Mental Health Case PRESENTATION Form

Response was completed on 02/20/2024 5:33pm.

Record ID	9

ECHO Autism

Mental Health

Case Presentation Form

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Complete this form to the best of your ability. This survey is individualized and should only be completed and submitted by the listed clinician. A unique confidential client ID number (ECHO ID) has been provided that must be utilized when identifying your client during clinic.

As a reminder, this ECHO Autism: Mental Health program is focused on adapting cognitive-behavioral therapy for autistic people with mental health disorders. We invite you to present a case of a child, adolescent, or adult with autism (or suspected autism if no formal diagnosis) who could benefit from

cognitive-behavioral therapy as part of a comprehensive approach to treatment for mental health disorders. We will be focusing on mental health treatment, not autism assessment or diagnosis.

Email our clinic coordinator Brandy Dickey at dickeyb@missouri.edu if you have any questions or comments.

PLEASE NOTE: Project ECHO case consultations do not create or otherwise establish a provider-client relationship between any Expert Hub clinician and any client whose case is being presented in a Project ECHO setting.

ECHO ID: MH055

Presenting Clinician: Patti Mingus

Co-Presenter Name(s):

none

Presentation Date: 2024-02-26

Presentation Type:

(•) New ( ) Follow Up

Please answer the following questions about your clinic or practice:

What type of Clinic/Facility are you? Private Practice

Clinic/Facility Name & City: Springfield

Clinic/Facility State: Missouri

Clinic/Facility Phone Number: 417-268-0340

Clinic/Facility Fax Number: patti.mingus@gmail.com

Answer the following questions about your client:

Gender:

(•) Male ( ) Female ( ) Trans Women ( ) Trans Man ( ) Nonbinary ( ) Other

Client Age: 32
(Yrs)

Age: Months
(Mos)

Insurance: None

Insurance Company: NA

Race: White/Caucasian

Ethnicity: Not Hispanic/Latino

What problem(s) would like help with for your client(s)?

Please list top three problems:

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1)

Helping him get past emotional state to begin processing life cognitively.

2)

Helping him live in the present and not in the past trauma.

3)

Helping him learn to trust himself as a capable human being.

Please list three strengths of your client:

1)

He is able to maintain employment and provide for his family.

2)

He states that he wants to feel better and wants his life to be manageable.

3)

He loves his family.

What motivates your client?

His desire to improve his life and his relationships with his family

Does your client have any restricted interests (i.e., special interests or intense interests)? If so, please list here:

video games

Does this client have an autism diagnosis? ○ Yes ○ No ◉ Unknown

Comments:

He has two children who are both diagnosed with ASD and who are non-verbal. He had several diagnoses as a child but he is not sure if ASD is/was one of them. His wife reports that he does has ASD but she is not able to produce any medical records to support this diagnosis, which she reports was made in Oklahoma.

Development History

Communication Ability **(Please indicate the client's highest communication)**

- [ ] Nonspeaking (i.e., no functional words)
- [ ] Uses single words
- [ ] Uses 2-3 word phrases
- [x] Uses sentences
- [x] Chats with others (e.g., reciprocal conversation)
- [ ] Uses gestures (e.g., pointing, waving and/or leads other to wants/needs)
- [ ] Uses AAC Communication and/or devices

Sensory Concerns

- [x] Sensitive to noise
- [ ] Textures
- [ ] Smells non-food items
- [x] Sensitivity to touch
- [x] Sensitivity to crowds of people
- [ ] Sensitivity to lights
- [ ] High pain tolerance
- [ ] Low pain tolerance

Severity Level of Sensory Concerns:

( ) Minimal (•) Moderate ( ) Severe

Behavior Concerns

- [x] Anxious or worries
- [ ] Short attention span
- [ ] Hyperactivity

- [ ] Obsessive-compulsive
- [x] Aggressive towards others
- [ ] Hurting animals or other people
- [x] Unusual or excessive fears
- [x] Depression
- [ ] Defiant
- [ ] Self-injury (e.g., head banging, head punching, biting, scratching, cutting, picking, etc.)
- [ ] Toileting issues, accidents
- [x] Irritability/Moodiness
- [ ] Hallucinations
- [ ] Food seeking
- [ ] Pica (i.e., eating non-food items)
- [ ] Public Masturbation
- [ ] Inappropriate sexualized behaviors
- [ ] Property destruction
- [ ] Fascination with water
- [ ] Elopement/Wandering
- [ ] Impulsivity
- [x] Homicidal concerns
- [ ] Suicidal concerns
- [ ] Involuntary movements

You indicated that the client is aggressive. Who are they aggressive with? (Check all that apply)

- [ ] Mom
- [ ] Dad
- [ ] Other caregiver
- [ ] Sibling/s
- [ ] Peers
- [ ] School Staff
- [ ] Home Staff
- [ ] Strangers
- [ ] Outpatient Providers
- [x] Other

Please describe:

He and his wife have engaged in physical fights when angry.

You indicated the client has homicidal or suicidal concerns. Please indicate the level the client has thought through such plans.

- [x] Homicidal/Suicidal Thoughts
- [ ] Homicidal/Suicidal Plans
- [ ] Homicidal/Suicidal Attempts

Severity Level of Behavior Concerns

( ) Minimal (•) Moderate ( ) Severe

Examples of developmental or behavioral concerns:

Client has engaged in both physical and verbal aggression to his wife and other people in his community and at his place of work. He reported he daily has thoughts about harming others but he does not act on these thoughts.

Has there been a significant loss of skills? (e.g., daily living, self-help, academic)

( ) Yes (•) No

Comments:

Client has very poor hygiene but this is likely a lack of training rather than a loss of skills.

Mental Health Treatment History

Please list current psychosocial treatments (note: medications are not included in this section):

Treatment type (e.g., cognitive-behavioral therapy, play-based therapy, family therapy):

Client is currently in individual counseling with this provider using CBT focusing on learning about emotions, using his thoughts to change his feelings and avoiding letting past trauma determine current emotional states and behaviors.

Frequency type (e.g, weekly, monthly)

weekly

Age when started:

just started 6 weeks ago

(Yrs)

Reason for treatment:

Client is the father of a child in the Head Start program and was referred to see a counselor to provide emotional support due to family relationship issues. Upon assessment it was determined he is suffering from anxiety and depression and would benefit from individual counseling to provide emotional stabilization before relationship issues are addressed further.

Is it helping?

(●) Yes ( ) No

Comments:

Client reported at the last visit that he feels the sessions are helping him as he is beginning to think about his feelings and this is the first time he has been open with a counselor.

Treatment type (e.g., cognitive-behavioral therapy, play-based therapy, family therapy):

Client reported he was in counseling as a teen and it was talking about his feelings.

Frequency type (e.g, weekly, monthly)

weekly

Age when started:

13 (Yrs)

Reason for treatment:

Client reported he struggled with his emotions as a kid and his parents being in two different states and he moved back and forth and they were both drug users and they were neglectful.

Is it helping?

○ Yes ◉ No

Comments:

Client reported he just sat and didn't talk.

Treatment type (e.g., cognitive-behavioral therapy, play-based therapy, family therapy):

Client reported he was in play therapy as a kid.

Frequency type (e.g, weekly, monthly)

weekly

Age when started:

elementary school

Reason for treatment:

Client reported he was sent to counseling because of getting into trouble at school and at home. He reported he played games with the lady but he did not feel like it did anything. He reported his parents did not attend with him.

Is it helping?

- Yes
- No (selected)

Comments:

Are there any psychosocial treatments that have been previously tried, but discontinued? If so, please list treatments here and explain why they were discontinued.

All prior treatments were discontinued due to lack of progress. He also was moved each year to live with the other parent so there was no continuity of treatment from year to year. He also changed schools each year making social development difficult. He reported he had no friends except his brother.

Medical/Psychiatric History

How often does this client receive care from your facility?

First time

Please list all diagnoses or illnesses:

Age of diagnosis: unknown (Yrs)

Diagnosis/Illness:

Generalized Anxiety Disorder, by history
Post Traumatic Stress Disorder
Major Depressive Disorder, Recurrent, by history
Seizure Disorder, by report
Rule Out Autism Spectrum Disorder

Date - Year: current

Professional making diagnosis: current general practitioner

Diagnosis/Illness:

Please check all of the following that apply:

- [x] Seizures
- [ ] Heart Problems
- [ ] Constipation
- [ ] Nausea/Vomiting
- [ ] Vision Changes
- [ ] Fever
- [ ] Trouble Swallowing
- [ ] Stomach ache/pain/reflux
- [ ] Staring Spells
- [ ] Dental carries/pain
- [ ] Diarrhea
- [ ] Chronic Ear Infections

- [x] Headaches
- [ ] Menstrual
- [ ] Environmental Allergies
- [ ] Skin Problems (e.g., rash, eczema)

Please list current medications and supplements:

Medication: Venlafazine

Dosage: 150 mg

Age when started: unk (Yrs)

Reason for medication: anxiety

Is it helping?
- (x) Yes
- ( ) No

Medication: sertraline

Dosage: unk

Age when started: unk (Yrs)

Reason for medication: depression

Is it helping?
- ( ) Yes
- (x) No

Medication: Abilify

Dosage: unk

Age when started: unk (Yrs)

Reason for medication: mood stabilizer

Is it helping? (x) Yes ( ) No

Medication: hydroxazine

Dosage: unk

Age when started: unk (Yrs)

Reason for medication: anxiety

Is it helping? ( ) Yes (x) No

Medication: topomax

Dosage: unk

Age when started: unk (Yrs)

Reason for medication: seizure/tremor/spasms

Is it helping? (x) Yes ( ) No

Comments:

Client reported all of his medications are prescribed by his regular doctor. He was advised to seek the care of a psychiatrist for a full evaluation and medication review.

Are there any medications that have been tried, previously, but discontinued? If so, please list medications and explain why they were discontinued.

Client reported he tried Wellbutrin in the past but is was not effective so he quit taking it.

Preventative Health

Has the client had a well-check visit in the past 12 months?

- ( ) Yes
- (•) No
- ( ) Unknown

Have you had communication with the client's primary care physician/nurse practitioner?

- ( ) Yes
- (•) No

Resources

Resources (Check all that apply):

- [ ] Special Health Care Needs
- [ ] Behavioral Therapy/ABA
- [ ] Missouri Autism Project
- [ ] Speech Language Therapy (SLT),
- [ ] Physical Therapy (PT)
- [ ] Occupational Therapy (OT)
- [ ] Regional Office/SB40 Board (Dept. of Mental Health)

- [ ] Juvenile Office
- [ ] Children's Division
- [ ] Community Mental Health Center
- [ ] Community Psychiatric Rehab
- [ ] Community Psychiatrist
- [ ] Social Security Disability (SSI)
- [ ] Waiver Services
- [x] None of the above
- [ ] Other-Any other service provider

Comments:

Client has tons of services in place for his children but has no services for himself. This provider does not know where to begin in making referrals for this family.

Testing

Have the following tests been performed?

Chromosomal Microarray

( ) Yes (•) No ( ) Unknown

Karyotype

( ) Yes (•) No ( ) Unknown

Fragile X DNA

( ) Yes (•) No ( ) Unknown

MRI of the brain

( ) Yes (•) No ( ) Unknown

EEG

Yes No Unknown

Sleep study

Yes No Unknown

Lead blood level

Yes No Unknown

EKG

Yes No Unknown

Audiologic (hearing) exam

Yes No Unknown

Vision screening

Yes No Unknown

Dental check-up

Yes No Unknown

Academic testing

Yes No Unknown

Intelligence testing

Yes No Unknown

Other notable findings neuropsychological and psychological testing

Yes No Unknown

Additional comments:

Sleep History

No = never; **Rarely** = 1 time/week; **Sometimes** = 2 - 4 times/week; **Usually** = 5 or more times/week

Does the client fall asleep within 20 minutes? If yes, how often?

- [ ] No
- [ ] Rarely
- [ ] Sometimes
- [x] Usually

Does the client co-sleep? If yes, how often?

- [ ] No
- [ ] Rarely
- [ ] Sometimes
- [x] Usually

With whom does the client co-sleep?

- [ ] Parent(s)
- [ ] Sibling(s)
- [ ] Grandparent(s)
- [x] Other

Is co-sleeping a problem?

- [ ] No
- [x] Rarely
- [ ] Sometimes
- [ ] Usually

Does the client awaken more than once during the night? If yes, how often?

- [ ] No
- [x] Rarely
- [ ] Sometimes
- [ ] Usually

Are nighttime awakenings a problem?

- [ ] No
- [x] Rarely
- [ ] Sometimes
- [ ] Usually

Does the client snore loudly?

- [ ] No
- [x] Rarely
- [ ] Sometimes
- [ ] Usually

Is snoring a problem?

( ) No (•) Rarely ( ) Sometimes ( ) Usually

Does the client seem tired during the day? If so, how often?

( ) No ( ) Rarely (•) Sometimes ( ) Usually

Is this a problem?

( ) No ( ) Rarely (•) Sometimes ( ) Usually

Comments:

Client works second shift and works 10 hours at a time, doing manual labor so he is always reporting he is tired.

Trauma/Abuse History

	Yes	Suspected	No
Trauma/Abuse History	(•)	( )	( )
Physical Abuse	(•)	( )	( )
Sexual Abuse	( )	( )	(•)
Intrauterine Exposure to Alcohol/Drugs	( )	(•)	( )

Comments:

Client reported physical and emotional abuse by both sides of his family and neglect by both sides of his family.

Social History

Client resides with:

Other

Other:

Wife

Has legal custody of the client:

Biological parents are:

Divorced

List other significant caregivers that live outside the home (e.g., family, friends, grandparents, neighbor)

Client has a relationship with his parents which is negative and angry due to unresolved issues from the past. He also has a relationship with his older brother who he works with. The brother seems to have some of the same mental health issues and is angry and aggressive often as well. They work at the same place and spend time together daily.

Comments:

Family History

Condition/Disorder

	Mom	Dad	Brother	Sister	Mat GM	Mat GF	Pat GM	Pat GF
Genetic Disorders	☐	☐	☐	☐	☐	☐	☐	☐
Autism Spectrum Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Intellectual Disability	☐	☐	☐	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐	☐	☐	☐
Seizure Disorder (e.g., epilepsy)	☐	☐	☐	☐	☐	☐	☐	☐
Mental Health Concerns (e.g., Depression, Anxiety Disorder, Bipolar)	☑	☑	☑	☐	☐	☐	☐	☐
Substance abuse	☑	☑	☑	☐	☐	☐	☐	☐

Comments:

Client has reported both his parents suffered from mental health concerns and from substance abuse issues. He has not reported any further back into his family history at this point. He has a brother who also has current mental health concerns and past drug issues.

Educational History

Grade in School: No longer in Full-Time Education

Ever repeat a grade? ○ Yes ◉ No

Are there learning problems? **(Please check all that apply)**

☐ Math ☐ Reading ☐ Writing

Can this patient read? Yes

Legal History

Does the client have a prior or current legal case? Unsure

Case Details

What is going well in your treatment with this client?

Client has attended all sessions and has been attentive and willing to share information.

What current barriers do you face?

Client complains that he does not have enough time to do homework assignments, even if it is just to think about things in a different way and report back the next session. He is not applying what he is learning in the moment in sessions. His wife is often wanting to provide information in a way that is not supportive or helpful. I wonder if a visual agenda might be helpful to keep him on task. He gets easily side tracked talking about the past, maintaining a sense of powerlessness and blame rather than taking control of his own thoughts and emotions in the present.

Are there any steps you have taken to improve your process?

I have asked his wife to say what she needs to say in a supportive manner and then to leave the sessions so he has his own time to work and process his feelings.

Please indicate if you use any of the following strategies with this client:

- [ ] 1. Use of visual aids
- [ ] 2. Incorporation of patient's special interest onto the session
- [x] 3. Increased involvement of family members
- [x] 4. Accommodations for patient's sensory sensitivities
- [x] 5. Explicit didactics about emotions
- [ ] 6. Posted agenda of therapy session

Form Status

Complete? Complete