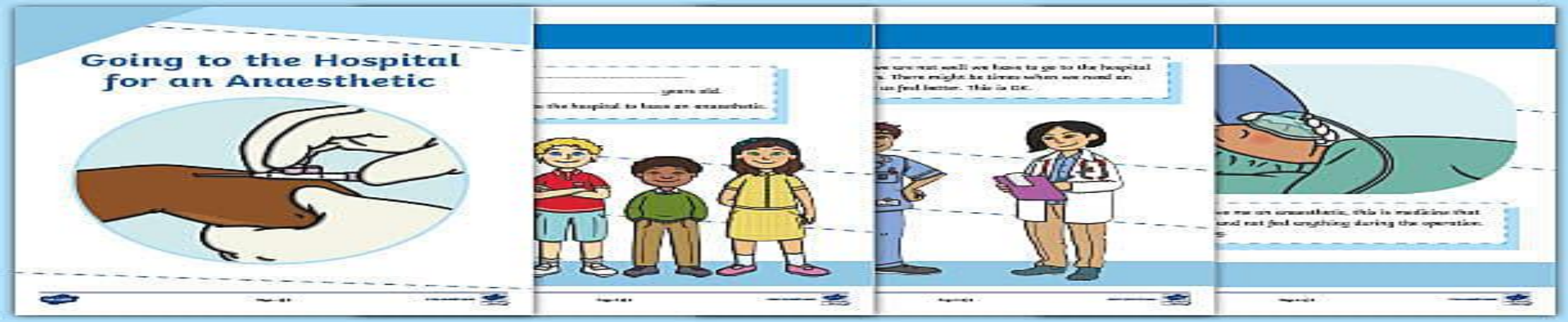
Prior to the interview/observation, speak with carers/family about:

- Sensory issues (*lights, noise, colours*) – low arousal environment.
- Risks (*aggression, self injury, absconding*).
- Challenging behaviours, triggers and warning signs.
- Ability to communicate (*usual way of communicating*).
- Use of visual cues.
- What works and what doesn't.
- Existing management strategies (*e.g. behaviour support plan*).

Modifications to Assessment

Prior to the interview/observation, speak with carers/family about:

- Location (*home, clinic, day placement*).
- Time of day (*avoid waiting in busy unstructured environments*).
- Duration (*shorter sessions and may take more than one interview*).
- Clear structure (*start, finish, who is present, what will happen*).
- Prepare for interview ahead of time, with social stories and pictures, if needed.



Modifications to Assessment

During the interview/observation:

- See alone and/or with support.
- Stick to time frames and boundaries.
- Don’t initiate touching.
- Be aware of your eye contact.
- Use simple visual aids.
- Establish capacity by asking simple questions and increasing complexity.
- Rules of good interviewing apply + (no leading and caution with multiple choice).
- Beware of scripted answers, echolalia and ‘yes/no’ or Do you hear voices?.
- Allow sufficient time to answer (verbal processing may be impaired).
- Cross reference (reframe questions).
- Check their understanding (e.g. explore what ‘sad’ or ‘happy’ means).
- Verbal ability declines dramatically when under stress.

General Treatment and Management

- The same as for that disorder, in the general population.
- **BUT** they may need some reasonable adjustments.
- Good support of Autism will play a major factor in good outcomes.
- Can be susceptible to side effects / atypical response to medication.
- May not be able to identify/report effects or side effects.
- Clear target for treatment; start low, go slow, monitor & evaluate.
- Psychological interventions may need modification of both content & process depending on the person's individual abilities.
- **Stop if it's not working + re-assess**

Anxiety and Autism

- Very common but not an intrinsic part of autism (30% - 86%)
- May present typically or atypically.
- May exacerbate autistic features (appear more autistic).
- Overlap between symptoms of ASD & anxiety can complicates assessment
  - OCD **vs** Repetitive interest & behaviours
  - Social impairment **vs** social anxiety
- Emotional explosions (overwhelmed by social demands or sensory stimuli).
- Fight (aggression, self harm), flight (absconding) or freeze (catatonic).

Co-occurring Anxiety in Autism

Vulnerabilities

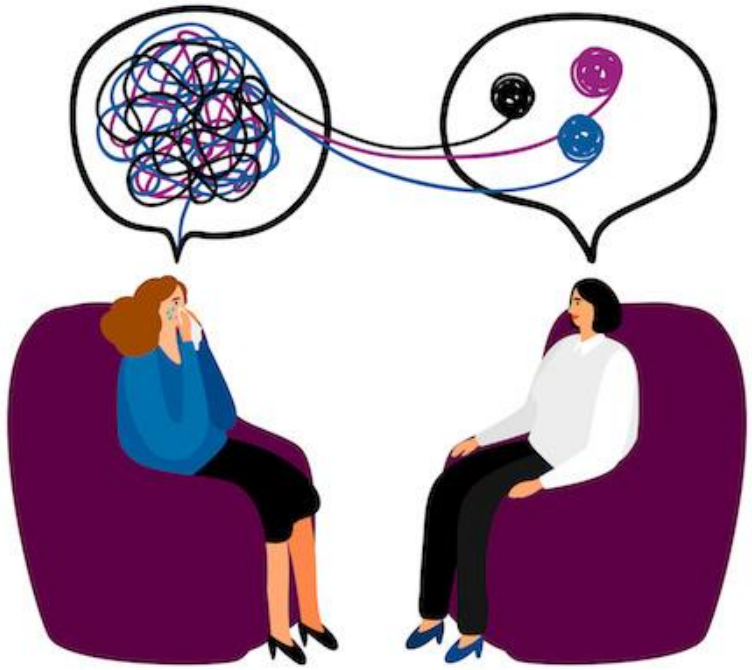
- Difficulty understanding others perspectives
- Difficulty understanding non verbal cues
- Not understanding unwritten rules of social interaction
- Increasing awareness of differences
- Rule based explicit learning
- Sticky narrow over focused attention – miss relevant information
- Executive functioning difficulties (organising, sequencing, generalising).
- Sensory issues

= Intolerance of Uncertainty (avoidance or control becomes a routine)

Management of Anxiety in Autism

1. **Prevention (good Autism support)**
   - Adapt the environment:
     - Make it more structured & predictable
     - Reduce sensory arousal
     - Individualised schedule - what activities will occur in what sequence.
     - Needs to be what can be used on the worst possible day
   - Maximise receptive & expressive communication
     - Structured, clear & specific.
     - Write it down or use visuals (think about using Social Stories)

Management of Anxiety in Autism



2. **Intervention**
   - Psychological therapies; first-line management
   - CBT / behaviour therapy / social skills training / psychoeduction
     - Identify & teach emotional recognition (own and others)
     - Teach to identify symptoms & rate anxiety level
     - Repeatedly practice & rehearse scoping skills
   - Medication
     - Antidepressants seem less effective & risk activation (lower doses)
     - ? Risperidone (weight gain, raised prolactin)
     - Benzodiazepines may paradoxically, heighten agitation, impulsivity, disinhibition

Autism or OCD

- Autistic people can also have OCD.
- Both present with repetitive thoughts & behaviours (overlap)
- Type of behaviour – washing, checking vs ordering, flapping etc.
- Is it an intense focal interest or sensory?
- Is the interest / act interesting or enjoyable / soothing? - ASD
- Is it distressing & resisted? - OCD
- Onset & trajectory, some intense interest may become obsessions

Treatment for OCD

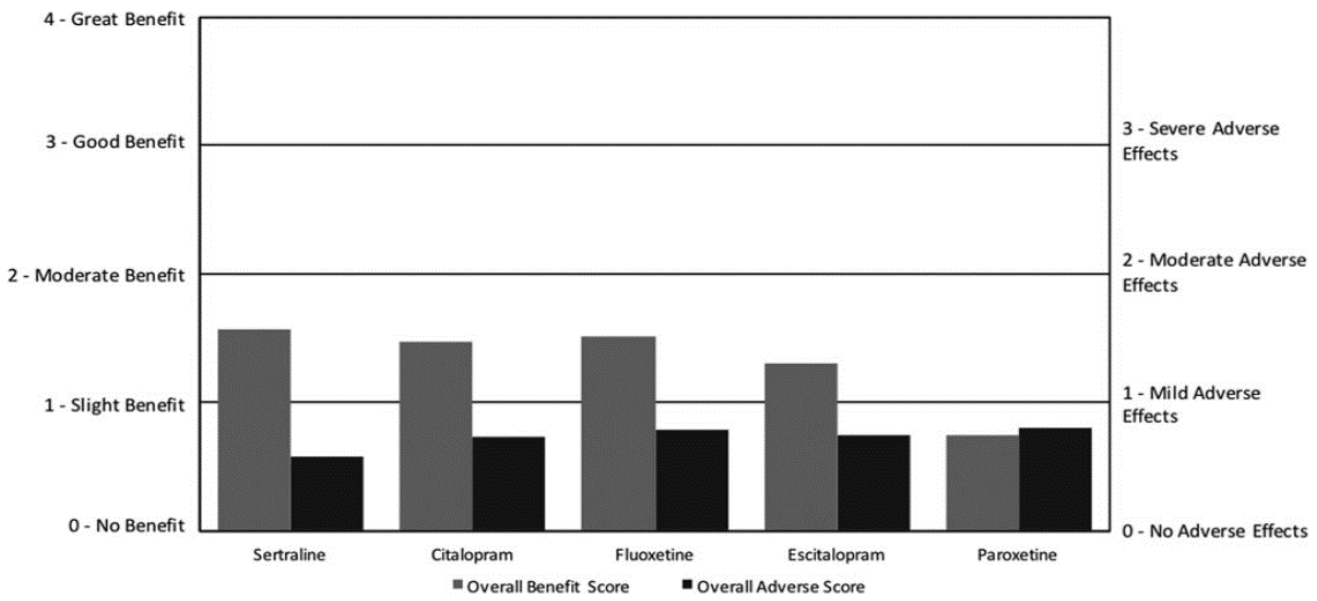
- Non pharmacological
  - CBT approaches & mindfulness techniques.
  - Exposure and Response Prevention (ERP).
  - May take longer with more sessions.
  - Generalization of learning needs to be considered.
  - Include carers to support & continue the process of exposure.
- Pharmacological
  - Little evidence for medications to treat restricted/repetitive behaviours.
  - For OCD – treatment as usual but may be less effective.
  - Caution - lowered tolerance, especially activation with SSRI's.

Depression and Autism

- Symptoms can be the same as in NT persons (depressed mood, anhedonia, sleep & appetite changes, activity levels).
- Assessment complicated by alexithymia, reduced ability to self report.
- Symptoms may be masked by autistic traits (e.g. social withdrawal vs lack of interest in social interaction)
- Persistent irritable agitated mood rather than depressed mood.
- Aggression, self injury, changes in RRIB, regression, rumination.
- Depression may exacerbate autistic features.
- The key is notable changes over time from what is usual for that person.

Treatment of Depression in Autism

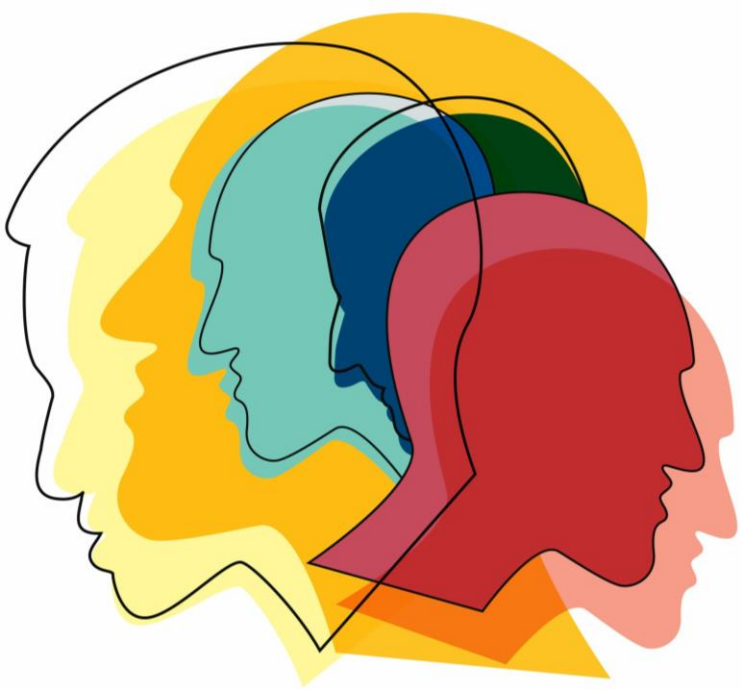
- Non pharmacological
  - Modified CBT approaches & mindfulness techniques
- Pharmacological
  - Treatment as usual
  - Activation / agitation
  - GI effects
  - Weight gain



Bipolar and Autism

- Exact prevalence unclear but increased risk (~5%).
- More common in females.
- Most easily recognised in high-functioning verbal individuals with ASD by the classic presence of distinct alternating cycles of elated & depressed mood.
- Diagnostic confidence decreases with increasing level of ID.
- Irritability & aggression are common but look for new onset or major change.
- Track mood & any associated variables (e.g. sleep, menstruation).
- Rule out physical/medical cause e.g. hyperthyroidism.
- Treatment as usual.

Schizophrenia and Autism



- Non-affective psychosis in ASD - 9.56% *(De Giorgi et al 2019)*
- Shared genetic factors.
- Language difficulties, poverty of speech, formal thought disorder, overvalued ideas, & deficit in interpersonal relationships were present in both groups.
- Core features of ASD may be mistaken for psychosis if the clinician lacks relevant clinical history or information regarding baseline functioning.
- Red Flags for Psychosis in Autism:
  - Perceptual abnormalities, beliefs & behaviors different from baseline.
  - Change in social, cognitive, or adaptive functioning from baseline.
  - Odd unusual behaviors that do not fit with typical interests or rituals.
  - Carers unable to decipher the person's speech.

Overlap between Autism features & Psychosis

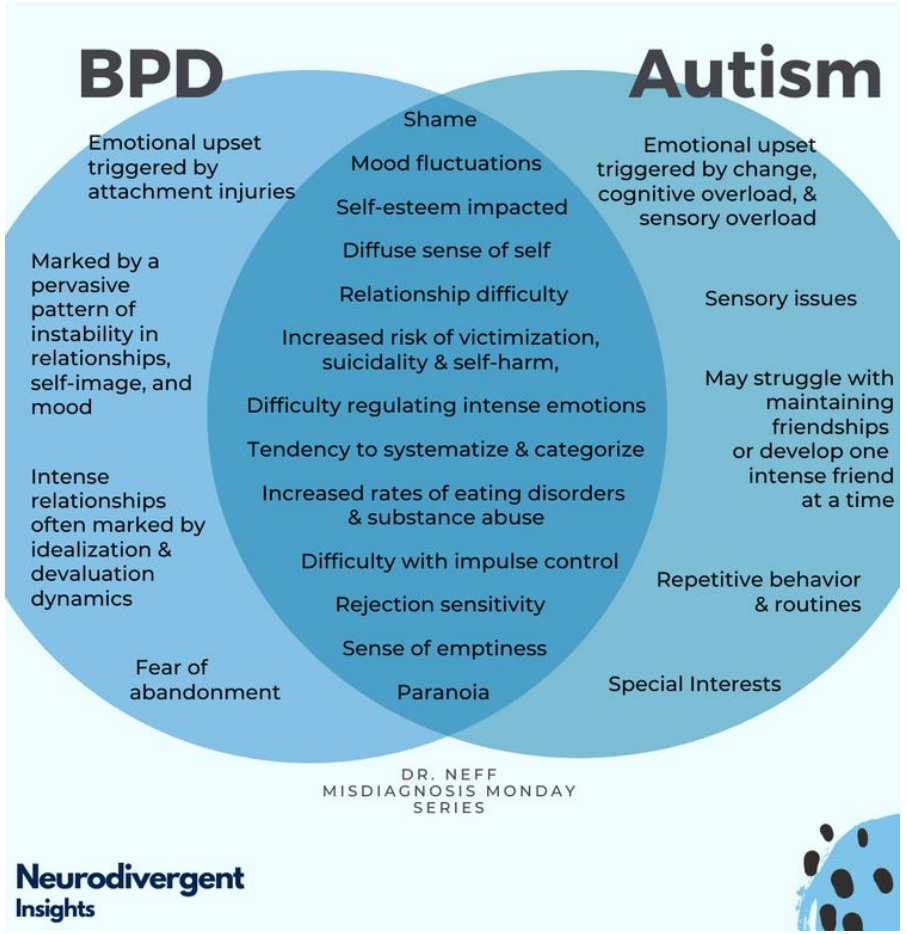
	ASD	SSD
Social/emotional	Lack of reciprocity Restricted affect Misreading social cues History of bullying & abuse Alexithymia	Social withdrawal Blunted affect Low mood Paranoia Alexithymia
Communication	Language delay Literal & scripted (odd) Unusual prosody Echolalia	Unusual bizarre speech Poverty of speech
Thought	Restricted interests (odd) Perseveration Concrete, literal responses Perceptual processing oddities	Perseveration Delusions Hallucinations Disorganisation
Behaviour	Odd repetitive movements	Posturing and stereotypies

Management of Psychosis

- Treatment as usual.
- Caution due to possibly increased risk of adverse effects.
- Many may already be prescribed antipsychotic medication.
- Earlier use of clozapine may be helpful.
- Adherence issues.

BPD and Autism

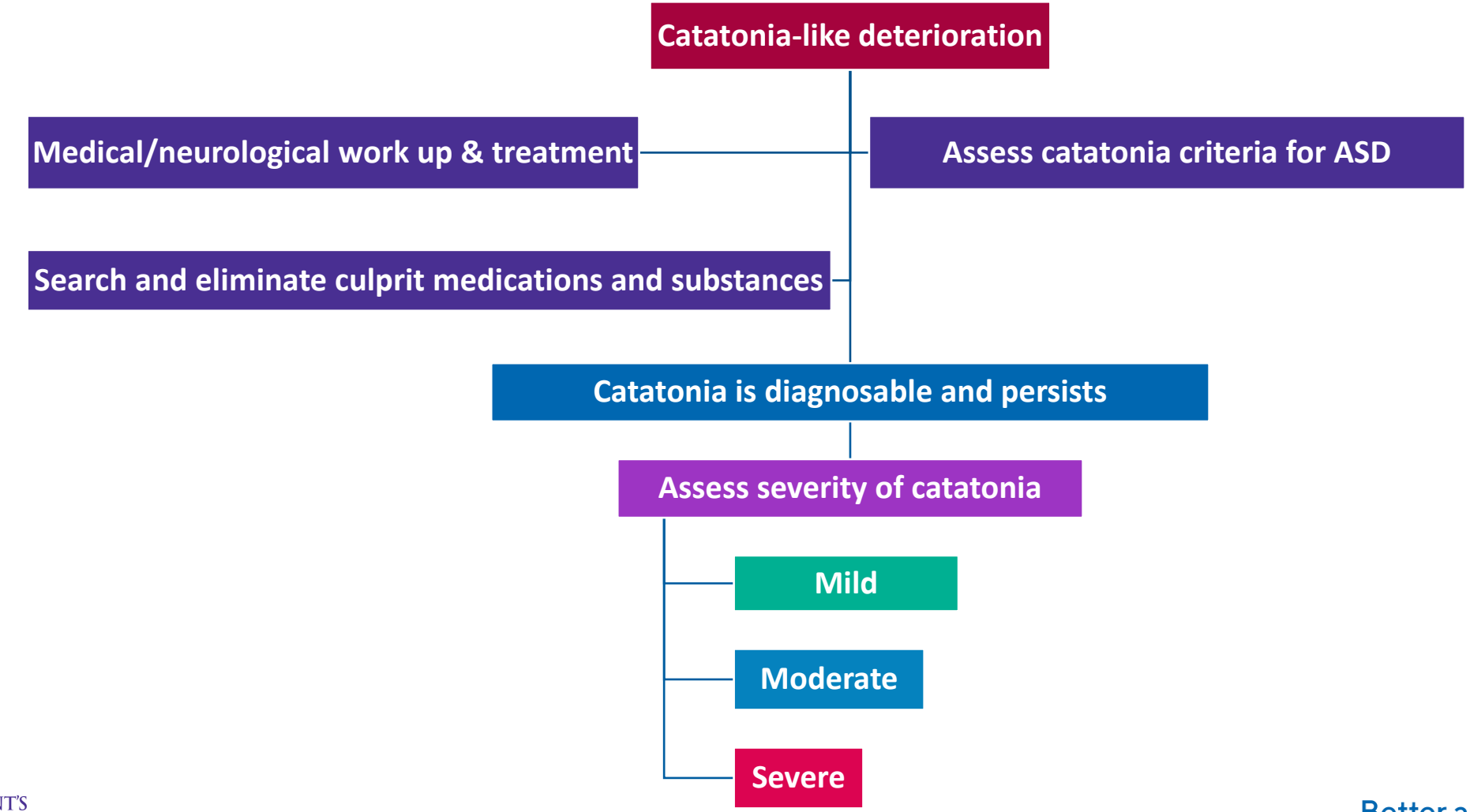
- ASD occurs in BPD, and BPD in ASD.
- Research is limited & evidence on assessment & treatment is weak.
- Both disorders have major overlaps with ADHD, mood & psychotic disorders.
- Higher rate of suicidal behavior & depressive disorders in ASD.
- Individuals with ASD experience high rates of bullying & abuse.
- Self-reported ASD questionnaires may not necessarily be accurate.
- A developmental history is required but can be difficult to obtain.
- DBT & MBT can be effective in ASD alone & with BPD comorbidity.



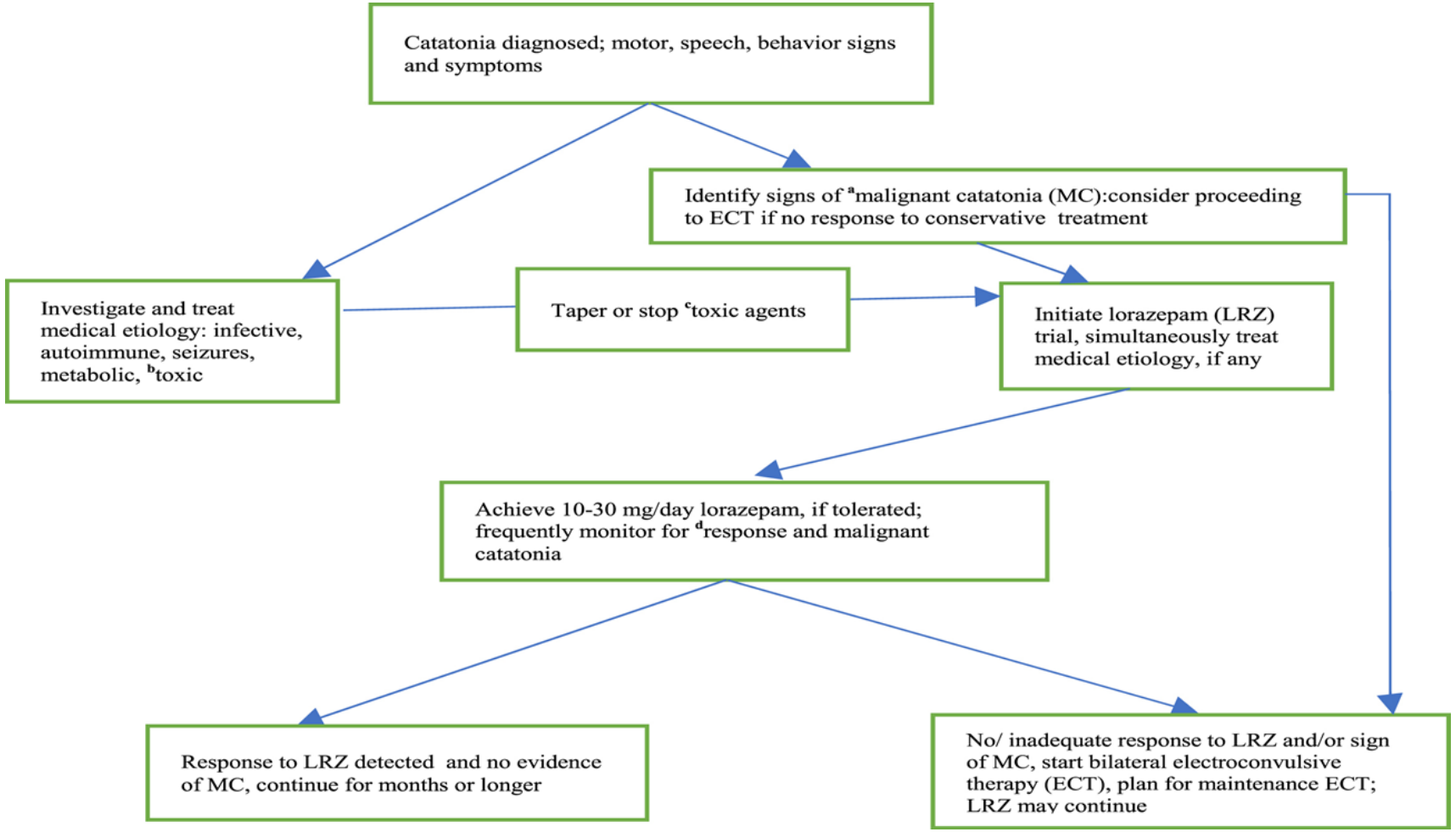
Catatonia and Autism

- Catatonia is a relatively common condition in ASD ~10%
- People with ASD & catatonia are at increased risk for negative outcomes with a 60-fold increase in mortality, which may include suicide.
- Onset is often in adolescence with functional regression.
- Benzodiazepines & ECT are the most effective treatments.

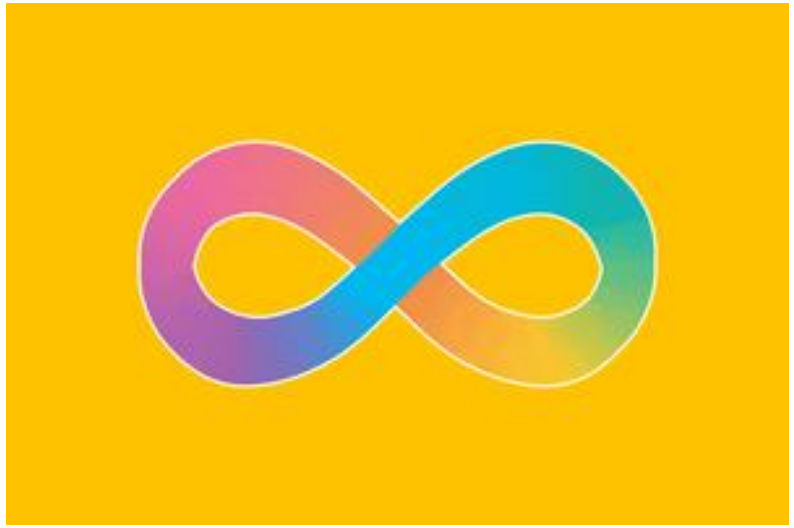
Catatonia in Autism Assessment



Catatonia in Autism Treatment



ADHD and Autism



- “Neurodiversity”
- “Neurodivergence”
- Similar risk factors.
- Phenotypes overlap (FXS, 22q11 deletion)
- Some similar symptoms – social problems, planning difficulties, sleep problems, need for structure.
- Co-occurrence probable - *ADHD symptoms are present in 30% of children with ID and 50% in children with ASD (Sinzing, 2008).*
- Limited research.
- Seem (anecdotally) to respond less well to stimulants.

Suicide and Autism

- Significantly increased risk (66% experience ideation).
- Research & evidence base is poor.
- Especially high amongst women without ID.
- Camouflaging & unmet support needs appear to be risk markers.
- Excluded from services *“People like me don’t get support”.*
- Double empathy deficit & lack of informal supports.
- Not believed, or misperceived by others as coping.
- Autistic individuals usually answer factually & precisely.
- Psychological therapy can be effective but takes longer.

Conclusion

- People with autism can have the full range of comorbid mental disorders.
- Are at increased risk for these disorders.
- Experience difficulty accessing mental health supports.
- Assessment & treatment may need adjustments.
- Anxiety is very common and often related to intolerance of uncertainty.
- High rates of catatonia and increased suicide risk.
- Significant overlap of autistic features, psychosis and PD.
- Developmental history is. key in differentiation.

Thank you

For a copy of these slides, please email vdds@svha.org.au with subject header *“Please send Autism and comorbidity webinar slides”*

Resources

National Guideline for the assessment and diagnosis of autism in Australia (2023)
https://www.autismcrc.com.au/best-practice/assessment-and-diagnosis

National Autistic Society Good Practice Guide for professionals delivering talking therapies for autistic adults and children.

https://s2.chorus-mk.thirdlight.com/file/24/asDKIN9as.klK7easFDsalAzTC/NAS-Good-Practice-Guide-A4.pdf

NICE Guideline, Autism spectrum disorder in adults: diagnosis and management

https://www.nice.org.uk/guidance/cg142/chapter/Introduction

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