Supporting the mental health of a neurodivergent person with co-occurring Autism and ADHD

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Prof Steve Trumble (00:00:04):

Hello everybody and welcome to all those who have joined us for tonight's webinar and also the viewers who are watching the recording afterwards. Big crowd tonight. As far as we know, I think it's been one of the most popular topics that MHPN has put forward, so it's wonderful. Great to have you. MHPN would like to acknowledge the traditional custodians that the lands, seas and waterways across Australia, upon which our webinar presenters and participants are located. Wish to pay our respect to elders, past, present, and future for the memories, the traditions, culture, and hopes of Aboriginal and Torres Strait Islander Australia. Steve Trumble's my name and I'll be facilitating tonight's session. I'm a GP by background, although I've worked in medical education, really all of my career at Monash and in Melbourne and now Deakin Universities and I'm located on the land of the Wadawurrung people. Now we have a fabulous panel tonight to do justice what is such an important topic. You will have seen the bios that came out with the webinar invitation, so in the interest we cover as much of their content as possible. And lots of time for questions. We'll skip going over the panel bios, but you can see the panellists there in front of you. And I'll go around in order of how we'll go through the presentations. So starting with you Andrew, welcome.

Dr Andrew Leech (00:01:25):

Thanks Steve. And hi everyone. I'm Andrew Leech. I'm a GP in Western Australia and very interested in this area and looking forward to speaking tonight.

Prof Steve Trumble (00:01:35):

Great. Now we've got a lot of people on from Western Australia type have a look at what's in the chat room, so that's great. What was it that particularly led you to focus in this area of general practise or clinical practise?

Dr Andrew Leech (00:01:49):

I find this to be a fascinating area. It's so challenging but so rewarding and I think some of my autistic patients and ADHD patients are some of the most interesting and charismatic, but also highly intelligent people that I see and really grateful for the support when they get a thorough comprehensive reviewing in general practise. So that's for me the most important thing. I find it really rewarding.

Prof Steve Trumble (00:02:20):

That's great Andrew. And certainly as a GP your heart gets a bit of a lift when somebody comes into your room who is engaging and interesting, isn't it? So that's now speaking of engaging and interesting. Now Monique, you are the second presenter I think. Would you like to introduce yourself and tell us what led you to practise in this particular area?

Monique Mitchelson (00:02:39):

Hi, I'm Monique Mitchelson and I'm a neurodivergent clinical psychologist. So I'm late diagnosed autistic and ADHD. And I got drawn to working in this area because the first major workplace that I worked in after uni was a private practise that specialised in autism and ADHD with a supervisor. That was very affirming. And then I got my diagnosis, my husband got his diagnosis, a few family members got their diagnoses. So that's really furthered my interest.

Prof Steve Trumble (00:03:16):

Oh, fantastic. And we always find these webinars go exceptionally well when there's somebody on the panel with lived experience, but also to be a clinician working in the area. It's going to be a wonderful night tonight. So thank you so much. Thank you. So in the presentations after Monique, we'll go to Emma. Welcome. Emma, can you introduce yourself and tell us a bit about what lead you to this area of practise?

Emma Ketley (00:03:38):

Certainly. So my name is Emma Ketley and I'm a mental health occupational therapist and similarly to Monique, I'm also a late diagnosed neurodivergent person with a diagnosis of ADHD from 2022. And my work with mental health, I realised there was so much intersectionality between the diagnosis of mental health and neurodivergency that it just really excited me and got me interested.

Prof Steve Trumble (00:04:05):

Fantastic and great to have a mental health OT on the panel. That's an area that we often don't spend a lot of time looking at in these webinars. So you'll have a lot of good input tonight. And you also, I believe you coordinate one of the MHPN networks. This is the other thing that MHPN does obviously is the networks across Australia. What do you enjoy about that coordinator role, presuming you do enjoy that coordinator role? I'm not being presumptive here.

Emma Ketley (00:04:31):

No, I certainly do enjoy it. I set that up last year, the ADHD WA network, so the mental health professionals network in recognition really of the federal resource and inquiry into mental health and ADHD care, realising that working in the adult space with neurodivergency, I had had very little training and I perceived very little personal development opportunities. So I got together with the MHPN to secure funding to roll out the network for WA. And we've had three meetings now and it's been great to see the interest from other colleagues and professionals.

Prof Steve Trumble (00:05:13):

That's fabulous. And Monique, you'll be interested, somebody's recognised your voice from your podcast, so it just shows that all the different methods of reaching out to people actually do work. So that's really good. Well spotted to that person in the chat group. Now the fourth presentation, and we've structured it on the suggestion of the panel pretty much is this young person would probably make their way through the health system is Joe McDonald. So Joe, could you introduce yourself, your clinical role and what led you to practise in that area particularly?

Dr Josef McDonald (00:05:49):

Yeah, hi, I'm a neuropsychiatrist from Newcastle New South Wales. Started training in neuropsychiatry clinics and spent a fair proportion of my training time there and found the work very rewarding and really liked the opportunities both for collaboration but also the neuroscience aspect. So that's what drew me to this field.

Prof Steve Trumble (00:06:18):

Great, fantastic and wonderful to have such a great panel. We've got lots of talk about and I won't read through the learning outcomes. Next slide please. I think because you've seen all those, but we'll go. And also just to mention the slide relating to the fact that the content of this webinar, and I've lost track of where we are with the slides, the content of this webinar is for educational purposes only and is not clinical advice. We're here to learn from each other, not to treat each other or to offer clinical advice. And if there's anything the webinar that causes you to stress, it's absolutely understandable. Please do seek out care from your own gp, your local mental health service or practitioner or contact lifeline on 13 11 14. So let's rip into the presentations now and we'll start with Andrew. Andrew, you have 10 seconds.

Dr Andrew Leech (00:07:15):

Thanks Steve, I'm glad we made it. I want to just take this from a general practise perspective and a primary care perspective to start with as Oscar has come in with his family member and he's probably quite anxious and may not even want to be coming in to see us. And I think that's first important to recognise that we may not have an overly productive first session, but certainly a time or a chance to build rapport with Oscar and to get to know him and reconnect with him. He may have had a period of time where he hasn't actually been seen by any medical service or by his allied health team. So just gently coming back to finding what's been going on for him. And it may take time, it may take a number of consultations and may need to rebook him to come back. But maybe that first visit is really just a listening session, getting to know him, building that rapport, letting him know that we're here to support him and try and figure out what's been challenging for him.

(00:08:23):

Some of that history might come collaterally through his family and taking a really strengths-based approach is probably a great way to start. And we know that he loves his gaming, his fortnight, his PlayStation. I have learned about many games and Fortnite seems to be the number one. So pulling Fortnite up on my computer screen, showing him this is what I know about it and asking him a bit about what he's doing on the games to really try and engage with him. That might be the icebreaker that we need just to start that process. Next slide please.

(00:09:00):

So then we sort of need to go back to the drawing board a little bit. Oscar's had a gap in support potentially we need to find out a bit about what happened with the last few years, what's been going on for him, bit more about the diagnosis. There may be some information on the file and the record, but it's always good to start fresh and look at things again holistically and broadly. So understanding how that diagnosis came to be and how it was made. And also then whether it's evolved or changed since it was made back in his primary school years and what treatments might be in place because it sounds like he has stopped taking those medicines at home or GPS are good at this and that's thinking broadly. This might not be related to the medications or the ADHD and autism, it might be related to something else. And he's in his room a lot. Is he sleeping well or is body clock completely reversed? Is he on any screens throughout the night and is that impacting his mental health and his mood? Really important to think about mental health. Is there a depression or an anxiety emerging? We know there can be a correlation between mental illness and neuro adversity. So important to screen. And I was thinking about psychosis as well. If he's become withdrawn, is there something else going on that hasn't been considered such as a psychotic episode? Next slide.

(00:10:27):

So I'm assuming that Oscar's going to be withdrawn and quiet, but if he's not, I'm really happy to engage with him and involve him in this process. And just because someone else has brought him in to see me, I still feel that it's very important to let him know what we're thinking and what is going on without over concern, making him more anxious, but just letting him know that he's very welcome and we want to try and work through some of these things with him. So it might involve some tests or some extra reviews or I'm going to see someone else that is going to help me, but I'd just like to be upfront and involve him in that process, not exclude him because potentially he's not able to make eye contact or he is feeling really overwhelmed by this, so how can we help him through that? And I think that might take a few steps to build rapport. Next slide.

(00:11:20):

So with that broad screening, I might use my K 10 or das 21 again depending on how engaged Oscar is in this process. Also using the collateral history from the family and asking them a little bit about what they've seen going on for Oscar over the last period of time. Doing a general blood screening, always helpful. We tend to pick up something from that broad screen of iron and thyroid and vitamin D and other vitamins because quite often food nutrition has become something that may not have been as well supported as it could have been. Again, thinking medically, do we need to do anything else in-house, a CG or blood sugar or a urine drug screen? Is Oscar starting to smoke marijuana or is there something else going on behind the scenes that we don't dunno about? So just very broad and I may not do all of these things, I'm just thinking what potentially I could include in my tests. Next slide.

(00:12:22):

As quite often is the case, building a team so that we have a support network involved to help Oscar. And as you would all be aware involving a psychologist or an OT plus maybe a support worker, maybe a speech therapist, those sort of allied health network that we need to rebuild. Oscar may already have connections, but what often happens is there is a disconnect between the child's system, the paediatric system and the adult system. And that team may have become lost or he may have been lost to follow up exercise. So important and that may be supported by an exercise physiologist. I find them a great way to just reengage with going to the gym or reengage with a sport and get back to being active. Even just going for walks, having someone to work with him so he doesn't feel the pressure to do it himself or the family don't feel that pressure. Next slide.

(00:13:17):

So we might do a mental health plan, we might utilise the NDIS to help fund some of those services and down the track I'll look again at that medication. If it is something that's become a problem because he's stopped taking it, do we need to actually put the responsibility back to someone else for now so that he's reminded to take it or is it simply just a matter of he's forgetting and he's not noticing the medication needs to be taken, we need to develop a system for him. Some of those good tools we have in GP such as a care plan or a health assessment might be able to also help us to gauge the goals for Oscar moving forward so that we can get to where he wants to be and where he wants to reach over the next period of time. And then getting back to his sleep, does he need some melatonin or does he need an antidepressant to help with his anxiety and what's going on for him with his mental health? Thank you.

Prof Steve Trumble (00:14:09):

Great, thanks so much Andrew. And I should just jump in and remind people, which I didn't say in the introduction, that if you want to ask a question of the panel, please do use the ask a question button, which is down the bottom. If you move your mouse and if you're on a mobile, you've got to use your finger. I think obviously down the bottom right hand corner of the screen it should become active and there should be the three little dots down the bottom there. And if you click on the three little dots, it'll give you, where is it? Ask a question. If you click on that, then you can post a question and we'll try and pull all those together to ask the panel towards the end. So bottom right hand corner, hover the dots there and you should be able to ask a question. So thank you so much. Now the young man, Oscar has found his way to Monique now, so we'll hear from you. Thanks Monique.

Monique Mitchelson (00:15:08):

Sure. So when Oscar presents to the psychologist clinic, it may have been possibly the first contact that he's had in terms of therapy. So often when people are coming into therapy for the first time, he has gone through an assessment process as a child, it's often spending that first session making sure things like the sensory environment are okay, especially if the person's autistic. So asking the client if they find anything in the room difficult for them sensory wise, asking how they learn information best and retain information best from an executive functioning point of view, being explicit and explaining these are the rules and expectations of therapy, this is how I work, getting information from the client, getting that history. And then really I think exploring for Oscar, does he have an understanding of his neurodivergence, so his autism and ADHD because often people diagnose as children, no one may have ever explained what does that actually mean for them.

(00:16:17):

Or they may have done therapy or gone through services as a child but don't remember what was told or the tools that they were shown earlier on. And just making sure to help Oscar understand his neurotype through an affirming lens because often information about diagnoses can be delivered in quite a deficit focused lens, which can make people feel defective or worthless and hopeless. So actually exploring the difference in his neurology, what are his strengths, what are the areas that he may need more support with, does he understand himself and his needs? And yeah, has he accepted his neurodivergence? And I think that's a really good place to start off with. Next slide please. So I like to work in a multidisciplinary team because often people will have lots of support needs. So usually if people have sensory needs or needing assistance with daily living tasks, I'll refer to an occupational therapist to do a sensory profile.

(00:17:27):

All autistic people should know their sensory profile. It's very helpful in avoiding burnout and the effects on mental health and meltdowns and shutdowns and looking at a functional capacity assessment, which is really helpful in what supports does that person need with day-to-day tasks. I'll then do an executive functioning assessment if the person's in A-D-H-D-R. And what I like to use is the brief because it gives you a really great profile that you and the client can go through of what are their executive functioning strengths, what are the executive functions, what are the areas that they need support in, and you can actually work with that person individually to develop executive functioning strategies and then educate their family as well if you have their permission. So really bringing in executive functioning strategies. Otherwise there's often not a lot of movement for people in terms of their wellbeing and mental health.

(00:18:23):

Next slide. So exploring with Oscar perhaps why he hasn't been using his medication. There was difficulty for him remembering to take it in high school. He feels like he doesn't need it and just exploring some of the reasons why, because some people diagnosed as children may have had an adverse experience with ADHD medication or they feel like it was forced on them and it's just reminding them that you're an adult now. No one can force you to take medication in terms of ADHD medication. It's your choice and exploring maybe some of the barriers and negative experiences or beliefs that might be blocking him from utilising medication. So then keeping in contact with the GP and liaising is really important. And then keeping in contact with psychiatrists and usually that will be with ADHD medication review and any other co-occurring stuff that Oscar might need support with regarding medication as well. Next slide.

(00:19:35):

So when you are working with a neurodivergent person, as a psychologist, I work in a neuro affirming way, so affirming the person's identity and adapting existing therapies to suit the person, be individualised and trauma focused. And often when working with autistic and ADHD people, there is high co-occurrence with mental health and we're aiming to treat the mental health, not to cure or fix the autism or ADHD. So often it's helping people cope with change uncertainty, working on people regarding anxiety and low mood, the loss of employment. So for autistic people in particular, the loss of that routine would be a massive thing to cope with. And routine helps scaffold ADHD as well and exploring things like self-worth identity and for Oscar, his employment was linked to his special interests and it can be really devastating as an autistic person to lose a link to your special interest or being able to talk about your interests.

(00:20:43):

Exploring with Oscar, has he had any mental health before, not making assumptions and really making sure to explain things thoroughly and what were some of the therapies if he has had therapy before that worked for him, what didn't and exploring why is really important and really looking at is he linked in with other neurodivergent people because yeah, often neurodivergent people socialise through their interests and passions and sometimes socialising with other neurodivergent people is a little bit easier due to something called the double empathy theory. So I'd look at connecting him with the neurodivergent community who can validate some of his experiences and provide some support. Next slide. Also looking at linking him in with disability employment services in terms of job seeking. And I think just recognising that often autism and ADHD, the rhetoric has been that it's something that is diagnosed in childhood and we really aim to, I guess bring in support so that the person no longer needs support as an adult. And often that's actually not the case. So both autism, A DH, ADHD and neurodevelopmental and that means people often do need ongoing support across the lifespan and often need increasing support at different times in adulthood because the expectations and the burdens of adult life often are more and the responsibilities are more so particularly when working, getting a pay rise promotion for people, having kids opening their own business and for women going into perimenopause and menopause, those are the areas that people do need more support in. That's it for me.

Prof Steve Trumble (00:22:32):

Great. Thank you so much and some fabulous responses in the chat room to what both you and Andrew said. You're obviously really striking a chord with people. I should also just quickly say to apologise to people, we can't use the closed captions, they're just not reliable with the technical content. They've got to be proofed before they go out, but they will be on the recording. I know that's not ideal for people who prefer the captions, but they will be there on the recording and the recording will be coming in due course. And also a final add for the questions if you want to ask those, you've got to move your mouse down the bottom right hand corner, hover over those dots and the ask a question thing will pop up. A few people have found it already mainly to tell me that their screen's frozen in which case you refresh. Wouldn't it be nice if life was like that? But thank you both to Andrew and to Monique and Monique for just giving us her views. Then we'll now move to Emma and Emma. There's already been a question about the OTs in this field and the sensory assessments and whether they need to be referred to the OT or whether you can do those off your own bat, but I'll let you give your presentation first.

Emma Ketley (00:23:45):

Okay. Alright. And I'll answer that question perhaps afterwards. So meeting Oscar now we've met him as a 22-year-old. He is presented with his parents reporting some behaviours of concern. They're concerned about his sleep cycle. They're perhaps concerned that they feel that he's gaming a bit too much. He has no formal support, but he does live with his family. And all of these behaviours of concern have come about in the transition of him moving from place of employment at the hardware store, which as we said has scaffolding some of his executive functioning perhaps has provided him with a regular routine and he's now transitioned somewhat unexpectedly to being made redundant. We know previously when he had the transition around the age of the end of high school that he had become so dysregulated with that transition and the loss of support that he'd actually engaged in self-harm biting himself to the point of significant. This is again, another crucial time and it's I'm going to be working with him with curiosity being affirming as to respecting his sense of agency and adult to help him engage in meaningful activities around what he needs to do, what he wants to do and what he feels he's expected to do. The next slide please.

(00:25:12):

There's going to be a number of considerations outside of what we would consider neuron normative in working with someone with ADHD and autistic and as a person of lived experience, I also kind of understand this, so we might expect him to blurt info dump when we're talking. That's not Oscar being rude. That's actually Oscar being very, very engaged with us. So it's a compliment, not a criticism. There might be some sensory perceptual differences, which is why Monica has mentioned the sensory profile. And I also want to point out that even though we're going into his home environment or meeting him wherever he chooses, we're actually in additional demand because we're actually introducing him to someone he's not familiar with. And so our prime aspect, our prime priority should be about making him feel relatively safe. So you can't see it right now, but my favourite jumper is a dinosaur jumper and I love dinosaur fidgets. So I will actually probably have some of those because that's his better interest and that's how we can form connection. Next slide please.

(00:26:25):

So as I said, Oscar's work was a fantastic scaffold whenever there had been a transition and a loss of support from outside of that environment or within that environment whenever there's been a transition at increased demand. So Oscar's work, he was engaged, he had values, he felt purpose, he was literally engaged. So that got a thumbs up habitually. It met the need of having somewhere safe, secure, regular and routine. And it was well within his performance skills. He was able to do the job easily and actually he enjoyed doing things like the technical components and we know he did that well because of his manager's feedback. So I will always be highlighting those strengths and skills are still there, but because it's a dynamic disability, there's going to always be an interplay with the environment. But as a summary point, his work was an enabling environment.

(00:27:20):

It enabled him to have a sense of professional identity and its provided scaffolding right now we have unexpected redundancy, which is hard for anyone and for Oscar, we all behaviour is communication. So by engaging in the gaming, he's telling us what activities he feels connected to that make him feel safe and that he's interested in. And that's something to respect because that's his communication. He's experiencing a loss of habitation, he's lost his work role and that structure and his performance skills, he's not, it may look like decompensation, but again, it's because transactionally within that environment, he actually might not have the opportunities to function independently depending on the family's level of creating those opportunities for him. So my question with curiosity is to really explore with him how does he feel that current environments support or limit what his goals, dreams, and aspirations are, again, respecting his sense of agency. Next slide please.

(00:28:28):

There is a big stop sign again, I qualified back in 2020 2002, sorry. And perhaps some of the features of what we're looking at look like depression. He's talking about feeling worthless, having no purpose and he looks like he's socially withdrawing. We want to consider though his brain type because it might not be depression, it might be autistic burnout and maybe it's both. But with his behaviour helping communicate, he's actually telling us what he needs, what he's seeking to feel safe and secure. So our job is to collaborate and partner with him recognising where he's at and make him feel relationally safe within our engagement with him and to take smaller steps recognising that day-to-day each visit, he might have a preferred time, he might want to have engaged in certain activities and we will do that at his pace step by step. New slide please. Next slide please.

(00:29:40):

The importance of really determining whether it's autism, burnout or depression is that obviously he's at high risk if we dive straight into capacity building as occupational therapists, if we look at unloading too many assessments all at once or having raised neuro majority or neuron normative ideas around treating depression. So we're going to really work with him around understanding what these behaviours of concern are actually functionally doing for him, what needs and wants they're actually meeting for him. We're going to look and reflect back his current strengths and enabling environment. And I will be doing this through having interviews with him and his family, also administering the huda, looking at the sensory profile so we can look at where the triggers are and the glimmers, those little moments of enjoyment and also executive functioning. We can meet all of those questions. We might have executive functioning by seeing him engage in activities like the other panel said, we may also want to consider co-occurring health issues, sensory processing issues, any other mental health or even unrecognised chronic pain or anything else that could be part of his profile.

(00:31:00):

Our intervention will be about engaging him in a safe client led way, which will be affirming and strength focus. And we're going to work to address the overwhelm and the burnout first. So we're going to have a activity plan that will decrease demand and look at increasing supports, formal or informal adapting tasks so that they're simpler and more engageable. And as I said, identifying those moments of joy, those glimmers, we're going to work with his nominated support and we're going to have ongoing MDT communication. And then once we've done that, we've got to a point where he feels safe and contained and it's led by him. Then we might consider behavioural activation, a DL capacity building and look at consultation and advocacy, maybe an NDIS assessment and application DES referral or even revisiting study. And all throughout we'll look at MDT communication and referral to other professionals as required. Thank you.

Prof Steve Trumble (00:32:04):

Thanks Emma. And you've anticipated a question in the chat about the glimmer and you've explained it's those little glimpses of lightness and enjoyment, so that's great. Thanks for getting ahead of the game on that. Speaking ahead of the game, I should just give people a bit of a warning. We probably will go about five minutes over to make up for the five minutes we lost when fiddling around at the technical side. So if people can delay their dinner or bedtime or whatever it is, please hang out for that extra five minutes or so towards the end. And now Joe Oscar's found his way to you as a psychiatrist or can you tell us your approach please?

Dr Josef McDonald (00:32:46):

Yeah, thanks Steve. I'll try and move through this relatively quickly so that I can leave some time for questions. But essentially I'll start off looking at a bit of an overview as to co-occurring autism and ADHD and really to say that the diagnosis of both autism spectrum disorder and ADHD was really only permitted by the DSM five, which was released in 2013. And so as opposed to ADHD and autism alone, there really is limited literature in regards to this population with the combined presentation. But nevertheless, based on the evidence and what we see in clinical practise is that it is relatively common. So the estimated prevalence of ADHD and autism is approximately 38% and the possible explanations for this relationship are quite complex. Next slide please.

(00:33:58):

So just for my approach, looking at the case study, these are my first impressions and the issues as I would see them. So we can see that there are difficulties in occupational and interpersonal functioning which are more acute recently. We also have a history of difficulties with emotion regulation, particularly in that year 11 period in which there were sensory sensitivities also, which culminated to self-harm. And so that's something that I would want to address in my assessment. We have quite a sudden decline in mental state following a termination of employment. And so that'll be an area of inquiry. And we can still see that Oscar does use his parents to assist with occupational functioning, but based on the vignette, we presume that there are really limited social supports outside of the family. Next slide please.

(00:35:01):

So when thinking about the assessment, I'd be first looking at the approach. So the first point I think is who are we going to get information from? And so that might include family and I'd ask Oscar if there's anyone else who would be important to get information from. But we want to also be careful not to infantalize Oscar. And so it's important to respect confidentiality and to work collaboratively. Bely an appointment of this nature may need to be longer than what is generally used for an initial assessment. And what I might say to someone like Oscar is if you feel as though you need a break, please feel free to leave the room and you can come back in when you feel ready. We want to avoid the feeling for Oscar of being trapped or feeling as though he needs to remain seated the entire time, particularly for a long appointment.

(00:36:03):

Initially what I would then do is look at exactly what are the symptoms of concerns. So try and avoid medical language and just get to the bottom of what the exact concerns are and what their timeline is, when did they start and how did they develop, particularly if things are either improving the same or getting worse. And throughout the assessment, what I would be doing is screening for potential comorbidities. And so when someone usually says me, and this might be for example, six or eight months after the initial decline, I would be thinking, well, why isn't Oscar getting better? Is there something that is potentially being missed? And so I would be looking at depressive disorders, anxiety issues with sleep, perhaps an undiagnosed obsessive compulsive disorder, whether there is an independent eating disorder, new substance use or more severe, but lower prevalence comorbidities like psychosis, bipolarity and catatonia.

(00:37:07):

We have to be aware of diagnostic overshadowing. What that means is we don't want to attribute features that are developmentally usual for Oscar as evidence of a mental disorder that may not exist. So we wouldn't want, for example, Oscar's fixed interest to be used as evidence of say, withdrawal and then inappropriately start treatment for a mental disorder that isn't relevant and contribute to polypharmacy. So we then have to be careful about the symptoms that we're ascribing to a potential comorbidity. And so I would be looking for things like anhedonia, which is a complete loss of interest in his usual activities, suicidal thoughts and psychomotor disturbance. And by psychomotor disturbance, I mean slowed movements, maybe Oscar isn't moving that much at all or the opposite. So psychomotor agitation, lots of movement, lots of pacing and a change from his baseline. The age of onset is important to consider. So newer symptoms in adolescences for example, may be more relevant to a mood disorder rather than symptoms that appeared say when Oscar was five or six and a risk assessment. And the two main risks that I would be looking at here is obviously the risk of self-harm or suicidal thoughts, but also the risk of his oral intake and weight loss is an important consideration. Next slide please.

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And so for someone like Oscar, I would be routinely screening for a history of epilepsy or ticks which are relevant to treatment and also hypothyroidism, other medical confounders which may mimic a mental disorder. I'd be looking at his current medications, history of side effects and any reasons why Oscar might've stopped taking his medications, say for side effects or stigma for example. And then looking at any sort of vulnerability to mental health issues. So looking through the family, say there are a family history of depression or bipolar disorder that may colour our impressions and raise our suspicion of comorbidity. I'd be reviewing the circumstances of the diagnosis of autism and ADHD looking at what led to the presentation, what were the symptoms of concern from his parents at that time. And take a developmental history. And this might be something that isn't achievable at the first initial presentation, but something that I would be thinking about filling in longitudinally in the examination.

(00:39:55):

I'd certainly be looking for features of catatonia and during that time I wouldn't be inspecting specifically for signs of self-injury, but I would just be aware of that, say looking for signs of say, bite marks on his hands or say injuries to his head based on just the historical pattern of self-harm. I routinely take a heart rate blood pressure, I would weigh Oscar and get a BMI for a number of reasons. One, if Oscar's oral intake isn't adequate, then it may be a medical emergency or you might have to escalate medical treatment. I might have to involve other colleagues and a dietitian. Also, psychotropic medications frequently come with metabolic side effects and so we want to monitor for weight gain as well. And I'd review any relevant pathology, which Andrew alluded to, those kinds of blood tests. Next slide please.

(00:40:55):

So in terms of management, I've kept it fairly open-ended here based on the case, I'd want to make sure that the fundamentals are also done well. So we'd want a good MDT with psychology, occupational therapy and speech pathology. Also, we may include a dietitian based on Oscar's oral intake. I'd guide my management not only by the diagnostic labels but also by formulation. And so formulation in the psychiatry sense is really an explanatory statement as to why Oscar is here. So why in particular was the loss of his work and role important to Oscar at that time? And identifying which supports may be able to help us in carrying out our management plan. There really is limited guidance from the literature in regards to pharmacotherapy individuals with both autism and ADHD. But the overall principles are that cautious titration should be considered. There tends to be higher rates of adverse effects and ities tolerating treatment and we'd be considering the risks and using that also to help us inform what the follow-up period might be and what type of follow-up is important. And so overall, that would be my approach.

Prof Steve Trumble (00:42:22):

Thank you Joe. And so good to see so many comments in the chat that how important it's to see a neuro reaffirming psychiatrist. In fact, all the professionals have been very positive and supportive and appropriate tonight. So I think that's just a great way to present your material. Lots of excellent content. Let's now get into some of the questions and oh my Lord, there've been lots of questions coming in. One of the ones I wanted to get out of the way a bit earlier I guess is about the diagnosis. And this came up during the preparation for the webinar, and I'm going to claim some poetic licence maybe, but when you work back through Oscar's age at the age that he was diagnosed, probably what was in the book then would've been Asperger's syndrome. And we've given him on the papers the diagnosis of level one. So I don't know, Monique, are you well placed to tell us a little bit about that change and I guess and how clients view the terminology in that area?

Monique Mitchelson (00:43:25):

Yeah, absolutely. So as Joe mentioned, when the DSM five came out in 2013, quite a few things changed regarding autism and ADHD. And one of the changes was that the term Asperger's was taken out of the DSM and instead we got autism spectrum disorder with different levels of support needs. And within the autistic community, there has been a bit of, I guess, discomfort with the term Asperger's since about 2011 when a historian looked through archival material and basically found that Hans Asperger, whilst he wasn't a member of the Nazi party in World War ii, that he did play a role in sending disabled kids to be euthanized. So yeah, trigger warning, but basically I guess the debate around the term Asperger's is that he kept the kids that had the high intellectual capacity and capacity for language, and then the children that not deemed worthy of being part of society were sent to die basically.

(00:44:35):

And so that's where dislike of the term Asperger's has come from within the autistic community. So the term ASPE and stuff like that is not really favoured. There will be individuals who maybe of older generations or young children that were given that term and it's up to each individual what they would like to use to refer to themselves or what they identify with. But a lot of people, including professionals, aren't aware of the historical context and that updated information. So I think it's important to talk about it because I didn't learn about it in my training only recently through the autistic community did I learn about that and the terminology.

Prof Steve Trumble (00:45:20):

Thank you for those insights. Does anybody else want to make a comment about the diagnosis that we've got for Oscar here and how important that is to what happens next? I mean, there's lots of elephants in this room at the moment, and one of the ones is about access to services of course, and there's been quite a lot of discussion in the chat about not getting access to disability services. Any thoughts about that? Because what the questions that's leading to is how do people go about getting a good diagnosis when there aren't a lot of really skilled practitioners on the ground? That's an impossible question, but does anybody have any thoughts about, let's do the referrals first. What are your tips for finding practitioners who can really help in this area? What do you look for?

Dr Andrew Leech (00:46:10):

I might start Steve.

Prof Steve Trumble (00:46:11):

Yeah, please do, Andrew.

Dr Andrew Leech (00:46:12):

Yep. This is a really challenging area and I know it's occurring across Australia and in Western Australia here we're having a lot of challenges in accessing services. It's challenging because patients not only have to spend more money to access help, they have to do a lot more work in trying to find that help and find a team that they connect with and build that team. So it might take months to years to find the right people. And that is not only just with diagnosis, but also with therapy and treatment. And there's a huge demand for services. I think in terms of what that means for us in primary care is we spend a lot more time holding onto patients, spending more time thinking a bit more broadly and doing a little bit more work with them and maybe reviewing them more regularly. I try to get them back once every quarter for a long appointment just to do those check-ins and make sure they're on the right track, even if we don't have the right team ready to go. And that then provides opportunity to do more investigations if needed or think about other things that we can do in that meantime. So certainly have to think on the go with that. And I've learned a lot about this area on how to fill those gaps and voids and also get to know who is in your area, who are the people that you trust? And often those referrals get more triaged if they do trust. You're

Prof Steve Trumble (00:47:41):

A bit of a critical in there. You're an unusual gp. What about others? Are there other practitioners in your pantheon who you might call upon? I'm thinking of everybody from mental health, social workers, speech pathologists. I mean there must be others you can draw upon who could help in these.

Dr Andrew Leech (00:47:57):

Yes, yes. I think in this area you start to get to know people really well and then start to have even case conferences and things like that. You start to really have a little network and not uncommon for me to send a text message to someone saying, would you please mind helping out with this person? Or would you be open to accepting this referral? So it sort of helps with the process and the journey for the patient, but it's, it's not always that straightforward, but in your area you tend to get to know that network and those allied health professionals and even have some of them in-house in the clinic, which has been great.

Prof Steve Trumble (00:48:34):

Right. What about the others? I

Emma Ketley (00:48:35):

Jump in.

Prof Steve Trumble (00:48:36):

Yeah. Emma, do you have an entourage or a crew? I'm getting side there.

Emma Ketley (00:48:42):

I certainly do.

Prof Steve Trumble (00:48:44):

Right. Tell us about,

Emma Ketley (00:48:46):

So obviously having the MHPN network in WA means that we've got a great list of practitioners and allied health and the whole MDT represented in people that regularly attend meetings because they've got a real passion. So I think if I was looking for support for a family member, I would look for someone that has got a history of being really interest led within this field because that curiosity is the foundation for learning and for good practise. And so when you've got the MH PNS in your area and you've got an ADHD network, that's absolute goal for finding those supportive colleagues and or professionals to work with you or your family member.

Prof Steve Trumble (00:49:34):

Fantastic. Couldn't be better said. Thank you for that. Can I maybe take us in a different direction though, because I'm conscious of time being shorter tonight. There's been a lot of just questions about gender differences and the way different genders present and the way you might approach people of different genders. What are the panel's thoughts about gender specific aspects of these two conditions or aspects of a person?

Monique Mitchelson (00:50:02):

I think, yeah, I guess in terms of the diagnostic criteria, the diagnostic criteria and a lot of the diagnostic assessments have been based mainly on observations of white young boys. So if you're anyone who's not a white young boy, there are going to be biases in terms of some of the diagnostic criteria, what we were taught as clinicians as well, and how we interpret data and things like the A DOS, particularly for autism in adults and in women. So I think it's just a matter of doing the training, doing reflection, getting good supervision and trying to unpack some of the stereotypes and the biases the best that you can when working with people of different genders, different ethnicities and cultural backgrounds, and particularly adults as well. And just being aware of the biases often I think can be helpful as a clinician in terms of making sure we're doing the best service that we can and not letting people slip through the cracks who are actually autistic and ADHD because it can be quite hard to, I guess touching on what the questions Steve brought up, it can be quite hard if you're an adult woman, to find a clinician that's great at assessing and diagnosing autism and ADHD in adults, particularly if you internalise and mask your autistic and ADHD traits, people who are externalised tend to get picked up a bit better.

(00:51:45):

But then I've had fellow colleagues, other clinical psychologists that were very externalised as children and adults that did not get picked up for diagnosis because of stereotypes and bias. So I think we really need updated tools, we need updated training, and I hope some of those are in the pipeline. And particularly with the National Autism Strategy coming out at the end of the year, there will be an emphasis on updated training for all allied health and medical professionals that will be affirming co co-designed co-presented by autistic and ADHD people and clinicians make sure that that lived experience is being heard as well as the data. Yeah,

Prof Steve Trumble (00:52:33):

Fantastic. Thanks for that. I might, this question, I really want to get onto the webinar tonight, which was asked several times by people in the leadup, which was about what happens when there's some resistance to the diagnosis, either from the person themselves or their families. And there's been quite a lot of chat in the group about how you support families. What is people's approaches, each of you, I guess how do you approach it when there is some pushback against a solid diagnosis being made in this area? How do you go about approaching that? Joe, did you have any start at the psychiatry and I guess what do you do when somebody is resistant to the diagnosis?

Dr Josef McDonald (00:53:22):

Well, to be honest, because I only see adults and to see a psychiatrist in Australia is not the easiest of tasks when it comes to health. It can be a longer wait list, it can be expensive. I don't typically see people who themselves are resistant to the diagnosis to be honest. And in fact, I think one of the changes that I've seen in my practise over the past few years is just such a precipitous increase in awareness that people are usually actually quite eager to not only undergo an assessment, but to hear what the impression is. So I think what is perhaps more common is the stigma surrounding disclosing the diagnosis to say family, friends, partner.

(00:54:32):

I think there's an additional element to that in adulthood in that people also look back on their own lives and say, if only I was identified earlier, if only treatment could have been initiated earlier. And there can, because quite often what we see is comorbidity, whether it might be elements of low self esteem, episodes of failed treatment previously because of perhaps not considering neurodevelopmental aspects to the presentation that there can be a real reluctance to disclose. One thing that I routinely offer is I'll say if people find it helpful that they can certainly bring their partner or significant other to the appointment if they like and we can discuss it. I think it's something that's very individual, it's going to depend on the relationship and what I'll say is there's no onus on them to disclose anything if they do not wish to do so. And so that's my experience really treating adults.

Prof Steve Trumble (00:55:47):

Great, thanks for that. And I'm curious from the others who are probably seeing people a bit earlier in the piece, Emma or Monique or Andrew, how do you approach it?

Dr Andrew Leech (00:55:57):

Steve? It's quite interesting because I see a lot of children undergoing a diagnosis and the parents saying, I also feel that I have autism or I have ADHD. And I think a lot of adults now or the adolescent even are recognising their own journey with this and potentially that they would meet the criteria or have a diagnosis. Not all of them are going on to get a diagnosis. So I think even just knowing that this is part of them and if they wish to get a diagnosis that's something that might help them to then further understand themselves. Quite the opposite again is that there is little, actually not as much resistance as I would've thought. And people are very open and accepting to this, in fact, frustrated if they don't get the answers that they were seeking. So a little bit of the opposite at the moment, but if someone is not keen on a diagnosis, I absolutely would support that and continue to work with the one, whatever they would help them to get to understanding themselves better.

Prof Steve Trumble (00:57:03):

Yep. Great. Thank you. And Emma, somebody's asked the question, Katrina's asked the question, can an OT make the diagnosis? Is this something that you do as part of your practise?

Emma Ketley (00:57:14):

No. So we don't actually make the diagnosis, but we can provide a lot of supporting collateral evidence for the symptomology and working within MDT. We can then obviously work with a psychiatrist or a clinical psychologist that can be informed by some of that behaviour. What is the great thing about OT is that we can meet people where they're at in terms of going to different environments. So if you've got someone that is high masking particularly we've talked about a bias perhaps with women being able to mask, I will actually be able to see them in their familiar environment where they feel safe and engaged in their special interests. So I'll actually be able to see another aspect of someone's presentation coming back to that diagnosis question. It is interesting. There is a lot of ambiguous loss. I work with adults. I'm an OT that works with adults, particularly around the emotional piece with ADHD and autism and sensory.

(00:58:13):

And there is a lot of ambiguous loss when we have adults who are later diagnosed, that sense of loss opportunities and that sadness of what would've been, but the OT, looking at the meaningful engagement, the label to me, whether if someone identifies with the label for their own volition, that's great, but for me, I guess I'm looking at the functional implications of that. I'm trying to look at whether there's some of their behaviours where we can work with them so their needs are met, but that doesn't become, for example, limitations to accessing services. So in Oscar's case, his choice to kind of work within the gaming, it's not carry on with gaming isn't an issue, but what might be an issue in a barrier to care is if he inverts his sleep cycle and ends up sleeping throughout the day when most support services would be in operation.

Prof Steve Trumble (00:59:09):

Right. Well, thanks so much. You froze a little bit in the middle there, but that wasn't a problem. We understood everything you said. I think we can probably hold the satellite together for another 10 minutes if people can stick with, but I do want to ask just a few more questions before we get people to give their final wrap up before we go. And I was going to go, I think probably to Monique with a question from Kiara who's asking again about masking and that because of the comorbidities, people could have something like schizophrenia alongside the fact that they do have autism and ADHD, but they might mask some of their psychotic symptoms because they're very good at it during the assessment with mental health professionals. But then all hell breaks loose when they get home. Is that something that we see with people with these complex mental health problems on top of who they are?

Monique Mitchelson (01:00:04):

I think probably Joe would be a better person to ask about that. In terms of from the neuropsychiatry lens, for me as a clinical psychologist, usually if someone is acutely psychotic or unwell, that's when they usually are more under the care of inpatient services, mental health team, psychiatry, mental health nurses. If someone is acutely psychotic, I clinically would be looking at would they actually have the ability to mask in that situation? Because autistic masking is something that you do intentionally over time it can become almost subconscious, but it takes effort. So to make eye contact an autistic person and I guess perform typicality to make other people comfortable and to not get bullied or discriminated against, you are in interactions deliberately thinking, okay, I need to make eye contact for the two seconds, then look away, then make contact. Okay, make sure you don't have a flat facial expression on, make sure you're modulating a tone of voice. Am I making enough gestures, but not too many? Am I saying the right thing at the right time so I don't offend people? There's lots of layers of thought, action, energy and effort going into masking, hence why it can be quite exhausting and lead to autistic burnout. So if someone's acutely psychotic, I would be clinically looking at would they have the capacity to do that while psychotic.

Prof Steve Trumble (01:01:44):

Does that resonate with you, Joe? Have you had this experience in your practise of somebody with that constellation?

Dr Josef McDonald (01:01:50):

Yeah, and it can be quite a complex process at arriving at an accurate diagnosis. And the age that Oscar's at this age is really when we start to see quite complex psychiatric comorbidity emerge. So this would be the at-risk period for say something like schizophrenia to emerge. And the difficulty with schizophrenia in autism, and I'll just put the ADHD aside for a moment, is that its onset is usually insidious. So it's gradual and it's slow. The initial presentation wouldn't necessarily be an immediate acute psychotic episode. So we might see a prodrome, which is coming before on sort of psychotic symptoms of anxiety and depression. There's probably been a treatment with different psychotropic medications. We would then see usually the negative, what we call the negative features of schizophrenia. So difficulties, further difficulties with executive functioning and apathy. And you can see the difficulty in trying to tease that apart in certain aspects of autism.

(01:03:07):

And then we might start to say the onset of psychotic symptoms, but even with the onset of psychotic symptoms, sometimes it can be very difficult to arrive at a diagnosis because particularly in more say, severe forms of autism, there might be unique aspects of speech that might confound an assessment for delusions or thought disorder, or there might be styles of speech or interests that make it very difficult to try and decide if there's been a change in mental state. So really the importance again is going back to getting that developmental history, trying to find a baseline and how the person has departed from that baseline. When you add in the ADHD, it becomes more complex because the first line treatment for ADHD is usually stimulants. Stimulants will worsen psychosis. So then if we go to treat psychosis, say in the context of schizophrenia and they're required to withdraw the stimulants, then we might see more externalising behaviours or dysregulation. And so it's quite a complex issue. I'm not sure if that necessarily answers the question of masking. It might be more about the complexities say, or the team trying to arrive at a diagnosis. I think it can be very complex. Sometimes it is not, but I've certainly had cases where it is a very complex process

Prof Steve Trumble (01:04:38):

That's been a feature of all the questions that have been coming in about people with trauma, people with gender identity issues, people with a whole lot of other things that are impacting on their or who they are. And it's becoming very difficult to tease these apart. We are going to have to bring it to a conclusion though I'm afraid. I'm not sure. Is there anything anybody wanted to say about any of the other questions that we might've had? Particularly there were some questions about supports within schools, I think was something that was asked quite frequently beforehand that can be problematic. It'll vary from state to state. I guess. I don't know, we can really get into it tonight, but getting some help from the various professionals who can try to give strategies for use in schools would've to be the approach, I guess. But I'm sorry, we are going to have to move to the wrap ups now, so I'm going to ask each of the presenters to give us their final thoughts. Just a couple of minutes each and we will go through in the order that people presented. So we'll start with you Andrew.

Dr Andrew Leech (01:05:42):

Thanks Steve. And I think this for a GP side is that building of that team to create a collaborative network for the patient to wrap ourselves around the patient providing different inputs from different specialties. And that takes time as we've explored tonight. It takes time to find the right people and it doesn't always work perfectly. So we have to be patient and offer that our patient regular follow up so that we can look after them in between while they might be waiting to get the support that they need, creating a affirming environment also in a general practise setting. So we don't want to be too threatening. We want to be quite empathetic and be really strengths-based and caring in how we speak with patients who are autistic. Thanks, Steve.

Prof Steve Trumble (01:06:36):

Great. Thank you so much, Monique.

Monique Mitchelson (01:06:39):

I think the best thing you can do as a psychologist is to go and do some training and personal reflection on the inherent biases that we all carry as human beings and do some neurodiversity affirming training that is co-led or led by someone who is autistic. And ADHD has the lived experience because from the very start of the client's experience with you as the professional, you can basically build that in your affirming language. And often when a diagnosis is delivered, you can really build a positive foundation for that person with their identity from when they're a small child so that you don't have to go and undo all of the negative feedback and the negative stuff around getting a diagnosis and trying to reduce stigma I think is really important. So if you're giving psychoeducation about autism and ADHD diagnosis, adaptions to therapies in an affirming way that's going to really be helpful for the client.

(01:07:52):

And I think just considerations that often people do need ongoing supports and sometimes one-on-one supports as well, regardless of the level. Level one, people do still need support. That's in the DSM. It's not that you need no support. And yeah, I think just recognising that often 10 sessions on a mental health care plan a year is not enough for people with neurodevelopmental differences. And the government really needs to invest more funding in supports for neurodevelopmental differences and disabilities and change some of the environments like the schools, like some of the hospital systems, the funding systems. Because for neurodivergent people, we often are the canary in the coal mine and the environment really can make or break us as well as the attitudes of the people around us.

Prof Steve Trumble (01:08:52):

Thank you so much for those reflections. Emma, your views

Emma Ketley (01:08:57):

That neurodivergency is primarily a difference. It's a difference in brain wiring and I guess our environment can be enabling or disabling and within that social model of disability, it's quite often how we deliver services and what we expect people, social expectations that limit people's participation. The biggest thing that we can do with our clients is not to lead, leave them with a legacy of distrust or suspicion because that in itself is an access issue for them. So you definitely go on lots of training, read up, listen to podcasts, do whatever you want to do to understand more, but also ask questions with the community. The biggest part of my training has been actually spending time with community and getting to hear their voice and getting to understand it so much clearer. And the biggest thing we can do to be affirming is to use that curiosity and if we're not sure, just to ask.

Prof Steve Trumble (01:10:07):

Thank you. Absolutely. And use your networks. And Joe, final words from you. Thanks.

Dr Josef McDonald (01:10:14):

Yeah, I'd just like to reiterate, I think it's important to structure the review correctly and I think listen deeply and not to just rely on the labels. I think coming up with a good formulation and a good explanatory statement and discussing that with the patient to build a shared understanding, I think is always a good start to treatment.

Prof Steve Trumble (01:10:43):

Right. Well we got there. So thank you all so very much. If people can stay with us, a few more things just to mention now, the upcoming webinars will have a focus on people with borderline personality disorder. First of all, multidisciplinary strategies to navigate feelings of rejection and abandonment, hugely important. And that's on Tuesday, the 23rd of July. And then another one looking the principles of mentalization based therapy in your practise, which is Monday, the 9th of September, the podcast on anger and mental health, A three-part series. Just search for MHPN presents and you've preferred podcast app. And while you're there, look for Monique's podcast as well and get into that. You can also join one of the more than 300 networks where mental health practitioners meet to share the richness that you've shared in the chat tonight about where you might find somebody who can help you in these areas.

(01:11:41):

So if you want to find out more about those online or in person networks, go to the MHPN website and have a look at what's there. So thank you so much for attending tonight. There will be a recording. It will be edited. All that bit in the middle will be cut out, which means I will age 10 years from before and after all that happens, it'll be fascinating to watch, but it will be nicely edited. There'll be proper subtitles, captions that will be thoughtfully put together and that'll come out and you'll be notified when that's available soon. Please fill out the survey, click on the link down the bottom there for the survey or scan the QR code that's there on the screen at the moment. You will get statements of attendance. You'll still get CPD points for tonight. I hope it's been as useful for you as it has been for me.

(01:12:32):

And your statements will be on the MHPN portal in two weeks and the recordings and the resources will be there in about one week. So before I close, I'd like to thank everybody for your perseverance tonight, but also to acknowledge people with lived experience of the conditions that we discuss on these webinars. And also the carers who have lived with mental illness in the past and those who continue to live with mental illness in the present as well as the conditions that make them who they are. So thank you to everybody for your participation this evening. I wish you a better rest of evening than we've had, but it's been a fabulously educational event. So thank you to our panel and we wish you all goodnight.