Mental Health Case PRESENTATION Form

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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: MH059

Presenting Clinician: Shyan Warren

Co-Presenter Name(s):

Presentation Date: 2024-04-22 Y-M-D

Presentation Type:

(•) New ( ) Follow Up

Please answer the following questions about your clinic or practice:

What type of Clinic/Facility are you? Community Mental Health Center

Clinic/Facility Name & City: Compass health Network- Jefferson City

Clinic/Facility State: Missouri

Clinic/Facility Phone Number:

Clinic/Facility Fax Number:

Answer the following questions about your client:

Gender:

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

Client Age: 12
(Yrs)

Age: Months
(Mos)

Insurance: Medicaid

Insurance Company:

Race: White/Caucasian

Ethnicity: Not Hispanic/Latino

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

Please list top three problems:

1)

Unwilling to talk within session and does not understand his emotions.

2)

Forgets to practice skills outside of therapy.

3)

Struggles with low self-esteem and communication.

Please list three strengths of your client:

1)

Can stayed focused on a task for long periods of time.

2)

Smart and driven

3)

Analytical mind

What motivates your client?

Time with his extended family and video games. Loves seeing his cousin and family on his dad's side.

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

Video games, when playing games nothing else matters. Struggles when he is very invested with a project or game and will get agitated by outside distractors such as eating and hygiene.

Does this client have an autism diagnosis? (●) Yes ( ) No ( ) Unknown

If Yes, age at diagnosis: 11 (Yrs)

Who made diagnosis:

Jay Short, PsyD

Comments:

Late diagnosis but symptoms showed at a young age.

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
- [ ] 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
- [x] 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
- [ ] Aggressive towards others
- [ ] Hurting animals or other people
- [ ] Unusual or excessive fears
- [x] Depression
- [ ] Defiant
- [ ] Self-injury (e.g., head banging, head punching, biting, scratching, cutting, picking, etc.)
- [ ] Toileting issues, accidents
- [ ] 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
- [ ] Homicidal concerns
- [ ] Suicidal concerns
- [ ] Involuntary movements

Severity Level of Behavior Concerns

○ Minimal ◉ Moderate ○ Severe

Examples of developmental or behavioral concerns:

Did not progress as quickly developmentally (verbally) was not able to be understood until age 2 but speaking was rare, delayed in walking, toileting issues until 6 years of age, social cues missed, shuts down in conversations, blunt direct commentary.

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

○ Yes ◉ No

Comments:

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):

Individual outpatient therapy with the use of CBT.

Frequency type (e.g, weekly, monthly) weekly

Age when started: 11 (Yrs)

Reason for treatment:

Past suicide attempt
Depression
Disassociating and isolating himself
Low confidence to set boundaries
Fear of rejection, abuse, manipulation
trying new things

Is it helping? ○ Yes ◉ No

Comments:

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

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

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

Medical/Psychiatric History

How often does this client receive care from your facility? Has been served frequently

Please list all diagnoses or illnesses:

Age of diagnosis: 11 (Yrs)

Diagnosis/Illness:

03/01/2023 Generalized anxiety disorder
03/01/2023 Post-traumatic stress disorder, unspecified
11/20/2023 Unspecified psychosis not due to a substance or known physiological condition
11/20/2023 Autism spectrum disorder requiring support (level 1)

Date - Year: 3/1/23

Professional making diagnosis: Javed Choudhry

Diagnosis/Illness:

Please check all of the following that apply:

- [ ] Seizures
- [ ] Heart Problems
- [ ] Constipation
- [ ] Nausea/Vomiting
- [ ] Vision Changes
- [ ] Fever
- [ ] Trouble Swallowing
- [ ] Stomach ache/pain/reflux
- [ ] Staring Spells
- [ ] Dental carries/pain
- [ ] Diarrhea
- [ ] Chronic Ear Infections
- [ ] Headaches
- [ ] Menstrual
- [ ] Environmental Allergies
- [ ] Skin Problems (e.g., rash, eczema)

Please list current medications and supplements:

Medication: Abilify

Dosage: 2.5 MGs

Age when started:

(Yrs)

Reason for medication: Depression

Is it helping?

- (●) Yes
- ( ) No

Medication:

Comments:

Asthma medication

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

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

Comments:

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

Results:

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 ○ Usually

Is falling asleep a problem?

○ No ○ Rarely ○ Sometimes ◉ Usually

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

◉ No ○ Rarely ○ Sometimes ○ Usually

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

○ No ◉ Rarely ○ Sometimes ○ Usually

Are nighttime awakenings a problem?

(●) No ( ) Rarely ( ) Sometimes ( ) Usually

Does the client snore loudly?

(●) 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 struggles to fall asleep but reports once he is asleep he is fine. Abilify helped.

Trauma/Abuse History

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

Comments:

Was abused by his father verbally and physically, DFS was involved
Client witnessed violence between mom and dad and mom and her new partner, fighting, yelling, mom would go to him for help and tell him to call the cops. Client visited paternal side of the family and they would not return him to mom and cops were involved, Client was very mad and distraught over these instances.

Social History

Client resides with: Mother

Has legal custody of the client: Mother

Biological parents are: Divorced

How many people live in the home *not* including the client? 4

Who lives in the home with the client?

Relationship (1/2 sib, step-parent, etc.): sister

Age: 15 (Yrs)

Gender: Female

Relationship: Mom

Age: (Yrs)

Gender: Female

Relationship: Sister

Age: 8 (Yrs)

Gender: Female

Relationship: Brother

Age: 8 (Yrs)

Gender: Male

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

Grandparents- dad's side

Comments:

Mom has a partner who she fights with in front of the client, partner goes back and fourth with living in the home.

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:

Mother has PTSD and ADHD

Educational History

Grade in School: 6th

Ever repeat a grade? ○ Yes ◉ No

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

☐ Math ☐ Reading ☑ Writing

Explain:

Client has unclear handwriting.

Can this patient read? Yes

Resources

What best describes the client's current education program?

☑ Full time in education regular class
☐ Time split between regular and special education classes
☐ Full time special education
☐ Aide/Paraprofessional or extra help
☐ Home School
☐ Virtual Learning
☐ Alternative School
☐ Homebound
☐ N/A

Legal History

Does the client have a prior or current legal case? No

Case Details

What is going well in your treatment with this client?

Client is willing to participate in therapy and will practice his skills in the sessions.

What current barriers do you face?

Client does not talk much during sessions, he forgets to practice his skills outside of the home, mom also forgets to help him.

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

We had switched from talk therapy to goal oriented sessions where we would practice a skill and therapist would send home ways he could practice with mom.

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

- [x] 1. Use of visual aids
- [x] 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
- [ ] 5. Explicit didactics about emotions
- [ ] 6. Posted agenda of therapy session

Form Status

Complete? Complete