

Autism in Adulthood- Guidance for Referrers

(In this guideline 'autism' refers to 'autism spectrum disorders' encompassing autism, Asperger's syndrome and atypical autism or pervasive developmental disorder not otherwise specified).

We found that approximately 25% of all referrals that are assessed at the point of the Autism Triage Panel MDT meeting are accepted. During the meeting, the Panel conducts a clinical review for each referral and in the past 18 months, over 750 referrals have been triaged.

Due to the quality of the referrals, there is actually a LOW threshold for accepting a referral but there needs to be 1) enough information on the form 2) enough information suggestive on Autism.

What to avoid

1. A sparse referral with little information, with the comment "This is my best assessment in a 10 minute GP consultation".
2. Self-completed AQ10- Think about it. You have to include it as part of the referral, but if the patient actually struggles to process some of the questions, they are MORE likely to have Autism. SO maybe submit it with the comment "patient unable to respond to a number of questions".
3. An AQ10 of 10/10 completed by the patient holds less value.
4. A generic "copy and paste" referral from the internet or a medical website; it may not reflect your patient
5. Think about whether they actually need CMHT referral first
6. Siblings who have been diagnosed, and PATIENT thinks he/ she themselves may have ASD- unlikely
7. Avoid populating the referral by hand, or at least make your handwriting legible (maybe print in block capitals) because the [paperwork will be photocopied and the legibility deteriorates further.
8. Also, good-humoured contact, accessing services appropriately
9. Avoid "rule out ASD"
10. Avoid referrals where a psychologist has seen the patient before and not identified any concerns suggesting ASD, then this can count against
11. Social isolation, - eye contact, sensory stimuli- these are non-specific.

What is less likely to be Autism

1. Obsessional behaviours e.g. checking door locks, unrelated to ASD- magical thinking is mainly OCD, illogical, meaningless repetitive behaviour
2. Literacy issues may be Dyslexia rather than ASD
3. Consider EUPD amongst those who think they have ASD

4. Vocabulary and language awareness, idioms, adjectives, absence of “mind blindness”
5. Varied interests are extremely unlikely to indicate ASD
6. The patient who diagnoses or refers himself/ herself can indicate someone with a lot more ability than they realise e.g. first person accounts of self-reported evidence (“I” indicates self-reflection, insight.)

What to include

1. Use the correct referral form i.e. ASD not ADHD form
2. GP needs to look at the GP guidance on OSCAR, and enquire more of the patient e.g. are social situations confusing? If so. How?
3. SEE THE PATIENT and describe what you see/ your findings, rather than what they may submit in a letter.
4. An AQ10 with your own written comments in relation to a patient who struggled to complete it with you.

What is more likely to indicate Autism?

1. The AQ10 that contains the comment “patient unable to respond to a number of questions”. i.e. the person who actually struggled to even process the questions
2. The strong family history
3. The “lay” referral i.e. friends or family think the patient has ASD. The patient is not convinced but attends to keep friends/ family happy.
4. Look for repetitive behaviours that would be consistent with ASD
5. Development delay raises further suspicion
6. Trying and failing at life e.g. go to Uni, failed, come back.
7. Struggling or failing at work- disciplinary record
8. No previous contact with services also raises suspicion
9. Difficulty in understanding intention behind doing things
10. Rigidity- interrupted routine caused her to freeze/ distress

Do you have an all-round picture?

It is usual to get an informant where possible – someone who knows your patient really well and who can tell you both what they are like and their take on their present predicament(s). Individuals often give a very misleading picture of themselves and their difficulties.

What do you do next?

This depends on why your patient has come to see you. Is he/she seeking:

- a. A diagnostic assessment. Please use the service referral form and send to: Service for Adults with ADHD and Autism, Manygates Clinic, Portobello Road, Wakefield WF1 5PN, Tel: 01924 316490 Fax: 01924360806
- b. Interventions for Autism: a number of the symptoms of Autism can be helped by appropriate educative measures – training in social skills, interview skills and various cognitive and sensory strategies. These usually require referral to a specialist service or may be provided by other, non-health agencies such as Social Services or Voluntary bodies.
- c. Management of the psychiatric problems that often accompany Autism such as depression, anxiety and obsessive compulsive disorder. For these, a referral should be made to the local CMHT as normal and if that Team requires specialist input, a referral can be made to the Specialist Autism Pathway at a later stage.
- d. Help in obtaining access to benefit rights (and in being registered as disabled), occupational support, support in Further/Higher Education, or even in negotiating the Justice System. An increasing number of agencies have specialist expertise in dealing with Autism and it is worth asking for this.