Tier 1 Diagnostic Evaluation (ASD Not Diagnosed)

REFERRAL INFORMATION

Adam is a 10-year-old boy who was referred to a child psychiatrist for assessment by his general practitioner. Adam's school has become worried about his lack of socialization and apparent repetitive behaviours at recess and lunch, and his parents have become concerned about his marked agitation around meal times at home. Adam's mother reports that he often repeatedly asks her during mealtimes whether his plate is clean and insists that she washes it over and over again if he suspects anything has touched it. Adam's agitation often escalates into crying and screaming if his mother refuses to wash his plate several times. Adam's teachers report that he is well behaved and performing well academically, but appears increasingly isolated from his peers on the playground, spending most of his recess and lunchtime performing certain repetitive behaviours and examining and cleaning his lunchbox.

Adam's mother reports these issues to their family general practitioner. The GP (**Referrer**) queries whether these issues may be characteristic an ASD, or perhaps relevant to other psychiatric diagnoses, and refers Adam to a child psychiatrist who has the skills and experience required of an ASD **Diagnostician**.

RECEIPT OF REFERRAL

The child psychiatrist receives the referral and her administration assistant, who acts as the assessment **Coordinator**, arranges the assessment appointment. A suitable appointment date is found. In the lead up to the appointment (and with parental informed consent) the coordinator organises the collection of relevant information from parents, school and other professionals for a file review by the child psychiatrist.

TIER ONE - FILE REVIEW

Upon reviewing the previously collected information the child psychiatrist notes that Adam's birth and early developmental history is unremarkable with him meeting developmental milestones as expected. Prior to school entry, Adam's hearing and vision was assessed and found to be within normal limits. Adam sprained an ankle playing football at age 7 but has no other reported illnesses or injuries or experiences of trauma or abuse. Adam is not taking any regular prescription medication. Adam's primary school reports to date describe him as a well-behaved boy who follows classroom instructions and is academically performing above the class average. Adam has 2 younger brothers with no reported developmental delays.

TIER ONE - PARENT INTERVIEW

The child psychiatrist first meets with Adam's parents only, and conducts a semi-structured parent interview focusing on Adam's early development, and his previous and current behaviour. Adam's parents reported no concerns regarding his other areas of development as a young child, such as his communication or social skills, instead recalling him smiling, pointing, following instructions, as well as showing concern for and comforting others as a young child.

Adam's parents discuss his behaviour at home (**Community Setting 1**) and note that they first became concerned about Adam when he was approximately 3 years of age. At this time, they noticed that he was had more rigid routines and was more insistent on how various activities should be completed than other children of his age. Two examples listed by Adam's parents were: (1) Adam demanding that his parents use the back door rather than the front door when dropping him off at childcare, and (2) Adam insisting on changing his entire outfit if a splash of water, dirt or paint got on one of his clothing items. Adam would often cry and scream if his parents did not comply. Adam's parents would occasionally raise their concerns with child care workers, but had come to the conclusion that Adam was just being 'wilful' or that he was a 'perfectionist'.

Adam's parents reported that his rigid routines had persisted as he had grown older, and that the family had made significant adaptations to help keep Adam happy and comfortable. The recent escalation of Adam's behaviours around meal times had triggered them to seek further investigation.

Adam has two other siblings. Adam's parent reported no concerns with their other children and no family history of any intellectual disability, ASD, mental health issues or other disorders. Consistent with the file review, Adam's parents reported an uneventful pregnancy, labour, and delivery and that Adam achieved speech and motor milestones within expected time frames and that they had no current concerns regarding his language or motor abilities.

When asked about social interaction at home, Adam's mother noted that he didn't talk about any particular friends from school but that he gets on well with family members and the children of family friends outside of school. Both parents expressed that their greatest concern was Adam's insistence on routines and repetitive behaviours. They reported that Adam engages in repetitive checking of his cutlery and plates at home and will become very upset over small smudges or markings on these items even if he has seen them just been cleaned. He is very precise in his actions and has set ways of doing things. His mother reported that have will have a "meltdown" if things are not done as per his requirements.

TIER ONE – INDIVIDUAL INTERVIEW AND OBSERVATION

A second appointment was scheduled with the child psychiatrist, this time with Adam present (**direct observation**). The child psychiatrist conducted an informal interview asking Adam about his likes / dislikes, what he thinks he is good at and what he thinks he finds more difficult. Adam displayed well modulated eye contact throughout the interview, and he used a range of non-verbal behaviours, such as gestures and facial expressions (which appeared to be directed at others) paired with his use of verbal language appropriately. Adam appeared to have good insight into others' emotions and was able to participate in the back and forth of typical conversation. Adam's speech was appropriate in volume, pace and pitch. No repetitive behaviours were observed during the interaction although Adam was noted to avoid touching items or furniture in the room with his hands.

When asked about the difficulties during home mealtimes and about the repetitive behaviours at school lunch time, Adam reported that he needs to make sure that when he is eating that everything he is using is clean. He reported that he spends his recess and lunchtime checking his lunchbox for any "dirt" or "germs", so he "didn't have enough time" to play with his peers. He also said that he also does not interact much with other kids at school because he is worried that he will "catch germs" from them.

TIER ONE – MEDICAL EVALUATION

As part of the Adam's referral, his general practitioner had completed a comprehensive health check prior, and a written report was forwarded to the child psychiatrist. Adam was reported to be of age appropriate height and weight, and had blood pressure and heart rate within normal limits. Adam was confirmed to show no congenital abnormalities, and his mother reported no other medical concerns.

TIER ONE – OTHER

With permission from Adam's parents the child psychiatrist contacted Adam's Year 5 teacher (**Professional Informant**). During a telephone conversation, Adam's teacher reported on Adam's behaviour at school and in particular in the classroom (**Community Setting 2**). He described Adam as "a bit of a loner" and that he does not socialize much with his peers at recess and lunch but participates well in class and manages social group activities in the classroom appropriately. The teacher confirmed that Adam engages in repetitive checking of his lunch box at school, and generally has specific routines for completing tasks and how his table is set-up in the classroom, leading to significant distress if he is not able to follow these routines.

TIER ONE – DIAGNOSTIC DECISION

The child psychiatrist determined that there was sufficient evidence to rule out a diagnosis of ASD based on information from the file review (including medical evaluation), parent interview, direct observation and discussion with the teacher,

without utilizing standardized instruments or consulting with another professional. Adam's pattern of repetitive checking is better explained by Obsessive Compulsive Disorder (OCD) rather than ASD. He was engaging in repetitive behaviours to neutralize distressing thoughts associated with fear of contamination and germs. In addition, while Adam was struggling with maintaining friendships, this appeared to be secondary to his OCD symptoms.

FUNCTIONAL ASSESSMENT

The child psychiatrist (**Functional and Support Needs Assessor**) completed a Functional Assessment with Adam using the parent-report version of the Vineland Adaptive Behavior Scales – 3rd edition. Through this assessment, Adam's strengths were identified as his ability to communicate with others, as well as his above-average academic skills. The assessment also revealed ongoing challenges with interpersonal relationships, coping skills, and some daily living skills, particularly around meal times.

Adam's parents reported that he was intelligent, with an inventive mind that had the ability to "think out of the box". They also stated that Adam was very sweet-natured, with a strong sense of justice. When the child psychiatrist asked what Adam liked about himself, he said that he liked that he was smart and that "most people (children at school) liked him".

The strong and secure family unit around Adam is an enduring strength for Adam. It is noted that Adam's father has significant travel associated with his employment, and is often away for two to three weeks at a time. The periods in which her husband is away are often more challenging for Adam's mother in terms of her available time.

SUPPORT NEEDS ASSESSMENT

The Support Needs Assessment was completed by the child psychiatrist at the same time as the Functional Needs Assessment. Adam's parents expressed significant concern that his routine behaviours would continue to escalate, creating barriers to his participation in family life at home (e.g., anxiety and tantrums at broken routines) and in activities at school (e.g., establishing better relationships with other children). His parents also expressed distress at seeing their son experience anxiety, and that his behaviours were starting to "wear (them) down". Adam also expressed distress with his behaviours, but was concerned that "these are part of him".

COMMUNICATION OF ASSESSMENT FINDINGS

The findings from the ASD assessment were communicated to Adam's parents in a final face-to-face assessment. At the request of Adam's parents, this appointment took place without Adam being there. The child psychiatrist communicated the diagnosis of OCD to Adam's parents, and provided them more information about the condition. Several priority support needs were identified, along with associated recommendation:

1. Management of Adam's OCD-related behaviours at home, perhaps through a block of cognitive-behavioural therapy. It was recommended that Adam receive a referral to a clinical psychologist.
2. Management of Adam's OCD-related behaviours at school. It was recommended that Adam's family work with the clinical psychologist and the school to develop strategies to support Adam's therapy.
3. The development of Adam's social skills to improve his social relationships at school. It was recommended that Adam attends a social skills group, run by a relevant clinical organisation.

At the conclusion of the session, Adam's parents were provided with a comprehensive written report that stated the diagnostic outcome and the information that was collected during the assessment to reach this conclusion. They were also provided with a referral to a clinical psychologist who specialised in childhood OCD, and a further appointment was made with the child psychiatrist for 3 months for ongoing review of clinical symptoms and support needs.