Autism and Mental Health

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Who I am…

- I am a LCSW who practices at Brave Counseling and Psychiatry. Brave is a private practice that focuses on helping women and couples live their best lives.
- Prior to joining Brave I was a social worker and manager of Patient Family Support Services at MUPC, and have worked in a wide range of community and inpatient settings
- A parent advocate on an ECHO Autism Hub Team for Autism and Mental Health for 2019-2020.

Why is this a subject I am passionate about…

- I have worked primarily in mental health settings throughout my career. When my older son was diagnosed with autism four and a half years ago, I was thrown into the autism community/services.
- At MUPC I saw how strong the division was between Developmental Disability service providers and Mental Health providers. Often people are not able to easily access services in both areas.
- As a social worker I believe in seeing people as a whole. I know that people are not just a diagnosis and that we need to see the full picture to treat people. We need to work collaboratively with other providers in the interest of our clients.

My vision…

I want to see a system of services where people who are on the Autism Spectrum are able to access all the services they need. Mental health care should be accessible to all people who need it.

I want all providers to feel comfortable with serving people with Autism and Mental Health Issues and to be aware of evidence based treatment options.

A world where my son is able to easily get his needs met and can live a full life.

Let’s get to know you…

Polls:

What is your area of specialization?

a. Mental Health
b. Developmental Disabilities
c. Substance Use
d. Other (please specify what)

What is the framework you are operating from?

a. Social Work

b. Psychology

c. Direct Care professional (ie case manager, support services)

d. Physician

e. Student

f. Consumer or Consumer Advocate

G Other

What questions are you hoping will be answered?

The plan for this session

- Explore Autism Spectrum Disorders
- Look at Co-occurring disorders with Autism
- Mental Health Issues & Evidence Based Treatment Options
- Suicide Risk for People with Autism
- Challenges in Accessing Appropriate Services/What a Crisis Looks Like
- ECHO Autism and Mental Health
- Inpatient Mental Health Care- Challenges and Some Ways to Improve Services
- Review and Questions

A brief introduction to Autism
(Video from Autism Speaks)

History of Autism Video History

A history of Autism Diagnosis

DSM III: First time Autism was put in the Pervasive Developmental Disorder Category. Prior to this it was categorized as psychiatric and was considered a type of child Schizophrenia.

DSMIV: Autism was first presented as a spectrum of conditions. The DSM IV states that 75% of people with autism "function at a retarded level" and refers to mood abnormalities/depression and hyperactivity as part of associated features of autism. There is no place for a diagnosis of a mental health condition with autism.

DSMV: Eliminated asperger's, PDD-NOS, Classic Autism, and Rett Syndrome. Autism Spectrum Disorder diagnosis allows for co-occurring mental health conditions.

https://www.spectrumnews.org/news/evolution-autism-diagnosis-explained/

What is Autism?

Diagnostic Criteria

- A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive, see text):
- 1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
- 2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
- 3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

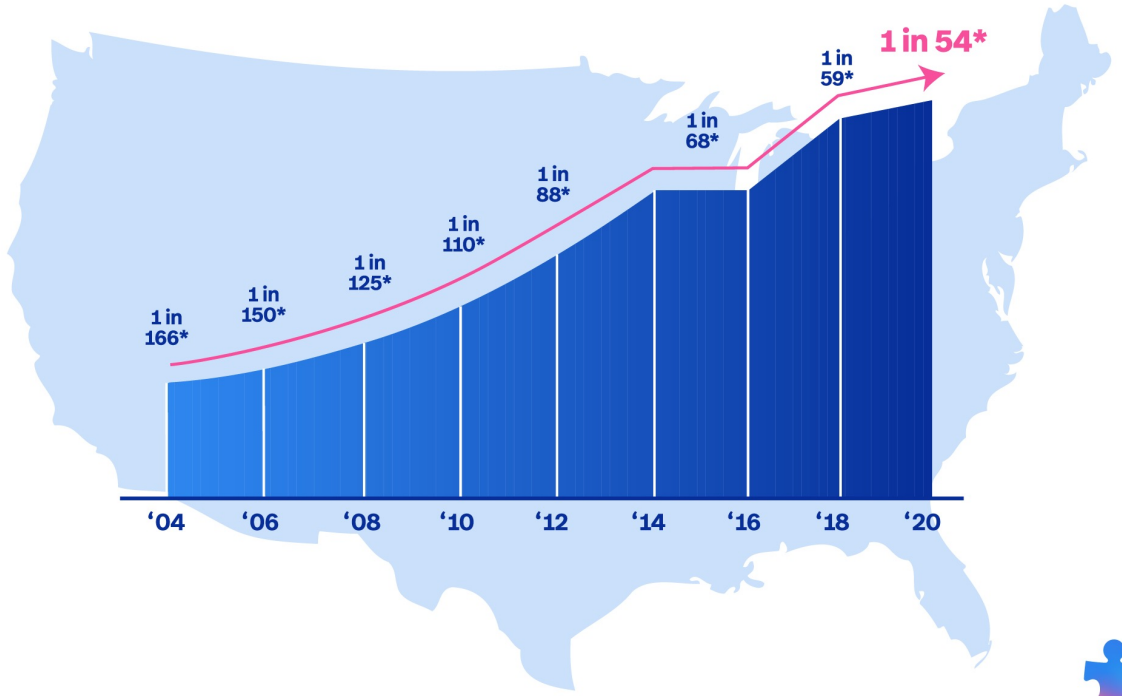
- B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):
- 1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
- 2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).
- 3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g, strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).
- 4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).
D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

The New Diagnostic Criteria Requires a Level of Impairment is Given:

Severity Level	Social Communication	Restricted, repetitive behaviors
Level 3 "Requiring very substantial support"	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 Requiring substantial support"	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how has markedly odd nonverbal communication.	Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 Requiring support"	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful response to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to- and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

Estimated Autism Prevalence 2020

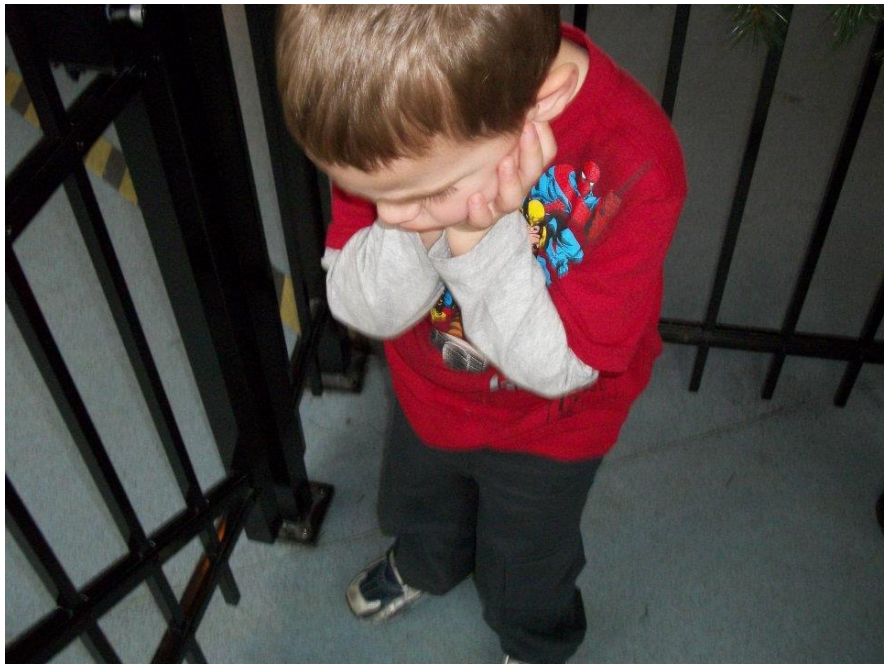


* Centers for Disease Control and Prevention (CDC) prevalence estimates are for 4 years prior to the report date (e.g. 2020 figures are from 2016)

autism speaks

Top things we see in Autism

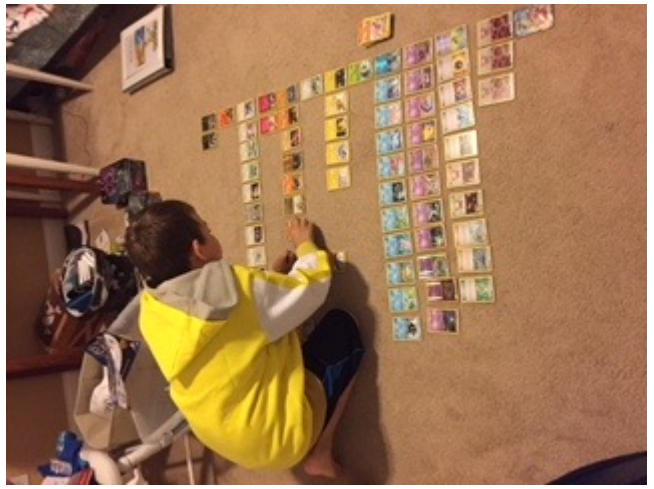
Crowded/Noisy Spaces can be overwhelming



Sensory Situations may be different

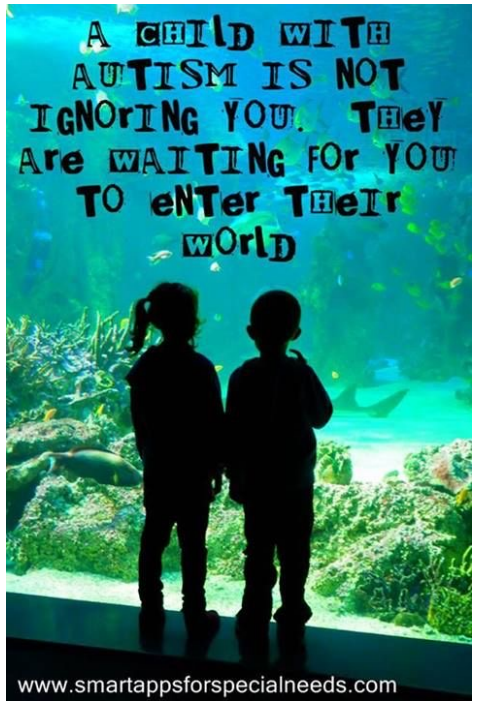
A different way of looking at things

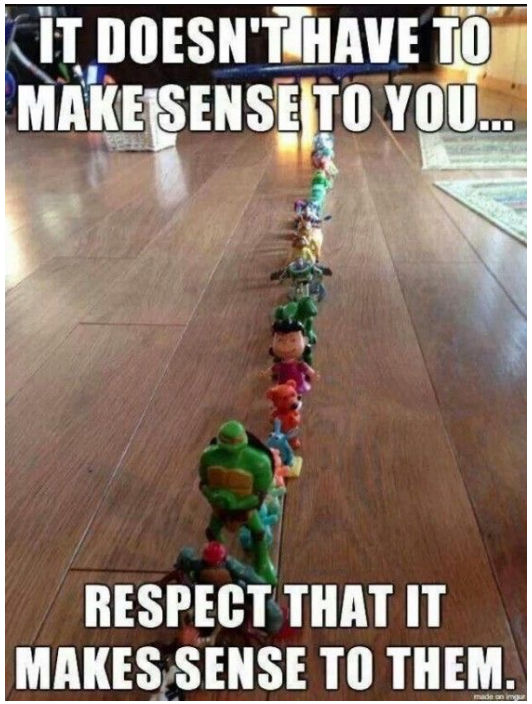
Obsessions & Things Must stay In Order



Things to keep in mind when interacting with someone who has autism:

- They are very literal. They will not understand idioms, metaphors, and plays on words.
- Communication issues are common. Know that they may take longer than expected to process your question.
- Reduce the stimuli in the environment when possible.
- Remember we all have a bubble. Some people on the spectrum have very large bubbles and others have none.
- Meltdowns are different from tantrums. They are an individual's way of trying to communicate. You can't discipline away a meltdown.
- Stimming is OK. It may seem weird to you, but it may feel good to the individual engaging in it.
- Just because someone is autistic doesn't mean they don't like people. Many people on the spectrum want friends and even romantic relationships.
- Many autistic people miss social cues

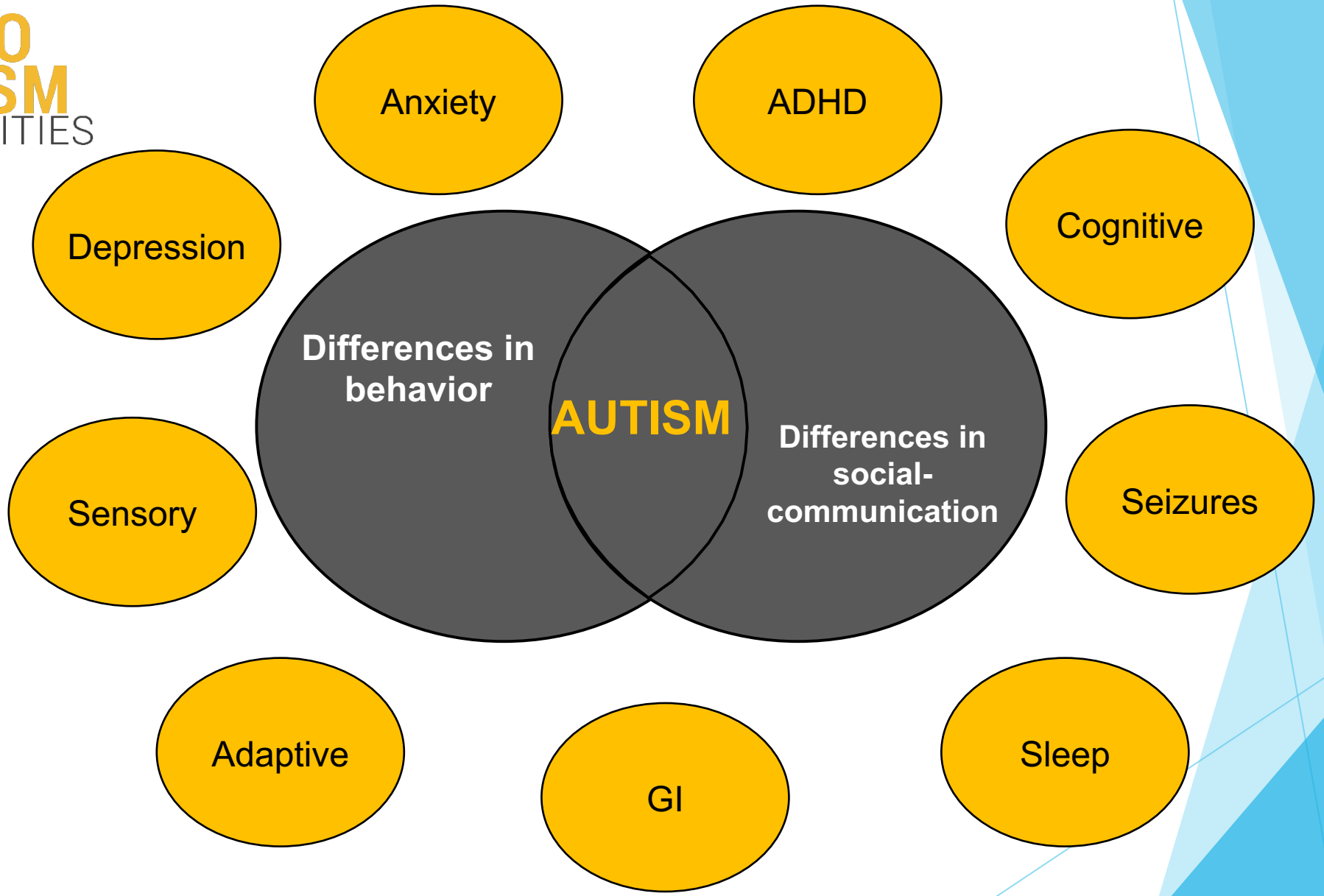




If you have met 1 person with autism… you have met 1 person with autism.

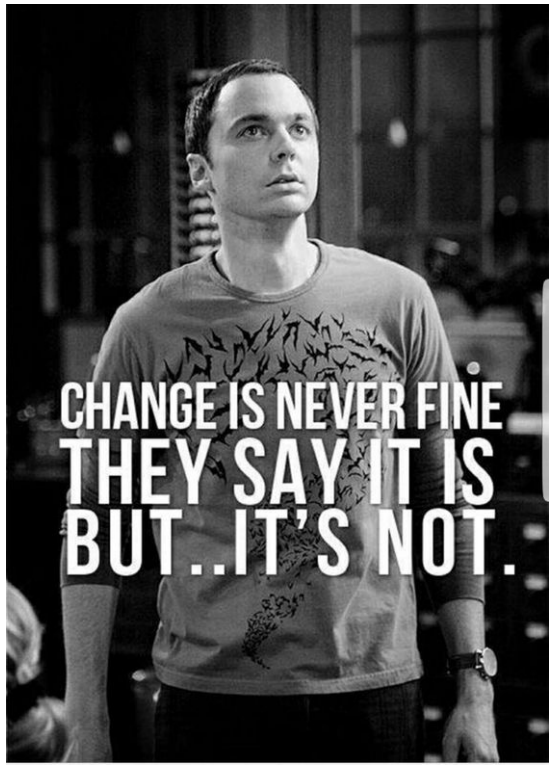
Co-occurring Disorders

ECHO AUTISM COMMUNITIES



Anxiety Disorders

- The most common co-occurring disorder with autism.
- Studies have shown anywhere from 22 to 84% of participants had symptoms of ASD & an Anxiety Disorder
- Some research indicates an even higher prevalence of Anxiety in individuals with “High Functioning Autism”



Types of Anxiety Disorders

Source: DSM 5

- Specific Phobia- Marked fear or anxiety about a specific object or situation; Phobic object or situation always provokes immediate fear or anxiety; Causes significant distress; Typically lasts for 6 months or longer
- Panic Disorder- Recurrent, unexpected panic attacks
- Social Anxiety Disorder- Marked fear or anxiety about 1 or more social situations (in children the fear must occur in peer settings); Must not be better explained by autism

Anxiety Disorders (Continued)

Generalized Anxiety Disorder- Excessive anxiety or worry, occurring more days than not for at least 6 months; individual finds it difficult to control the worry; Anxiety & worry cause: Restlessness or feeling keyed up or on edge, Being easily fatigued, Difficulty concentrating or mind going blank, Irritability, Muscle tension, Sleep disturbance

"Just checking that I've turned off the lights, dear!"

Obsessive Compulsive Disorder Source: DSM 5

Obsessions are defined by Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress

Compulsions are repetitive behaviors or mental acts that the individual feels driven to perform in response to an obsession

The obsessions or compulsions are time consuming

Behavior cannot be attributed to the symptom of another disorder like ASD

Treatment for Anxiety Disorders

- Cognitive Behavioral Therapy (CBT): Challenges negative thoughts with logic (can occur in a group or individually)
- Exposure Therapy
- Alpha Stim
- Medications: (i.e.) Prozac, Zoloft, Lexapro, Paxil, Wellbutrin, Buspar, Clonopin, Ativan, Vistaril

Strategies for Helping an individual with anxiety…

- Provide a schedule and follow predictable routines
- Mindfulness activities
- Deep breathing exercises
- Physical exercise/Yoga
- Journaling- this can be done in whatever way works best for the individual
- Coloring and other creative activities
- Calm down jar

ADHD

- High rate of co-morbidity with autism
- Inattention & Hyperactivity/Impulsivity
- Conner's is the most commonly used screening tool (it is administered to parent, school, and other involved agencies/daycare)
- Treatment often includes medication (Stimulants like Adderral or Concerta, Strattera, Tenex i.e.)
- Behavioral Therapy to address issues related to executive functioning
- Accommodations at school are often needed

Mood Disorders- Depression

- Depressed mood most of the day
- Markedly diminished pleasure in all, or almost all activities
- Significant weight loss or gain
- Insomnia or hypersomnia
- Psychomotor agitation or retardation nearly every day
- Fatigue or loss of energy
- Diminished ability to think or concentrate
- Recurrent thoughts of death

Source: DSM 5

Depression Treatments

- Antidepressant medications- Prozac, Zoloft, Lexapro, Remeron, Celexa
- Counseling/Therapy to allow a safe place to process feelings and support change (CBT is evidence based for people with ASD)
- Exercise & Healthy Diet can be a part of treatment
- Ketamine/Esketamine
- TMS-Transcranial Magnet Stimulation
- ECT- Electroconvulsive Therapy

Bipolar Disorder

- Bipolar I- Episodes of Depression & Mania (Increased self-esteem or grandiosity, decreased need for sleep, pressured speech, flight of ideas, distractibility, Increase in goal-directed behavior, risky behavior) (Source DSM 5)
- Bipolar II- Episodes of Depression & Hypomania (Mania Light ☺)
- Treatment includes: Mood Stabilizers (i.e.Lithium, Depakote, Lamictal), Anti-depressants
- Maintaining a healthy lifestyle can help

Oppositional Defiant Disorder

According to DSM 5 must include emotional and behavioral symptoms that last at least 6 months.

Angry and irritable mood:

- Often and easily loses temper
- Is frequently touchy and easily annoyed by others
- Is often angry and resentful

Argumentative and defiant behavior:

- Often argues with adults or people in authority
- Often actively defies or refuses to comply with adults' requests or rules
- Often deliberately annoys or upsets people
- Often blames others for his or her mistakes or misbehavior

Vindictiveness:

- Is often spiteful or vindictive
- Has shown spiteful or vindictive behavior at least twice in the past 6 months

Comparing ODD to Autism

Autism symptom

- Aggression/Meltdowns/Tantrums
- Prefer to be alone, Sensitivity to environment
- Difficulties with communication
- Flapping, repeating things, difficulties with social skills

ODD Symptom

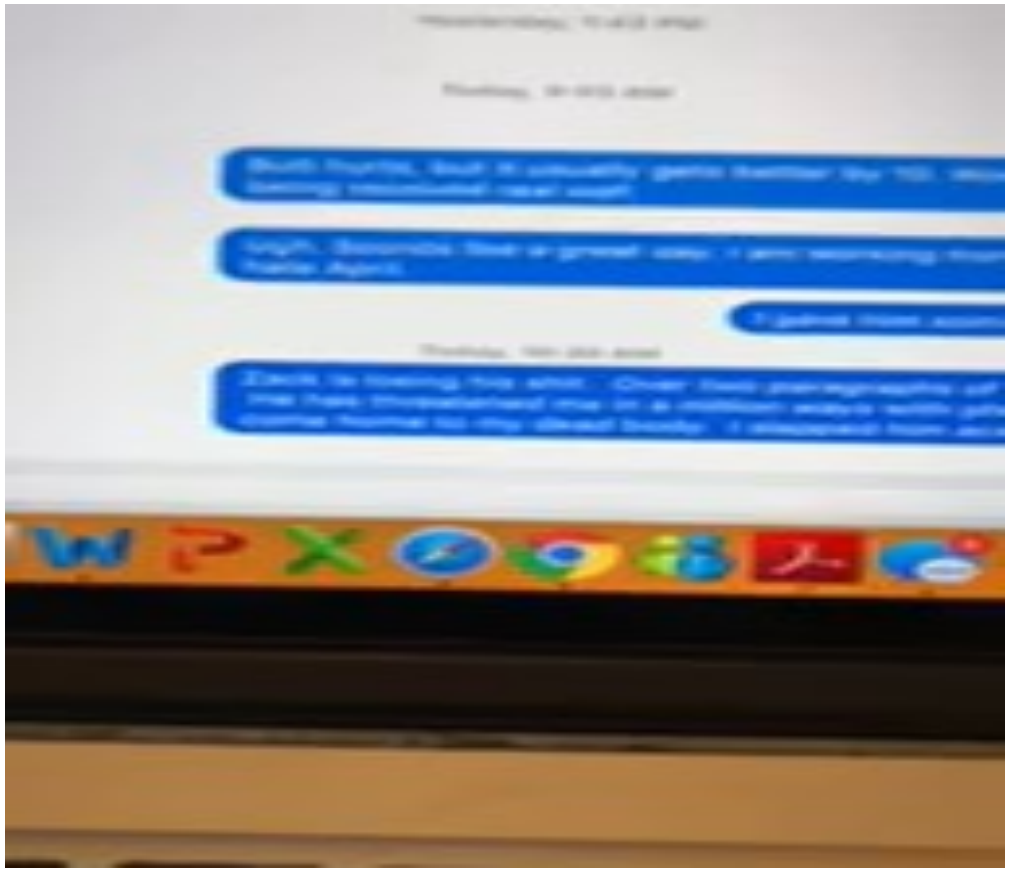
- Often and easily loses their temper
- Is frequently touchy or easily annoyed by others
- Actively defies adults requests
- Annoys others

Suicide Risk

- 72% of autistic adults scored above the psychiatric cut off for suicide risk on the SBQ-R. The general population's risk is 33%
- Risk Factors: Camouflaging (covering up autistic symptoms in front of others to cover up their condition); Non-suicidal Self Injury; Unmet Support Needs

"Risk Factors for Suicidality in Autistic Adults", Cassidy, S, Bradley L, Shaw R, et al, Molecular Autism, 9, 42(2018)

Mental Health Crisis in Autism



Crisis with MI & ASD

- Can appear to occur out of nowhere and escalate quickly
- Threats of self harm/suicide or harm to others
- Physical aggression such as punching/kicking holes in the wall/doors
- May ebb and then re-escalate over a period of hours or days with little sleep
- Caregivers often attempt to manage symptoms for awhile before reaching out for help

Challenges in accessing care…

- As quickly as a mental health crisis may escalate it can also de-escalate
- Families are worried about the risk to the person with ASD if they call the police (fear it may escalate the situation) or go to the hospital (long wait in an over-stimulating environment often followed with go home and follow up with autism services)

Why People with ASD and MI avoid MH Care…

- "Autistic people were less likely to agree with mental health diagnosis, and this was often because they didn't feel their healthcare professional understood their condition, or how to communicate with them properly."
- Reasons: Felt their autism characteristics were confused with mental health conditions and they perceived their MH difficulties to be result of autism

Docs.autismresearchcentre.com/papers/2018-Au-Yeung_Experience-misdiagnosis

ECHO Autism: Menth Health

OVERALL AIM: Increase access to mental health therapeutic modalities modified for individuals with autism

TARGET AUDIENCE: Licensed Therapists

FREQUENCY: Twice, monthly for 90-minutes

Cohort 1 meets on the 2nd and 4th Monday of each month, September - May

Brenna Maddox, PhD
Clinical Psychologist

Rachel Brown, MD
Child & Adolescent Psychiatrist

Melinda Odum, LCSW
Resource Expert

Ellie Madigan, BS, RN
Family Advocate

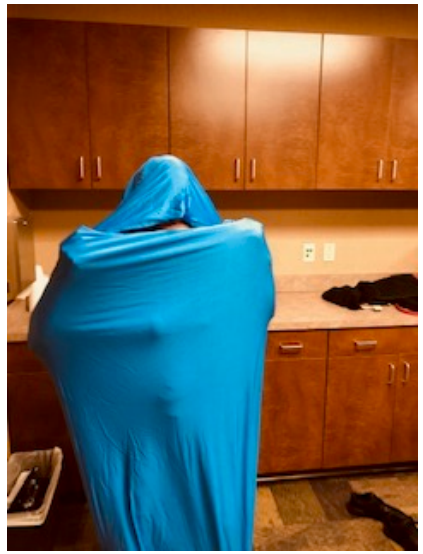
Challenges in inpatient psychiatric care

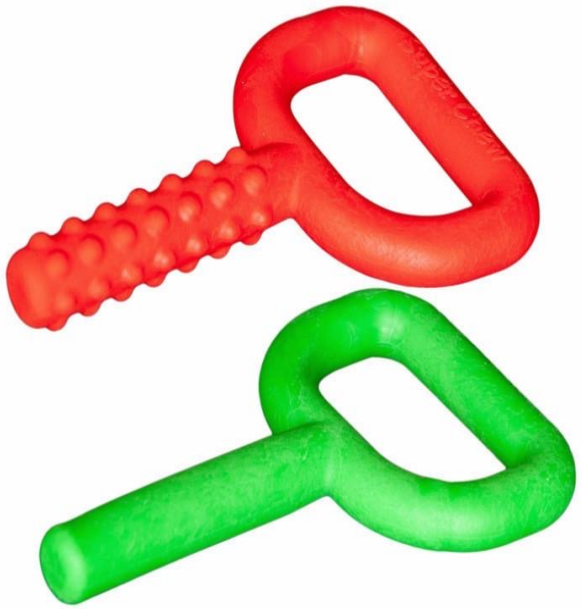
- Staff are not familiar with autism and misperceive stimming, loud speech, and other autistic behaviors as aggressive
- There are not appropriate materials for meeting sensory needs
- Group therapy
- Environment is over-stimulating
- It is often not possible to have comfort items
- Changes to routine/diet

Some ways to address this

- Having a BCBA (Behavioral Analyst) on team to help evaluate symptoms and develop plans for addressing disruptive symptoms
- Utilize an OT for recommendations on ways to address sensory needs
- Have sensory items (ie chew tubes, fidgets, and other materials for sensory input) available for clients
- Ensure that staff are educated about autism and are taught techniques for helping people with autism
- Work with local autism experts to evaluate potential sources of stress (ie buzzing lights)
- Access to sensory experiences that allow spinning, swinging, sound, and safe outdoor play
- Promptly coordinate with the person with ASD's caregivers to help in reducing sources of stress/de-escalation techniques

Some examples





In Summary…

- We need to find ways to coordinate care between autism and mental health services and when possible have providers who are cross trained/can address both issues
- Autism presents differently for each person, but we can all ensure a more sensory sensitive environment (reducing noise, bright lights, and crowds). Avoid using metaphors and idioms.
- In community mental health/therapy settings we can have fidgets, weighted blanket, and different seating options available. We can normalize needing to stand or move in session. Plan on utilizing hands on techniques and use the person's special interests as a way to engage them (ie a Minecraft or Pokemon feelings chart). Obtain training on CBT and how to adapt it to working with people with Autism.

- In Inpatient mental health settings we can reach out to the person's supports for preferences/needs as soon as possible. We can ensure all staff are trained on autism and are able to support people appropriately. Provide appropriate supports and modifications of the environment to set the client up for success.

- If you aren't sure what to do to support someone with a dual diagnosis please reach out for clinical consultation. ECHO Autism is an amazing resource for increasing knowledge around autism in general and the Autism and Mental Health ECHO specifically focuses on skills related to this topic.

Resources
Participants in ’20-’21 ECHO Autism

Ashlee	Jones	Psychologist- PsyD	Truman Medical Center
Ashley	Cross	PLPC	Embark Counseling Services
Brin	Ballard	LPC	Brin Ballard, MA, LPC
Claudine	Allen	LPC	ALM Hopewell
Cosha	Peterson	LPC	Compass Health
Courtney	Miller	LPC, NCC	Mark Twain Behavioral Health
Dawn	Ortega	LCP	Comtrea
Deanna	Wolf	Psy.D.	Burrell Behavioral Health Center
Deanna	Zarei	Doctoral Psychology Intern	Burrell Behavioral Health
Diana	Bastien	LP	Burrell Behavioral Health/CoxHealth Pediatric Center
Diane	Silman	LCSW	Self employed
Erin	Cloud	LMSW	Burrell Behavioral Health
Jamie	Crouch	LPC	Mark Twain Behavioral Health
Kelli	Taylor	Clinical Psychology Intern	Intern, Leffen Autism Center
Lora	Shreve	LPC	Burrell Behavioral Health
Matt	Waggoner	NA	Division of DD
Natalie	Carver	LPC	Burrell Behavioral Health
Patricia	Hinten	pre PLPC. (CIT)	Columbia Psychology Healing Center
Phillip	Smith	LPC	Compass Health Network
Robin	Rasse	LPC	Burrell Behavioral Health
Rochelle	Morgan	LPC	Compass Health
Sandra	Clark	Licensed Clinical and School Psychologist	Quincy Medical Group
Sarah	Lea	LP	Compass Health Network
Tabatha	Rice	LPC	Burrell Behavioral Health
Tina	Kirchner	LPC, LPN, Autplay certified	Compass Health
Valery	Johnson	LPC	Compass Health Network