

1.0 Descriptive summary of station:

The candidate has been asked to urgently see a patient Dianne, whom they have been treating for bipolar disorder for the past 2 years. Her illness is well controlled and her mental state has been stable. Dianne has requested the appointment, as she is concerned about her son Jack. Jack started preschool about 1 month ago. The teacher from the kindergarten approached Dianne last week and suggested she get Jack assessed for a possible Autism Spectrum Disorder (ASD) without much explanation as to why. Dianne would like to know what ASD is, how it is diagnosed and how it is managed.

1.1 The main assessment aims are:

- To explain what ASD is, how it is diagnosed and some of the management strategies that can be used to manage it.
- To manage the distressed patient whose son may have a diagnosis of ASD while still providing accurate information about the condition.

1.2 The candidate MUST demonstrate the following to achieve the required standard:

- Explain that the information may not apply to Jack, as he has not yet had a formal assessment.
- Explain that there is no scientific evidence linking vaccines to autism.
- Mention deficits in social interactions, behaviour and communication as key components of ASD.
- Mention at least one of each of the biological, psychological and environmental interventions useful in the management of ASD.
- Mention the importance of early intervention.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Disorders (e.g. sex, neuropsychiatric, sleep, somatoform, eating, etc.)
- **Area of Practice:** Child & Adolescent Psychiatry
- **CanMEDS Domains:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Diagnosis, Management - Therapy), Communicator (Synthesis), Scholar (Application of Knowledge)

References:

- <https://www.autismcra.com.au/national-guideline-autism-diagnosis-australia>
- Behavioural and Developmental Interventions for Autism Spectrum Disorder: A Clinical Systematic Review Maria B. Ospina, Jennifer Krebs Seida, Brenda Clark, Mohammad Karkhaneh, Lisa Hartling, Lisa Tjosvold, Ben Vandermeer, Veronica Smith
- PLOS, Published: November 18, 2008, <https://doi.org/10.1371/journal.pone.0003755>
- Paediatrics November 2012, VOLUME 130 / ISSUE Supplement 2, http://pediatrics.aappublications.org/content/130/Supplement_2 Nonmedical Interventions for Children With ASD: Recommended Guidelines and Further Research Needs Margaret A. Maglione, Daphna Gans, Lopamudra Das, Justin Timbie, Connie Kasari, For the Technical Expert Panel,, HRSA Autism Intervention Research – Behavioural (AIR-B) Network
- www.betterhealth.vic.gov.au/health/conditionsandtreatments/autism-spectrum-disorder-asd
- www.autismspectrum.org.au
- www.autismtreatmentcenter.org
- Autism spectrum disorders Tonge, Bruce; Brereton, Avril. Australian Family Physician; Melbourne 40.9 (Sep 2011): 672-7.
- Roberts, J. M. A., & Prior, M. (2006). A review of the research to identify the most effective models of practice in early intervention of children with autism spectrum disorders. Australian Government Department of Health and Ageing, Australia.

Committee for Examinations
Objective Structured Clinical Examination
Station 7
Adelaide September 2017



1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: Young woman, late 20s, neatly dressed, easy to talk to.
- Pen for candidate.
- Timer and batteries for examiner.

2.0 Instructions to Candidate

You have **eight (8) minutes** to complete this station after **two (2) minutes** of reading time.

You are working as a junior consultant psychiatrist in a community mental health centre. Dianne has bipolar disorder that you have been treating for the last two years. Her mental state has been stable for the past 18 months and there are no reports of recent concerns.

Dianne requested this appointment as she is concerned about her 3-year-old son Jack. His teacher at preschool suggested Dianne get him assessed for a possible diagnosis of an Autism Spectrum Disorder (ASD) with no explanation as to what the condition is and why she feels Jack should be assessed. Dianne understands that her son has not actually been diagnosed with Autism Spectrum Disorder (ASD) but would like to know about the condition as the possibility has been raised.

Your tasks are to:

- Provide accurate information on the current understanding of ASD and its causes.
- Explain how a diagnosis of ASD is made.
- Outline the management options available for ASD.

You are **NOT** expected to gather any history about Jack's development or behaviour.

You will not receive any time prompts.

Station 7 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
 - A copy of 'Instructions to Candidate'.
 - Pens.
 - Water and tissues are available for candidate use.
- Do a final rehearsal with your simulated patient.

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE that there are no cues / scripted prompts for you to give.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can'.
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the final task:

- You are to state the following:
***'Are you satisfied you have completed the task(s)?
If so, you must remain in the room and NOT proceed to the next station until the bell rings.'***
- If the candidate asks if you think they should finish or have done enough etc., refer them back to their instructions and ask them to decide whether they believe they have completed the task(s).

3.0 Instructions to Examiner

3.1 In this station, your role is to:

Observe the activity undertaken in the station and judge it according to the station assessment aims and defined tasks as outlined in 1.1 and 1.2.

When the candidate enters the room briefly check ID number.

The role player opens with the following statement:

'Hello doctor, thanks for seeing me at short notice.'

3.2 Background information for examiners

The aims of this station are to assess the candidates ability to describe current knowledge about the causes of Autism Spectrum Disorder (ASD), how the condition is diagnosed and what management options are available. They are required to do this while managing the distress evident in a mother who happens to be a patient with bipolar disorder.

In order to 'Achieve' this station the candidate **MUST**:

- Explain that the information may not apply to Jack, as he has not yet had a formal assessment.
- Explain that there is no scientific evidence linking vaccines to autism.
- Mention deficits in social interactions, behaviour and communication as key components of the ASD.
- Mention at least one of each of the biological, psychological and environmental interventions useful in the management of ASD.
- Mention the importance of early intervention.

A surpassing candidate may acknowledge the limitations of the information provided in that they are giving general information and that this may not apply to her child, but can assist in her understanding ASD and whether any of these issues and suggestions are relevant to her child and family. The better candidate will comprehensively cover a range of biological, psychological and environmental domains for diagnosis and interventions for autism spectrum disorder. The better candidate will be able to not only describe current knowledge about the causes of ASD but also the limitations of this knowledge.

About Autism Spectrum Disorders

ASDs are lifelong, pervasive developmental disabilities characterised by markedly impaired development and difficulties in social interaction and social communication; and restricted and repetitive, stereotyped interests and behaviours. It is a disorder that is usually diagnosed in early childhood with developmental delays in social interaction and language surfacing prior to age 3 years. A type of autism characterized by very early detection (< 30 months) may present with social coldness, grossly impaired communication, and bizarre motor responses.

It is a condition that affects a person's ability to interact with the world around them. ASD varies greatly in if presentation and has wide-ranging levels of severity and varying characteristics. Children with autism might have problems talking with others, or they might not look people in the eye when they talk to them. They may spend a lot of time putting things in order before they can pay attention, or they may say the same sentence again and again to calm themselves down.

The word 'spectrum' is used because the range and severity of the difficulties people with an ASD experience can vary widely. Currently all children on the autism spectrum are diagnosed with ASD. Previously, a number of different terms were used including autistic disorder, Asperger's disorder (milder version) and pervasive developmental disorder.

Research shows that about 1 in 100 children, (e.g. almost 230 000 Australians), have an ASD and that it is more prevalent in boys than girls. Because of the range of presentations, it is important to present an optimistic outlook in this scenario. Many famous people are considered to suffer from ASD: e.g. Daryl Hannah, Dan Aykroyd, Andy Warhol, Mozart, Thomas Jefferson, James Joyce and Stanley Kubrick.

Currently, there is no single known cause for ASD, however recent research has identified strong genetic links. ASD is not caused by an individual's upbringing or their social circumstances (see below).

There are a range of behaviours commonly linked with ASD. These may include:

- language – absent, delayed or abnormal developmental patterns
- play – isolated, repetitive, a preference for predictable play, difficulty with imaginative play; stereotypical behaviour, such as flapping and toe walking, and other behaviours that may cause self-injury.
- restricted or obsessive behaviour – with favourite topics, objects, places, people or activities
- rituals and routines – these bring some order to chaos and confusion. A change to routine can result in the person displaying high levels of stress, anxiety or acting out
- tantrums 'meltdowns' – can be a way to express extreme confusion, stress, anxiety, anger and frustration.
- sensory processing differences – difficulties processing certain sounds, colours, tastes, smells and textures. People may seek or avoid particular sensations. Some people will have difficulty with discriminating sensory information too, for example hot versus cold.

There is no medical test for diagnosing ASD. ASD is diagnosed through observation and assessment by health professionals, which may include a paediatrician; psychologist or psychiatrist; speech pathologist or occupational therapist. Usually two separate professionals will assess a child for ASD to confirm a diagnosis.

The tools used for assessment often include questionnaires for teachers, carers and family. These can be formalized by using the:

- Child Autism Rating scale CARS II
- Autism Diagnostic Observation Schedule ADOS II
- Modified checklist for autism in toddlers M-CHAT
- Ages and stages questionnaire
- Autism Diagnostic Interview (Revised)
- Autism Screening Questionnaire (ASQ)

Some children will show signs of ASD by the age of two and will be diagnosed then. Others may be diagnosed when they are older. The earlier ASD can be diagnosed the sooner therapy can begin. Early intervention has been shown to improve outcomes for children on the autism spectrum.

Causes of ASD

To date, there is no accepted single cause of Autism although there are numerous theories. It is becoming apparent that, 1) ASD is most probably caused by multiple factors interacting in complex ways (i.e. multiple genes, environment and brain) and, 2) that ASD is not etiologically homogeneous. That is, there are probably numerous sub-types of ASD each with differing aetiologies. For example, there is evidence of a sub-group of children diagnosed with ASD (20-30%) who show skill regression between 18 - 24 months after apparently normal initial development (Lainhart et al, 2002) while other children with ASD show consistently delayed development.

Genetics have been shown to play a role but do not explain the full picture or the recent increase in reported cases. Studies have shown that if one identical twin has the diagnosis, then there is a 30-40% chance that the other twin will develop ASD. This concordance is hardly ever seen with non-identical twins. (Bailey et al, 1995). When a wider definition of ASD is used, the probability rates rise to 90% for identical twins and 10% for non-identical (Bailey et al, 1995). The probability of receiving an ASD diagnosis when another sibling has already been diagnosed is estimated between 2 and 14%, a 10- to 20 -fold increase over the general population incidence (see Hertz-Picciotto et al, 2006. Research into genetics suggests that at least 40% of ASD cases may have an environmental cause (Hertz-Picciotto et al, 2006).

A few studies have begun to find some cases of ASD linked to maternal exposure to certain viruses (measles, mumps, rubella, herpes, syphilis, cytomegalovirus and toxoplasmosis) and chemicals (thalidomide and valproic acid). However, these account for a very small proportion of all cases (Hertz-Picciotto et al, 2006). More and more researchers are turning to environmental causes (e.g. heavy metals, PCBs pesticides and PDBEs) as a central hypothesis. Large-scale studies have been set up to begin to understand the contribution of environmental factors to the aetiology of ASD, for instance the CHARGE (Childhood Autism Risk from Genetics and Environment) study at University California-Davis.

A 2003 article in The Journal of Autism and Developmental Disorders reported a 10-fold increase in incidence of ASD diagnosis in the United States from 4-5 per 10,000 children (1980s) to 30-60 per 10,000 (1990s). A portion of this increase is undoubtedly due to greater clinician awareness and wider inclusion criteria, but this cannot explain such a rapid and dramatic increase.

It is widely accepted that atypical brain development underlies the development of the observable symptoms of ASD. These differences in brain development can be traced to either before birth or very soon after birth even though the behavioural and social signs of Autism tend not be observable until after 18 months following birth.

Studies have shown differential development in many brain areas including the frontal and temporal lobes, the cerebellum, and the sub-cortical amygdala and hippocampus. Scarcity of evidence, methodological challenges and conflicting findings have not yet allowed precise conclusions to be drawn about either the specific brain regions affected or the mechanism of development that lead to observed brain differences.

Other health conditions

Below are some other conditions known to be associated with ASD:

- muscular dystrophy – a group of inherited genetic conditions that gradually cause muscles weakness.
- Down's syndrome – a genetic condition typically causing learning disability and a range of physical features.
- cerebral palsy – brain and nervous system conditions causing problems with movement and coordination.
- neurofibromatosis – a number of genetic conditions causing tumours to grow along the nerves (the main types are neurofibromatosis type 1 and neurofibromatosis type 2).
- rare genetic conditions fragile X syndrome, tuberous sclerosis and Rett syndrome.
- foetal alcohol syndrome.
- intellectual impairment.
- attachment disorder.

Misconceptions about the causes of ASD

In the past, a number of things were linked to ASD, but extensive research has found no evidence to suggest that any of these contribute to the condition, including:

- the MMR vaccine.
- thiomersal – a compound that contains mercury, which is used as a preservative in some vaccines.
- the way a person has been brought up.
- diet, such as eating gluten or dairy products.

Any link between immunisation and ASD has been completely discredited. The key study that questioned this was the Wakefield Study in 1998.

Extensive research conducted globally for a decade did not establish any link between vaccines and ASD. Despite this finding, as a precaution, thiomersal in particular has been withdrawn from the standard childhood vaccines in Australia and many other countries.

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- 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 behaviours 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 lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behaviour to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behaviour [Level 3 – “Requiring very substantial support,” Level 2 – “Requiring substantial support,” Level 1 – “Requiring support.”]

- B. Restricted, repetitive patterns of behaviour, 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 stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
 2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behaviour (e.g. extreme distress at small changes, difficulties with transitions, rigid thinking pattern, greeting rituals, need to take same route or eat same 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 interests).
 4. Hyper- or hypo-reactivity to sensory input or unusual interest 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).

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behaviour [Level 3 – “Requiring very substantial support,” Level 2 – “Requiring substantial support,” Level 1 – “Requiring support.”]

- 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.

ASD may be comorbid with intellectual impairment and may have accompanying language impairment. It can be associated with a medical or genetic condition or environmental factor, or with another neurodevelopmental, mental, or behavioural disorder, or with catatonia.

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013. Autistic Disorder in ICD-10-CM diagnostic code.

Diagnosis of ASD in adults

It is not unusual for people on the autism spectrum to have reached adulthood without a diagnosis. Sometimes people will discover some information about ASD that makes them consider if that diagnosis fits their difficulties or symptoms. Some may then choose to talk to a health professional for a diagnosis if:

- they have been diagnosed with a mental health condition and/or intellectual disability during childhood
- they have struggled with feeling socially isolated, had lifelong social challenges or felt different from their peers throughout life.
- they have not benefitted from a range of interventions to assist with social challenges and wonder if these are lifelong problems.
- members of their family have suggested they may have ASD.
- a child or another family member has been diagnosed with ASD and some of the characteristics of autism sound familiar.

Summary of Treatments for Children with Autism Spectrum Disorders

There is no cure, but treatment can help. Treatments include behaviour and communication therapies and medicines to control symptoms. Starting treatment as early as possible is important (National Institute of Child Health and Human Development). A large number of treatments are currently used with children with autism.

For most of interventions, further research is required to: (a) examine which children are most likely to benefit, (b) identify the most effective strategies for supporting their introduction and use, and (c) ascertain the extent to which a child's experience of a treatment fosters his or her general adaptive functioning. The following is a summary of the research evidence for treatments identified in this review.

1. Biologically Based Interventions Medication

There is currently no medical treatment for the core features of autism, although attempts have been made to use medications to treat symptoms and co-morbid disorders of autism such as anxiety and ADHD, as well as to increase the likelihood that children will benefit from concurrent interventions. The following medications have been demonstrated to have some effect, although careful monitoring is required to measure effects and side effects: risperidone, SSRIs, stimulants, anticonvulsants. The following medications have been shown to be ineffective and/or harmful for children and adolescents with autism: naltrexone, secretin, adrenocorticotrophin Hormone (ACTH).

2. Complementary and alternative interventions

These include exclusion diets (casein and gluten-free diet), anti-yeast therapies, chelation, secretin, withholding the MMR vaccine and vitamin/dietary supplements including vitamin B6. There is minimal evidence demonstrating the effectiveness of these interventions and considerable evidence demonstrating no effect for some such as secretin and withholding the MMR vaccine.

3. Psychodynamic Interventions

Psychodynamic therapies are based on the assumption that autism is the result of emotional damage to the child, are seldom used today, as there is strong evidence to support the perspective that autism is a developmental and cognitive disorder.

4. Educational Interventions

Autism Intervention Programs and specific schools offer:

- smaller class sizes to improve teacher and student relationships
- the availability of school support officers to assist children to manage anxiety in class and in particular in group situations
- the use of alternate communication pathways such as PECS (picture exchange communication systems); Makaton; Auslan and text to speech software.

5. Behavioural Interventions

Behavioural interventions are those in which operant learning techniques based on learning theory constitute the predominant feature of the intervention approach (Francis, 2005). Applied behaviour analysis (ABA) is an approach in which operant learning techniques are applied in a systematic and measurable manner to increase, reduce, maintain, and/or generalise target behaviours.

Discrete Trial Training (DTT) is one of the instructional methodologies frequently used in ABA-based programs, and involves breaking down specific skills into small discrete components. The Lovaas program, also known as the Young Autism Project, is a widely imitated example of the intensive behavioural programs.

6. Contemporary Applied Behaviour Analysis

There are several contemporary ABA programs including Pivotal Response Training (PRT), Natural Language Paradigm (NLP), and Incidental Teaching.

There is universal agreement that behavioural interventions have produced positive outcomes for children with autism that are well supported by research. Few other treatment programs have been subjected to the level of research scrutiny that has been applied to behavioural interventions. However, there continues to be controversy about particular behavioural interventions and programs, concerns about methodological issues, and differences in the interpretation of research findings.

7. Developmental (normalised) Interventions

Developmental or relationship based interventions focus on the child's ability to form positive, meaningful relationships with other people. Generally, the aims of these programs are to promote attention, relating to and interacting with others, experience of a range of feelings, and organised logical thought. To date, there is little research evidence to support the effectiveness of developmental interventions for children with autism.

Further research is required to determine the effectiveness of these interventions. The Developmental Social-Pragmatic Model emphasises the importance of initiation and spontaneity in communication, following the child's focus of attention and motivations, building on the child's current communicative repertoire, even if this is unconventional, and using natural activities and events as contexts to support the development of the child's communicative abilities.

8. Floor Time (DIR)

Floor Time, or the Developmental Individual-Difference Relationship-Based Model (DIR), is a developmental approach for early intervention with infants and children with a disability, including autism. The program includes interactive experiences, which are child directed, in a low stimulus environment. Proponents contend that interactive play, in which the adult follows the child's lead, will encourage the child to 'want' to relate to the outside world.

9. Relationship Development Intervention (RDI)

RDI is a series of techniques and strategies built upon the typical developmental processes of social competence. The goal of RDI is to increase motivation and interest in social relating in individuals with autism and provide activities and coaching to assist them to enjoy and become competent in social relationships.

10. Responsive Teaching (RT)

Responsive Teaching (RT) is a parent-mediated program, grounded in contemporary child development theory, which aims to help parents to interact more responsively with their children Relationship Development Intervention (RDI).

Therapy Based Interventions

1. Communication Focused Interventions

A number of communication focused interventions are commonly used with children with autism. These may be used in isolation or integrated into a more comprehensive program. Some research has examined the effectiveness of communication focused interventions with mixed results but there is a lack of large, comprehensive, and well controlled studies

2. Visual Strategies and Visually Cued Instruction

Visual strategies and visually cued instruction are commonly used to facilitate children's expressive and receptive communication and to support their learning, information processing, and ability to navigate both the physical and social environment.

3. Manual Signing

Manual signing has long been used to support the comprehension and expression of children with autism. However, further research is required to evaluate the functional outcomes for children.

4. The Picture Exchange Communication System (PECS)

The Picture exchange Communication System (PECS) is a program that teaches children to interact with others by exchanging pictures, symbols, photographs or real objects for desired items. The goals of PECS include the identification of objects and the learning of responses to simple questions with multi-picture systems. It is a highly structured program.

5. Social Stories

Social stories were originally developed by Carol Gray (Gray & Garand, 1993) in order to explain social situations to children with autism and to help them to actively learn appropriate responses to social cues.

6. Speech Generating Devices

Speech generating devices (SGDs) have been used to support both the expressive and receptive communication of children with autism in particular to support comprehension, promote symbol learning, increase interactions with adults and peers, and support the expression of wants and needs.

7. Auditory Integration Training (AIT)

Auditory integration training aims to address the hypothesised hearing distortions, hyper-acute hearing, and sensory processing anomalies, which may cause discomfort and confusion in people with autism.

8. Sensory Integration Therapy

Sensory Integration Therapy aims to improve the sensory processing capabilities of the brain through the provision of vestibular, tactile, and / or proprioceptive stimulation. Current research does not support SI as an effective treatment for children with autism.

Combined Interventions

1. The SCERTS Model

The SCERTS model focuses on Social Communication, Emotional Regulation, and Transactional Support as the principal dimensions for intervention planning. The goal of the program is to directly address the core deficits observed in children with autism, based on a highly individualised approach.

2. Treatment and Education of Autistic and related Communication Handicapped Children (TEACCH)

TEACCH is a 'whole life' approach aimed at supporting children, adolescents, and adults with autism through the provision of visual information, structure, and predictability. The results of a small number of studies have indicated positive outcomes for children who access the TEACCH program.

3. Learning Experiences-An Alternative Program for Pre-schoolers and Parents (LEAP)

LEAP is a comprehensive preschool service, designed for both children with autism and typically developing children. LEAP has the components of an integrated preschool program and a behaviour skills training program for parents.

4. Family Based Interventions

A number of programs have been developed to provide support to the families of children with autism. Support may include helping parents to understand the nature of autism and their child's learning style, providing parents with teaching and strategies to help support their child's learning, helping family members to establish their own support networks, and providing information about other services and support programs that are available. In family support programs, therapists and professionals work with the parents, siblings, and significant others, rather than directly with the child with autism.

5. Family-Centred Positive Behaviour Support (PBS)

Programs Family-centred PBS programs involve parents and professionals working together, in a systematic and collaborative fashion, to address a child's challenging behaviour. Family centred PBS plans include

- (a) strategies for teaching and increasing skills that are intended to replace the problem behaviours,
- (b) strategies for preventing the problems before they occur,
- (c) strategies for dealing with the problems if or when they do occur, and
- (d) strategies for monitoring progress.

6. The Hanen Program (More than Words)

'*More than Words*' is an intensive training program for parents of pre-school children with autism. The program derives its theoretical framework from a social-pragmatic developmental perspective and emphasises the blending of aspects of both behavioural and naturalistic child-centred programs; the breaking down of activities into structured, small steps found in an ABA program, and the provision of opportunities to use language for functional purposes built into more naturalistic approaches. A preliminary evaluation of treatment outcomes has indicated that the program has some positive outcomes for children and families. Further research is required in order to evaluate this program more comprehensively." *Taken from Roberts, J. M. A., & Prior, M. (2006). A review of the research to identify the most effective models of practice in early intervention of children with autism spectrum disorders. Australian Government Department of Health and Ageing, Australia.*

3.3 The Standard Required

Surpasses the Standard – the candidate demonstrates competence above the level of a junior consultant psychiatrist in several of the domains described below.

Achieves the Standard – the candidate demonstrates competence expected of a junior consultant psychiatrist. That is the candidate is able to demonstrate, *taking their performance in the examination overall*, that

- i. they have competence as a **medical expert** who can apply psychiatric knowledge including medicolegal expertise, clinical skills and professional attitudes in the care of patients (such attitudes may include an ability to tolerate uncertainty, balance, open-mindedness, curiosity, 'common sense' and a scientific approach).
- ii. they can act as a **communicator** who effectively facilitates the doctor patient relationship.
- iii. they can **collaborate** effectively within a healthcare team to optimise patient care.
- iv. they can act as **managers** in healthcare organisations who contribute to the effectiveness of the healthcare system, organise sustainable practices and make decisions about allocating resources.
- v. they can act as **health advocates** to advance the health and wellbeing of individual patients, communities and populations.
- vi. they can act as **scholars** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
- vii. they can act as **professionals** who are committed to ethical practice and high personal standards of behaviour.

Below the Standard – the candidate demonstrates significant defects in several of the domains listed above.

Does Not Achieve the Standard – the candidate demonstrates significant defects in most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

4.0 Instructions to the Role Player

4.1 This is the information you need to memorise for your role:

You are Dianne the 27-year-old mother of Jack aged 3 years - you are a single mother. You and Jack live with your dog, Jemma.

Jack started preschool 1 month ago and you thought things were going well. However, when you went to pick Jack up from preschool his teacher approached you on Tuesday this week and said she was concerned about Jack. The teacher suggested you take him to the GP to start the process of getting him assessed for a possible diagnosis of something called an Autism spectrum disorder. Unfortunately, the teacher was rushing to a meeting and did not have time to explain why she was concerned.

You have never heard of Autism spectrum disorder before but have assumed it is some sort of mental illness. Over the past few days you have become increasingly distressed by the thought he may have a mental illness. You requested an urgent appointment with your psychiatrist (the candidate) to get information on the condition and what it may mean.

You are aware that your son has not actually been diagnosed with Autism spectrum disorder and that this might only occur after a doctor has seen him. You would like information about the condition as the possibility has been raised and you are getting increasingly worried about it.

About Jack

You fell pregnant with Jack after a brief relationship 4 years ago when you were having a hypomanic episode. You were not aware you were pregnant when the relationship ended with Peter and you have had no contact with Jack's father since. With regard to Jack's biological father, you cannot recollect much from this hypomanic period and have no idea how to find him.

You have been single since that time and have raised Jack on your own. Up until now, you have not had any concerns about your son's development. You always thought he was a normal little boy but Jack is your only child and you are not sure how he compares to other children. Your sister and husband live nearby and they have five children who regularly play with Jack. There have never been any concerns raised by the maternal child health nurse or your GP about Jack's development.

About your mental illness

You have a history of bipolar disorder – this means that you have a chronic mental illness that has times when you are very elevated and others when your mood is very low. You first became unwell with depression 5 years ago. You have had 2 manic episodes and one further depressive episode but you have been completely stable for the past 18 months.

If the candidate asks; while you have been distressed since seeing Jack's teacher you do not think you are unwell or becoming unwell. You deny feeling depressed or elevated in your mood. If asked, your sleep, appetite and concentration are normal. Your thoughts are not racing or slowed down. You are able to enjoy things that you usually do, and have hope for the future. Your energy levels are normal. You deny feelings of guilt or hopelessness. You deny suicidal thoughts. There is no anxiety or unusual symptoms (e.g. no voices, feeling unsafe, paranoid etc.) You take your medications regularly every day - which is called olanzapine (10 milligrams tablet at night). You have kept all your recent appointments because you are very committed to keeping well.

4.2 How to play the role:

Casually but neatly dressed female in her late twenties. Easy to engage, and listen attentively to what the doctor has to say. You can be somewhat anxious about Jack.

4.3 Opening statement:

'Hello doctor, thanks for seeing me at short notice.'

4.4 What to expect from the candidate:

The candidate may enquire if you have had any concerns about Jack's development and if your mental state is OK. The answer to both is no. The candidate should then go onto an explanation of the condition and how it can be managed.

4.5 Responses you MUST make:

'I think he is fine.'

'So what sort of difficulties could Jack have?'

'What causes autism; is it something I have done?'

'Can autism spectrum disorder be caused by vaccinations?'

4.6 Responses you MIGHT make:

If you are asked whether you think any of the presenting symptoms fit Jack:

Scripted Response: ***'No, he seems like a normal little boy to me but he is my only child and I am not sure what normal is.'***

If you are asked whether you were on any medications when you were pregnant:

Scripted Response: ***'No, I was off my medicines when I fell pregnant and the hypomanic episode settled without treatment.'***

4.7 Medication and dosage that you need to remember:

You are on olanzapine (OL-ANZA-PEEN) 10 milligrams daily.

STATION 7 – MARKING DOMAINS

The main assessment aims are:

- To explain what ASD is, how it is diagnosed and some of the management strategies that can be used to manage it.
- To manage the distressed patient whose son may have a diagnosis of ASD while still providing accurate information about the condition.

Level of Observed Competence:

2.0 COMMUNICATOR

2.5 Did the candidate demonstrate effective communication skills appropriate to the context of speaking with a worried parent of a young child? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:

integrates and provides information in a manner that can effectively be utilised by a carer requesting information about ASD; communication is accurate, empathetic and clear. Clear use of reflective listening techniques.

Achieves the Standard by:

providing an accurate and structured explanation about ASD to the mother; delivering information in a sensitive way that would be understood by most lay people; recognising that the information may be distressing to the carer and demonstrating discernment in selection of content; taking into account that no formal diagnosis has been made.

To achieve the standard (**scores 3**) the candidate **MUST**:

- Explain that the information may not apply to Jack, as he has not yet had a formal assessment.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2 or 1):

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1. This would include a failure to be empathetic or accurate.

Does Not Achieve the Standard (scores 0) if:

any errors or omissions impact on the accuracy of information provided; fails to be both empathetic and accurate in information provided.

2.5. Category: SYNTHESIS	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

6.0 SCHOLAR

6.4 Did the candidate prioritise and apply appropriate and accurate knowledge based on available literature, research and clinical experience on the possible causes of ASD? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

acknowledges that scientific information is not in a state of known versus unknown but is the subject of debate; recognises the impact of environment, people and new knowledge on current understanding; acknowledges their own gaps in knowledge.

Achieves the Standard by:

identifying key aspects of the available literature; commenting on the veracity of the available evidence; discussing major strengths and limitations of available evidence; describing the relevant applicability of theory to ASD; including information on genetic, environmental and neurodevelopmental aetiologies.

To achieve the standard (**scores 3**) the candidate **MUST**:

- Explain that there is no scientific evidence linking vaccines to autism.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements. There is also an acknowledgement about the limitations of current knowledge.

Below the Standard (scores 2 or 1):

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1. This would include providing inaccurate information regarding current knowledge.

Does Not Achieve the Standard (scores 0) if:

unable to demonstrate adequate knowledge of ASD; inaccurately identifies or applies literature / evidence.

6.4. Category: APPLICATION OF KNOWLEDGE	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

1.0 MEDICAL EXPERT

1.9 Did the candidate describe how a diagnosis of ASD is reached? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; clearly describes diagnostic criteria in detail along with commenting on severity; appropriately identifies the limitations of diagnostic classification systems.

Achieves the Standard by:

demonstrating an understanding of diagnostic systems to provide an explanation of how ASD is diagnosed; explaining about exclusion criteria; elaborating that there is no diagnostic test but that the diagnosis is made by history and observations, often by a multidisciplinary team; describing that mild forms may remain undiagnosed for years and do not prevent the individual from leading a normal life.

To achieve the standard (scores 3) the candidate **MUST:**

- a. Mention deficits in social interactions, behaviour and communication as key components of the ASD.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements. The candidate would be able to acknowledge some of the limitations of diagnostic criteria.

Below the Standard (scores 2 or 1):

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1. A failure to describe diagnostic criteria or the information is significantly inaccurate.

Does Not Achieve the Standard (scores 0) if:

provides inaccurate or inadequate diagnostic criteria; errors or omissions are significant and do materially adversely affect diagnostic explanation.

1.9. Category: DIAGNOSIS	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

1.14. Did the candidate demonstrate an adequate knowledge and application of relevant biological, psychological and social therapies can be used in the management of ASD? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

includes a clear understanding of levels of evidence to support intervention options in ASD; takes a systematic approach that covers the full range of specific biological, psychological and environmental interventions; promotes optimism in outlook; cites examples of famous people with the diagnosis. e.g. Daryl Hannah, Dan Aykroyd, Andy Warhol, Mozart, Thomas Jefferson, James Joyce and Stanley Kubrick.

Achieves the Standard by:

demonstrating an understanding of interventions that can be used in the early intervention and management of ASD; identifying specific outcomes and possible prognosis; outlines choices and rationales for biological, psychological and environmental interventions; outlining the role of family in management; sensitively considering barriers to care; identifying different professional roles involved in care.

To achieve the standard (scores 3) the candidate **MUST:**

- a. Mention at least one of each of the biological, psychological and environmental interventions useful in the management of ASD.
- b. Mention the importance of early intervention.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2 or 1):

scores 2 if the candidate does not meet (a) or (b), or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1. A failure to describe biological, psychological and environmental interventions.

Does Not Achieve the Standard (scores 0) if:

errors or omissions would impact adversely on patient care; recommended plan lacks structure and/or is inaccurate; fails to describe biological, psychological and environmental interventions; demonstrates excessive therapeutic nihilism.

1.14. Category: MANAGEMENT - Therapy	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

GLOBAL PROFICIENCY RATING

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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