UNDER TWELVE AND STRUGGLING WITH SCHOOL AND LIFE

Kenneth Nunn

Children's Hospital Westmead and Elver Statewide Joint DCJ and Health Trauma Team

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APPROXIMATE AND PRECISE

When it comes to treating mental illness and defining intellectual disability, we can be very precise, but it takes resources, training **and time** – our most precious resource

Aristotle helps us out with this dilemma and says **the task determines the level of precision**

We don't want 'perfection to be the enemy of the good' but we also want to do a 'good enough' job.

AN APPROXIMATE APPROACH TO DISABILITY

Is the child operating > two years behind at school

In one subject area – consider a specific learning disability

In most subject areas – consider a mild intellectual disability

2. Is the child operating > 4 years behind the age socially

In school only – consider social or separation anxiety

At home and at school – consider autistic spectrum disorder

AN APPROXIMATE APPROACH TO DISABILITY

If you can understand less than 50% of what the child says

- **Consider a communication disorder**

Can the child communicate her needs? **Expression**

Can the child understand your requests? **Reception**

Can the child use language to make friends? **Pragmatics?**

These are a good filter for requesting a speech evaluation using a something like a CELF-5

CHRONOLOGICAL AND DEVELOPMENTAL AGES

MILD - ½ - 2/3 CA
MOD – 1/3 -1/2 CA
SEVERE 1/5-1/3 CA
PROFOUND <1/5. CA

There is little progression beyond the level attained by 16 year

Mild 8 - 11	DA
Moderate 4 - 8	DA
Severe 3 - 5	DA
Profound < 3 years and mostly < 2 years old	DA

WHY UNDER TWELVE

- Year 5 - one year before secondary school and the great transition
- Before puberty dominates
- Child is more ready to accept help
- It’s kind not to let them suffer longer

ANXIETY – IS THE CORE DISORDER

Worries Fears and Threats

< 3 days is usually normal

- 3 weeks is worth flagging
- 3 months (a whole school term) needs to be addressed

Worries are what they call them

Threats are buried in the worries

Avoidance of threat and **Repetition** of worries are the behaviour that wear parents and caregivers / teachers down

Refusal is the dynamic between parent / teacher and child

WORRIES

THAT *'I CAN'T DO IT BECAUSE I DON'T KNOW HOW'*

THREATS

THAT *'I WILL FAIL AND BE CALLED DUMB'*, DISAPPOINT MY PARENTS, MY TEACHER AND THE OTHER KIDS WON'T LIKE ME.

AVOIDANCE, REPETITION AND WITHDRAWAL

OF THE TASK, THE ACTIVITY, THE SITUATION, THE SCHOOL

REFUSAL

TO TRY THE TASK, TO DO THE ACTIVITY, TO FACE THE SITUATION OR TO ATTEND SCHOOL

REGRESSION UNDER STRESS IN DEVELOPMENTAL SKILLS IS COMMON

TYPES OF ANXIETY - ESPECIALLY IN AUTISTIC AND ID

GENERALIZED

SEPARATION

PERFORMANCE

TRAUMATIC

CHANGE-RELATED

OBSESSIVE

SENSORY

BODILY - RELATED ANXIETY

SOMATOFORM, INCREASED / DECREASED ENTEROCEPTIION, GENDER UNCERTAINTY, EATING DISORDERS

HIGHLY GENETIC

BOYS = GIRLS PRIOR TO PUBERTY

BODILY ANXIETIES PREDOMINATE WITH PUBERTY AND ANXIETY DOUBLES IN GIRLS

THE THRESHOLD FOR GETTING ANXIOUS IS LOWER WITH INTELLECTUAL SOCIAL DISABILITY (ASD) AND COMMUNICATION DISORDERS

THE CONTENT IS MORE CONCRETE, MORE IMMEDIATE AND MORE LIKELY TO DO WITH SPECIFIC RELATIONSHIPS THAT MATTER

WHAT DOES IT LOOK LIKE?

- Attentional failure
- Activity Extremes
- Anxiety in extremis
- Agitation
- Attacking Self
- Aggression

WHAT DOES IT LOOK LIKE ?

ALL OF THESE CAN BE FROM MILD TO SEVERE ACROSS MANY DIAGNOSES

Arousal Extremes – when overwhelmed by the turmoil of their own activation or profoundly shut down

Attentional Failure – when goal directed cognition fails

Activity Extremes – when the regulation of motor function fails

Anxiety in Extremis – when the sense of threat is **unassuageable**

Agitation – when relief sought desperately is **unfindable**

Attacking Self – *when harm is directed* ***at the self*** *the aggression of self-injury*

Aggression – harm to others – when the aggression is uncontrollable

THREE EARLY SIGNS OF PHYSIOLOGICAL (SNS) AND EMOTIONAL AROUSAL

- Vasomotor changes in the face
- Widening of the eyelids
- Tachypnoea

THREE KEY SIGNS OF AGITATION

- Restlessness
- Inability to focus
- The non-specific search for relief or expression

DEFIANCE AND RELIANCE

WHAT APPEARS TO OTHERS AS DEFIANCE IS OFTEN RELIANCE ON THE PARENT / CARER / TEACHER AND FEAR TO BE AWAY FROM THEM

WELL-MEANING FAMILY AND FRIENDS CAN TRY TO ENCOURAGE INDEPENDENCE WITHOUT THINKING ABOUT HOW TO GO ABOUT IT.

MAKE-OR-BREAK SOLUTIONS WITH CHILDREN WITH DISABILITIES USUALLY BREAK

WHAT USUALLY WORKS IN ID AND ASD

LOW EXPECTATION ACTIVITIES BASED ON APPROXIMATE DEVELOPMENTAL AGE

THAT PUT THE PRESSURE ON ADULTS NOT THEM

INVOLVE A GREAT DEAL OF REPETITION TO GAIN MASTERY AND CONFIDENCE

IN FAMILIAR SITUATIONS WITH FAMILIAR PEOPLE

WITH SENSORY TITRATION – NOT TOO MANY THINGS, TOO MANY PEOPLE

INVOLVE INADVERTENT SKILL ACQUISITION

SEQUENCE FOR DAILY SUCCESS FOR ASD AND ID

Rehearse	Repeat	Remind	Recall	Reassure by Reiterating successes
Go over the day ahead before the day starts	Repeat the day's activities as they are done and need adjusting	What has already been done well and what comes next	As the day comes to a close	Before sleep provide a quiet positive reconstruction of the day

MILD TO MODERATE ANXIETY IN ID AND ASD

(IE: NO AGGRESSION / SELF-HARM, EMERGING MOOD ELEVATION FH OF BIPOLAR DISORDER PSYCHOSIS)

CONSIDER ALL THE NON-MEDICAL SOLUTIONS

IF THESE FAIL OR DISTRESS GROWS OVER 6 WEEKS

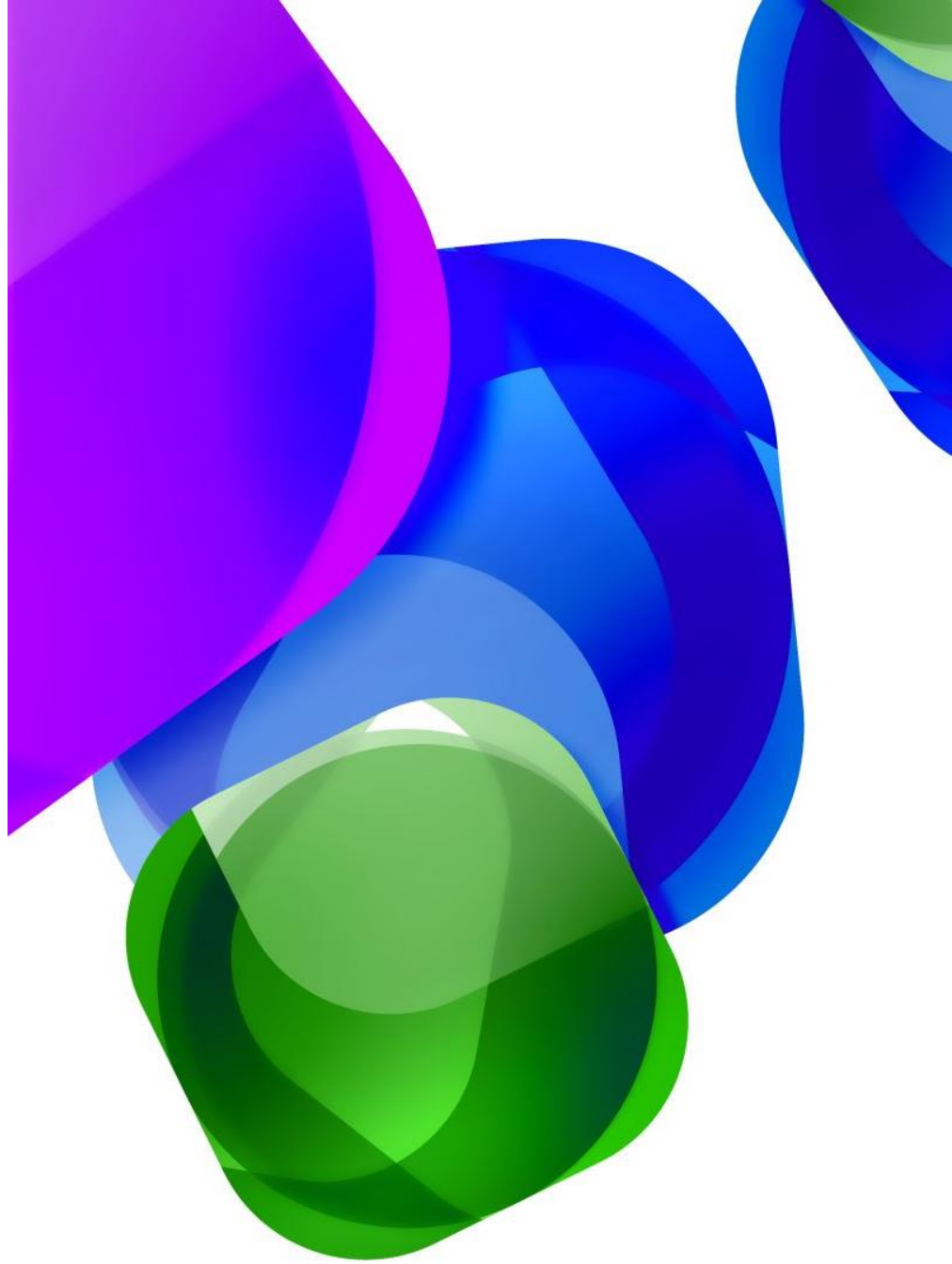
CONSIDER SERTRALINE 12.5MG EACH MORNING

INCREASE BY 12.5 MG EVERY 2 WEEKS UNTIL

YOU REACH 2MG /KG / DAY

WHAT CAN BE DONE FOR MOST CHILDREN?

- Take the pressure off in terms of time and performance
- Name the threats and the associated reasonableness of the avoidance and refusal
- Speak simply, clearly and avoid words like ‘must’, ‘ought’, ‘have to’ and the induction of guilt or threat.
- Give a simple story of how to get from ‘here’ to ‘there’ very very slowly.
- Support the parents to meet the child’s needs not everyone else’s expectations.



WHEN IT IS MODERATE TO SEVERE (AGGRESSION, SELF-INJURIOUS BEHAVIOUR)

FIRST REDUCE AROUSAL & AGITATION

SECOND GIVE AN OPPORTUNITY TO WALK IT OUT BEFORE TRYING TO TALK IT OUT AND ENABLE SLEEP

THIRD WHEN THE CRISIS IS OVER TRY TO UNDERSTAND THE THREATS AND FEARS

FOURTH PUT IN PLACE NON-MEDICAL SOLUTIONS

FIFTH Slowly draw away acute treatments and put in place long standing treatments

WHEN IT IS MODERATE TO SEVERE (AGGRESSION, SELF-INJURIOUS BEHAVIOUR)

FIRST REDUCE AROUSAL & AGITATION
Quetiapine (moderate) Olanzapine (Severe)

SECOND GIVE AN OPPORTUNITY TO WALK IT OUT BEFORE TRYING TO TALK IT OUT AND ENABLE SLEEP (Quetiapine XR 5mg / kg / dose)

THIRD WHEN THE CRISIS IS OVER TRY TO UNDERSTAND THE THREATS AND FEARS

FOURTH PUT IN PLACE NON-MEDICAL SOLUTIONS

FIFTH Slowly draw away acute treatments and put in place long standing treatments (Risperidone / paliperidone transition after twelve weeks to Aripiprazole)

WHEN IT IS MODERATE TO SEVERE (AGGRESSION, SELF-INJURIOUS BEHAVIOUR)

IF SAFETY is an issue then ambulance and police if necessary. If assistance available 5mg droperidol IMI and if necessary Midazolam 5mg midazolam

IF Agitation is established and marked, despite a quiet environment, they will usually not respond to verbal de-escalation.

IF it is difficult to communicate use calm and tone of voice NOT show of force

IF there is a family history of major mental ILLNESS (BPAD, SCZ and TR Depression) or use of substances call for help earlier and plan for these situations preventatively

DO NOT USE SSRI's, STIMULANTS, ANTIHISTAMINES TO MANAGE EMERGENCIES – they make things worse

WHAT ARE THE OTHER ILLNESSES FOR CHILDREN WITH ID, ASD AND COMMUNICATION DISABILITY

Depression - treat as chronic anxiety

OCD – do all the same nonmedical things as anxiety but use SSRI's such sertraline and climb to 25% high doses and trial for twice as long (12 -16 weeks)

Tourette Disorder – treat with low dose risperidone

ADHD – if stimulants make worse consider atomoxetine which aim for 1-5mg /kg /day and is able to be renewed by GP's on streamline.

Bipolar disorder, schizophrenia and treatment resistant depression are all more common in this population but still uncommon if expectations

All respond beneficially to addressing anxiety as I have outlined because all have core of anxiety.

The major mental illnesses will need long term psychiatric input and co-management.

ANXIETY IS THE CORE OF MOST DISORDERS… DISTRESS IS WHAT WE SEE

It is hard for parents not to be anxious, fearful and sometimes depressed and exhausted

LET'S GET SPECIFIC WITH YOUR QUESTIONS

THANK YOU

Professor Kenneth Nunn 7th March, 2024 Neurodevelopmental Hub Westmead Children's