

To the Members of the Mental Health Subcommittee:

Days after the Newtown Tragedy when there was a report that Adam Lanza may have been Aspergers and suffered from a mental health diagnosis I began wondering if this was true. If it was, what were the details of his journey and that of his parents, how early was he diagnosed, what was his school experience like, what services had been utilized, what did he need that he didn't get, etc.

You see, I have lived such a journey. I am in the unique position of being a parent of a 25-yr-old son who is Aspergers and challenged by a chronic and persistent mental health diagnosis, Bipolar Disorder. He has a long history of assessments, hospitalizations, treatment, depression and being bullied. I want to preface what you are about to read with the fact that in spite of a school district who continuously neglected our son's social/emotional needs and 'systems' that are broken, we have encountered many awesome professionals along the way who have tried their very best to assist our son and our family.

We believe that when the state closed the hospitals without developing a comprehensive, collaborative, available to everyone infrastructure, we were left with a broken mental health system in the State of CT. Navigating the mental health, school and other 'systems' is a daunting task to say the least. The time and frustration of doing this is much more consuming then raising a child with special needs. We have encountered a world of long wait list, insurance barriers, lack of appropriate providers, etc.

My husband and I first brought concerns to our pediatrician when we experienced and observed odd behaviors in our son at the age of 18 months. We then had him tested by the school district at the earliest age possible (3) for speech delays that we and his preschool were contributing to his aggressive behaviors at school. We questioned why he was not advancing from parallel to cooperative play; why even when he played parallel to other children, he was not observing them in the way that is typical – he was in his own world.

Throughout his history in public school, we advocated for his needs. Early on he would hold it together through the school day but melt down when he got home. He was so fragile that any seemingly little thing could trigger an outburst, which included throwing things, punching pictures on the walls, banging doors, etc.

When we pleaded with the school district for help, we received subtle and sometimes outward notions that we did not know how to parent, causing our son to behave this way. We noted over and over that he needed help social-emotionally.

In spite of recommendations from professionals the district hired to observe our son in school and provide assessments he did not receive the help he needed social-emotionally. He was put in more and more restrictive environments as his behaviors worsened at school. We were now being blamed for that as well; his behaviors at school had to be related to our parenting. Not until he was in 7th grade, after 10 years of being treated like we were the problem, did the assistant director of special education finally understand. The clinical nurse in my son's outplacement classroom, twenty miles from our hometown, noted she had tried every strategy she knew of and nothing was working to change his behaviors.

Let me note he was in a classroom for seriously emotionally disturbed teens; he had not yet been diagnosed on the autism spectrum and staff was not equipped to identify and/or work with the spectrum population. The school environment was disturbing our son deeply as we watched him slowly destructing. We then found Dr. Ross Greene who works with inflexible, easily frustrated, and explosive children and adolescents in the Boston area. We had our son assessed by his colleague, Dr. Stuart Ablon. The school district then agreed to send the PPT to Dr. Greene's seminar when he came to CT.

As we watched a film showing a young boy erupting out of control due to the basement door being locked for the first time, the assistant director of special education reached over and held my hand saying, "I had no idea". At that moment I knew she really understood what we had been living with. I thought she would have gotten this years before when our son was hospitalized at Riverview hospital at the age of almost 8 for four months. Riverview had recommended that we have an Intensive Family Preservation specialist work with us by observing our family and then teaching us parenting skills, as they, like the school district, thought our parenting was the cause of his behaviors.

We welcomed the service, noting we were willing to learn anything that would help to change our son's behavior. However, at the end of the 3 month service the worker had not offered any new skills. She noted in her report that in spite of our

setting clear limits, consistently sticking to them, ignoring negative behaviors, utilizing time out, etc. our son still had unpredictable, violent outbursts. This report somehow meant nothing to the assistant special education director back then; it would take another four years for her to, "See the light" at that Greene Seminar.

That year, in which we found Dr. Ross Greene, we also let go of a very successful retail business that we had for 8 years. This has been a tremendous financial burden on our family. That year, the district consulted with Dr. Ablon as to how to implement Dr. Greene's program, but it was impossible to apply their philosophy in an SED environment where the milieu was the opposite approach. After our son's second hospitalization straight from school that year, we pulled him out in May. He was home-bound tutored the remainder of that school year and again all fall without any social component.

After 7 months of being isolated at home, he was hospitalized at Yale. We had hired the only educational consultant that Dr. Ross Greene recommended, Dr. George Posner. He found San Marcos Treatment Center in Texas, which met all the recommended criteria made by both the psychiatrist and psychologist the school district had hired to assess our son that fall. Our son spent 7 months in that treatment center healing from the damage those years of being in an SED environment had done. He was diagnosed PDD/NOS (Pervasive Developmental Disorder / Not Otherwise Specified).

At month 6 our special education director insisted he come back to a CT residential facility, in spite of San Marcos not deeming him ready for discharge and their recommendation for a step-down facility. His psychologist and I scheduled a visit to such facility to assess whether or not it was an appropriate placement. When the special educational director found out, she and the institution insisted we fly our son home for a pre-admission appointment sight unseen at our expense. We were concerned that if this was not an appropriate placement, we could not afford to fly him back to San Marcos. We suspected that the CT facility was not going to meet his needs.

I had called such facility and several others to interview them about the population they served, the experience they had with children on the spectrum and/or children

who were challenged with non-verbal communication. NONE of them knew what I was talking about when I asked about non-verbal --- each noted the children they served were highly verbal. Non-verbal is just that; every other form of communication besides verbal (body language, facial expressions, tone of voice, sarcasm, nuances, etc.) In addition to this, their environments were heavily populated by adolescents with conduct disorder. In spite of reporting this to the special education director she insisted we fly him home.

When he returned we attended the pre-admission appointment with his psychologist and the special education director. As we walked to the parking lot, the special ed director noted this was not an appropriate placement; we would need to find a place that had less of a 'delinquent' population. It was the middle of the summer; we were left to manage him for several weeks of unstructured time, becoming the clinical step-down San Marcos had recommended.

He was home-bound tutored, while the special ed director brought us on a wild-goose chase visiting clinical day placements one-by-one. Each was similar to the SED environment he had been in before going to San Marcos. We tried one that did serve teens on the spectrum; however, most of the students were distinguishable (our son is indistinguishable) and he rejected the idea due to years of being bullied as a special ed student. The home-bound tutoring would continue the entire school year with a social component for all of 9th grade, provided by an autism behaviorist and a mentor he supervised. His behavior at home was nothing more than typical – **no outbursts what-so-ever**. For an entire year there was peace in our home.

He then spent his sophomore and junior year in public school with no social component what-so-ever in spite of ours and his psychologist pleadings at numerous PPT meetings and mediation. We were told over and over what a good kid our son was and how all the staff liked him. He slowly deteriorated and gravitated to the only peers who would accept him, marginal students with their own mental health challenges and the drama that goes with it. By the end of his junior year, we were still advocating for a social component at his annual review

PPT meeting. We were told how much he had improved since the year before, how well he was doing, how he didn't need social skill services, etc.

The week after the meeting, my son was arrested for an incident that took place in the school after classes had ended – the very time period we and his psychologist had warned about; unstructured / unsupervised times of the day. The district then outplaced him to an SED environment for the beginning of his senior year. This failed almost immediately, at which point he was home-bound tutored once again until graduation with no social component. Via the school district, he was assessed by Dr. Orv Karen from UCONN after graduation.

Dr. Karen provided a life skills and social assessment that included interviewing the marginal peer group he had established in high school. He noted grave concerns based on our son's peer reports; stating that if he did not get assistance separating from this group and receiving social skills training, he would be in trouble soon. Five months after his recommendation was ignored by the school district, he was arrested. He went to adult prison as a 14 yr old socially-emotionally (18 chronologically) for 6 months.

I received letters from inmates pleading with me to get him out of there as he was being eaten alive and did not belong there. Local police officers noted that maybe now our son would get the mental health help he needed. Really? In prison? The only mental health offered to him was suicide watch in isolation and medication. There was NO mental health component. Upon his release from prison, he gravitated back to the same negative peers. He was convinced that one of them was his best friend until his 'friend' cut our son's arm so badly he could have bled to death if it was not for a girl among them that forced the group to take him to the hospital.

The district contracted with a psychologist who worked with teens on the spectrum to assess our son. She diagnosed him Aspergers, assessed he was functioning at a 14 yr old level social-emotionally. He became hospitalized after her assessment due to a self-harming behavior (jumped into an icy pond mid-winter after a drama episode with several girls he was hanging out with) and noted to us personally that if he lived 5 more years we would be lucky. She had no significant guidance to offer for the treatment of an Asperger's young adult who **also** had significant

mental health challenges; she was used to the ones who may suffer with bouts of depression from time to time, but not those with Bipolar.

She acknowledged that some of his mental health challenges (Bipolar) he was born with and some were a result of the environments he was placed in and not having his autism appropriately addressed for many, many years. He now had secondary challenges on top of his already serious mental health issues. Her expertise was with a population who was Aspergers or others high functioning on the spectrum that did NOT have significant mental health challenges.

The most stable he has been during his adult years was an eighteen month period when he had a DMHAS mental health worker who stepped up to more of mentoring role. My son trusted him; this relationship, along with creative planning on the part of his Young Adult Service Director, Michelle Leister, prevented him from being hospitalized during a low period. Due to union restraints, this worker was bumped to another catchment area. At the time, there was no mechanism to replace him with a true peer mentor/social coach.

With the leadership of Nikki Richer, DMHAS has done an awesome job moving into the peer mentor direction and rolling out a new program that includes trainings and services. However, the peer mentor movement has **no component for those in DMHAS who are also on the autism spectrum.** The current peer mentor program is geared to the psychiatric needs of clients only (mental illness and/or substance abuse). The trainings do not prepare mentors for the unique needs of someone on the spectrum, nor does it include the critical SOCIAL COACHING that is needed by my son and others who are on the spectrum in the DMHAS system. We strongly believe that there are many others on the spectrum in DMHAS and in the general adult mental health population who have never been appropriately diagnosed.

We were hoping that our son would be able to soon purchase a mentor/social coach on his own via a Medicaid Waiver. State agencies, including DDS and DMHAS, applied for 3 waivers about 18 months to 2 years ago after working tirelessly for three years on the application. The federal government, from my understanding, denied CT such waivers as the funds would go to and be managed by several agencies vs. one main agency. Unknown to me, each agency then decided to apply

individually about a year ago. DDS applied and received their funding early this year and the first years' worth has been expended already.

My son would have been in DDS via the autism pilot years ago. However, when I contacted the director, Kathy Reddington, I was told because he was in DMHAS he would not qualify for DDS. When the waiver application was being developed, I asked DMHAS to put my son on the list of DMHAS young adults who were on the spectrum who needed the waiver. I was told there were only 5 slots and that my son was one of those five. I checked this status periodically throughout the waiver application process. Now I am being told to apply with DDS as DMHAS may not be applying for the waiver for quite some time.

Bottom line is, my son is in a state where he not receiving a needed service/services because he is between two systems. He may or may not get accepted into DDS where there is a waiver now available for those on the spectrum. If he does get in, in spite of my being proactive, it could take years on a DDS wait list to receive a budget to purchase the services he needs because we are applying so late. In the meantime, he is in the DMHAS system that may not have a waiver for years to come.

Remember, three years ago, the psychologist mentioned above said we would be lucky if our son lived five more years. We are fighting for our son's life here. I have been challenged with getting my testimony in writing over the past several weeks since the hearing because we have almost hospitalized him twice. We are his in-home clinicians and keeping him out of the hospital is a full-time job. I work full time and my husband is retired but now fighting cancer since September. My son is struggling with what will happen to him if we lost my husband, his rock; our rock.

He's also struggling with not having a job. He left a position at a retail store where he had worked just about full time until the shop was sold. The new owner gradually began bringing in family and reducing our son's hours. In addition, the new owner and his family spoke a foreign language, completely removing the social component of his job. In September, he was down to 15 hours and quite. He's a felon. This has been an enormous barrier. His DMHAS employment

specialists do not have relationships/lists of employers who are willing to hire felons.

If he was in the Hartford DMHAS catchment area, he would have access to an agency that DMHAS refers to who has relationships with and an extensive list of such employers. He's worked with BRS who hired an agency who had no such relationships and list. In addition, neither DMHAS staff nor BRS is familiar with the autism spectrum. He has been to numerous places to apply, told they liked what they heard during an interview, only to have his application go to corporate headquarters and be shot down due to the fact that he is a felon. Nike, UPS, Job Lot, grocery stores, etc. Walmart actually had him work there for several weeks via an employment agency; they liked his performance very much. However, when his application was processed by their corporate headquarters he was informed they could not hire him

Again, I have to wonder, did Adam Lanza's mother fight too and ultimately lose the battle and her life? Before we as a state make any hasty decisions out of fear, we need a full and comprehensive assessment of Adam's records / interviews with remaining family and those who knew him and his mother. We need to understand what led up to that tragic day in order to come up with informed legislation to address the problems. Acting out of fear will lead us nowhere. Acting out of compassion and real understanding will get us somewhere.

I am disturbed by the fact that the media and society in general won't acknowledge the truth of what happened that day in December; 28 people died, not the 26 that are often reported. Twenty children and 7 adults were murdered, not 6. And one person took his life. His actions were unthinkable but we need to speak the truth; he was a young man so troubled he did this horrific act and took his own life. People now are responding out of fear and lack of knowledge of the mentally ill. The statistics show that they are much more likely to be harmed emotionally, physically, or bodily and die through suicide than they are to do harm to others.

As a state and a nation, we need a better understanding of mental illness and the unique needs of those on the spectrum that also have a significant mental health challenge. It is time that we understand and accept mental illness as any other life-threatening medical illness. It's time we put money into research and

integrating those with mental health challenges into every avenue of society. Not merely tolerating them, or worse, bullying them, but truly integrating them into all the communities of CT and beyond.

This can be done. It is being done successfully through school environments that incorporate philosophies like Positive Behavioral Supports and The Responsive Classroom. Police officers can have a better understanding of this illness they are faced with on a regular basis via trainings being offered throughout the state, one with an autism component. Trainings are needed by anyone potentially in contact with the mentally ill and those on the spectrum. Professionals in many fields need to be re-tooled so that they are equipped to identify and work successfully with those challenged by mental illness and the autism spectrum disorders. We need to find where it is being done successfully and expand it into all schools and communities in CT.

Everyone is concerned about school safety, yet there is NO conversation on keeping ALL students safe. Who's keeping children with behavioral health needs safe from bullying, exclusion, marginalizing, etc.? We have all cried for the loss of life in Newtown, understandably. However, whose crying for the hundreds and thousands who take their own life out of despair, whose crying for the people who suffer in darkness, 'dying' emotionally on a chronic and persistent basis? Since Newtown, how much media time has been spent on gun control and how much has been spent on mental illness, the root cause of that tragic event????

I thank you for your time at the hearing and in reading this testimony. I have attached a list of recommendations and resources. I also attached input from Dr. Andre Bessette who has vast experience, including developing and facilitating a peer mentor program, working with children, adolescents, and young adults on the spectrum; some dually diagnosed with significant mental health challenges.

I am willing to meet with any of you and/or coordinate a meeting with the professionals in the resource list any time in the future to dialogue about this very critical topic.

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Recommendations

General:

- Due to the broad and complex nature of mental illness, more dialogue is needed; why have we as a state spent way more time on gun control over the past month, yet we only had one opportunity to discuss mental illness?
- Full investigation with public access to gain insight into how Adam Lanza got to this point; already reporters are perpetuating assumptions.
- Funding mental health research (other life-threatening medical conditions are being researched 4 – 5 times that of mental illness)

I want to note that we have encountered extraordinary people in the DMHAS system who have been instrumental in keeping our son alive; noteworthy is Dr. Ken Marcus, retired Medical Director and Michelle Leister, Director of Young Adult Services at River Valley Services in Middletown. Michelle has often thought, “Out of the box” to assist our son. However, we have observed the barriers caused by the union. When we lost his mental health worker/self-made mentor due to being bumped out of RVS because of union rules, we asked that they hire someone with experience and training to work with the autism population to work with our son. We quickly learned that the director has no say in who is hired; causing the individual needs of those served by DMHAS to go on unmet.

Because this is so broad and complex, I have broken it down into categories.

Those on the **autism spectrum** who also have a significant and persistent **mental health diagnosis**:

Mandatory Retool – any professional who has contact with the general public needs to have basic training regarding the autism spectrum (mental health professionals, social workers, pediatricians, primary care doctors, nurses, school staff, police, etc.)

Natural and Community-Based Supports – Training for siblings, extended family, neighbors, faith-based leaders, park and recreational staff, sports coaches, scout leaders, etc.)

License / Certification Requirements – Anyone licensed or certified by the State of CT in any field should be required to obtain a certain number of CEUs via autism spectrum trainings

In-Home Behavioral Health Models (ICAPS, FFT, MST, MDFT, etc.)

1. All need to be adapted (studied and evidenced based) to include the child/adolescent on the autism spectrum
2. Models specific to the autism spectrum should be developed using ABA and psychiatrically sound methods together

DMHAS – I am only familiar with what has been offered to my son / I am not familiar with what is offered to the young adult not on the autism spectrum or the older population

1. Consistency in all catchment areas throughout the state – i.e., employment assistance for Felons in Hartford but not in Middletown
2. Peer Mentoring – see attached input from Dr. Andre Bessett to understand how critical this is
 - a. Specific curriculum for all those being trained as Peer Mentors (certified) that addresses how to identify and work with those on the spectrum
 - b. Specific mental health/autism spectrum peer mentor certification that includes a social coaching component as well
3. Housing options for those on the autism spectrum needs to expand. Currently for young adults the only options are
 - Group homes mostly for transitioning DCF clients and those who are very involved (I believe one is in the Canton area being run by FOCUS and another in New London being run by Sound Community).
 - Supported Apartments – highly supervised
 - Apartment alone or with roommate if a good match can be found
 - Home with parents

*my son needs to be in an apartment complex in which

- each client has their own 1 bedroom or 2 bedroom shared by 2 clients if they are ready
 - a staffed apartment where clients can meet with Peer Mentors as needed / clinical staff on duty 24/7 just in case an escalation occurs / clinical sessions
 - there is a structured social component built in
 - same day/time each week – on site get together for pool, Ping-Pong, movies, video games, psycho-educational groups, advocacy discussions, etc.
 - each client has a Peer Mentor well-trained in the autism spectrum and mental health assigned to them to go into the community 1:1 to meet and develop friendships with typical peers
4. Respite – when my son ramps up at home and he starts to decompensate over days, it sometime gets to a point that we are not equipped to maintain him at home but he is not at the critical point of needing or qualifying for full hospitalization. There are respite facilities but they are inadequate to meet his needs.
- Currently the one he has attended is at River Valley Services in Middletown; I am not sure if they are all alike throughout the state.
 - This one has bedrooms for each client, a nursing station behind a glass window, a room for eating and I believe a TV room.
 - There needs to be
 - 1) An room for activities offered throughout most of the day, manned by Peer Mentors (pool table, Ping-Pong, video games, movies, board games)
 - 2) Social skills / psycho- educational group schedule
 - 3) Everyone who receives respite who does not yet have a Peer Mentor should be matched with one during their stay and continue when returning to the community

State Smoking Policy – it is inhumane to restrict hospitalized and respite clients a place to smoke outside. This ‘health’ policy in mental health environments is modeled after the movement in the medical community. It is my opinion that this was not well thought out. Many mental health patients smoke cigarettes because it reduces anxiety and it is legal. They should not be denied the rights that common citizens have just because they have a mental illness and are in need of state care. Having a designated place outside away from the building does not infringe on non-smokers rights; therefore, there seems to be no obstacle to this policy being reversed.

School:

Supportive environment in all schools

- 0 tolerance for bullying / many schools hang up the posters but only a small number really have affective policies (East Lyme Public Schools does a much better job at this then most districts)
- Positive Behavioral Supports and/or Responsive Classroom philosophies should be mandatory in all school districts

Functional Behavioral Assessments

Currently districts must provide a Functional Behavioral Assessment before a PPT can determine that the child needs to be outplaced to a special school. However, they are allowed to use a very small version of a much needed comprehensive one AND there is a conflict of interest when school staff are reporting on their own environments (including other staff) making it very subjective.

- Objective ones need to be done by independent assessors who provide a much more comprehensive report with recommendations
- If this can't be done, school staff providing the FBA should be trained to do the comprehensive version and be required to do so, providing the PPT with objective data to make informed decisions.
- The use of FBAs should include the point at which a PPT determines that a child needs a behavioral plan as part of the IEP and/or when the current behavioral plan is not effective

Enforce existing special educational laws

One that is often ignored is the amount of time special education students spend with typical peers per day, including after school activities at the schools. Another is transition planning – in general districts are not doing a good job with this. It has recently been reported that after graduating from high school, Adam Lanza, failed at trying adult endeavors, including college. How well had he been prepared during those critical years after his 15th birthday? Too many children are being identified way too late.

School –based clinicians should be in every school in the state

Screening for mental health at school when medical screenings are being done

Revamp the entire special education system – currently it is the burden of the parent to get schools to provide a free, appropriate education for their child. They have to study special education law, often fund educational consultants when their knowledge and expertise is not enough, and their jobs are in jeopardy

due to taking a lot of time off from work due to numerous PPT meetings, failed behavior plans that warrant parents to pick up their children from school, assessment appointments, etc. Funding should not be in the hands of administrators who make the decisions for the PPT in many instances (not legal but in reality staff are not always free to speak to objective input)– this is NOT an objective process. It is set up as a conflict of interest and to encourage adversarial relationships between school staff and parents.

General mental health:

Mandatory Retool – any professional who has contact with the general public needs to have basic training regarding mental health so they can help to identify as early as possible (pediatricians, primary care doctors, nurses, school staff, police, faith-based leaders, park and recreational staff, sports coaches, scout leaders, etc.)

License / Certification Requirements – Anyone licensed or certified by the State of CT in any non-mental health field should be required to obtain a certain number of CEUs via mental health trainings

Peer mentoring for all ages – this service should be researched further and offered via schools and state agencies.

General Mental Health Specific to Children and Adolescents

Extended Day Treatment, Partial Hospital Programs, and Intensive Outpatient

- Should begin after school with homework component -currently children are removed from school early to attend, greatly effecting their school work – if it starts later, there needs to be a homework component as they will get home too late to do homework
- Experiential Component and/or Model (i.e., Project Adventure, Wilderness model, etc.) should be incorporated into above models and/or a separate model should be offered (some children do not benefit from the art and talk therapies, yet they would benefit greatly from the models noted. The state has a Wilderness program for the summer but it is very limited as to who gets in – we need to broaden the summer opportunities and offer this after school

Park and Recreational Departments

Support should be given to each one in the state so that they can have a full-time special education director and a system that is supportive of the needs of ALL the children they serve. Two outstanding programs in the state are Wallingford and Groton Park and Recreation Departments.

Providers who can help with all of above

Positive Behavioral Supports / FBA

Kathleen Whitbread, Phd., Masters Level professor at The University of St. Josephs College / West Hartford. 203-88-8028 / kwhitbread@usj.edu

- Can explain PBS / FBA (expert at producing FBA)
- Teaches how to do a comprehensive FBA to teachers working toward their graduate degrees.

Responsive Classroom / www.responsiveclassroom.org

Collaborative Problem Solving

Dr. Ross Greene (Explosive Child) / www.ccps.info / Dr. Greene continues to consult extensively to general and special education schools, inpatient psychiatry units, and residential and juvenile detention facilities, but is not presently providing consultation services through the Center for Collaborative Problem Solving. To contact Dr. Greene directly, send an email DrRossGreene@gmail.com.

Trainings on autism spectrum

General – Autism Spectrum Resource Center (Lois Rosenwald) / Autism Society of CT (Sara Reed) have partnered to offer a variety of trainings. www.ct-asrc.org

Police – see link on above website. Lois Rosenwald has partnered with a mental health expert to provide trainings to police departments throughout the state to help them understand both the autism and mental health population

Clinical

Dr. Ross Greene above

Matt Hoffman / mhoffman@ucfs.org

Peer Mentor / Social Coaching for those on the autism spectrum with behavioral health needs

Dr. Andre Bessett / 860-963-6385 x3 / 860-933-6697 / ABessette@DayKimball.org / see attached

Dr. Jim Loomis / Center for Children with Special Needs - Glastonbury / www.autism.com / (860) 430-1762 / has worked extensively with school district on how to social integrate children with special needs

Input from Dr. Andre Bessette, psychologist who is very experienced with the autism and significantly involved mental health population. He is currently developing a behavioral health program for children and adults at Day Kimball Hospital and he is the Co-Founder of a peer mentoring program at TEEG, both in Northeastern CT.

(860) 963-6385 ext 3 / (860) 933-6697 / ABessette@DayKimball.org

- Anecdotally, and I believe the current research likely bears this out, individuals with a dual diagnosis of a significant mental health condition (e.g. bipolar, severe depression, anxiety) and autism spectrum or social learning disorders (e.g. Asperger's, PDD, NLD) present a concerning and perplexing challenge. These two conditions are often mutually complicating with regard to functional impairments and mutually inhibitory with regard to treatability and habilitative supports. Specifically, significant emotional dysregulation inherent in conditions such as bipolar disorder, superimposed on the ASD social perceptual/judgment vulnerabilities, *can and often do* place individuals at great risk for problematic behaviors, including interpersonal boundary violations, substance abuse, impulsive and self-destructive/sensation-seeking behaviors, disruptive or aggressive interactions, extreme isolation, and vulnerability to exploitation and abuse.
- In my practice, and in those of fellow clinicians that I have surveyed, we seem to be seeing a drastically increasing number of individuals with this dual diagnosis profile. At last count, in my caseload of approximately 60 clients, there are 8 individuals (from the age of 11 to 26) who fit this profile.
- As largely a more intellectually able cohort than most, they also present with the greatest social, emotional, and adaptive challenges, and tend to be the most treatment-resistant.
- So, while this specific dually-diagnosed cohort may comprise a minority of the DMHAS (or would-be DMHAS-connected) population, I have experienced them as being perhaps the most in need and at some of the highest risk with regard to some of the aforementioned vulnerabilities.
- It has also been my experience, as both a clinical expert in autism spectrum/social learning disorders and a co-founder of a therapeutic mentoring program, which such individuals happen to respond elegantly to therapeutic mentoring. Unlike traditional psychosocial counseling, therapeutic, goal-directed mentoring provides an opportunity for these individuals to build and generalize skills in a more naturalistic setting and in a more ecologically valid way. This has been a perennial challenge for clinicians in trying to help these individuals generalize skills and principles from the office setting to the community. The therapeutic mentoring data available thus far on clinically meaningful outcomes is promising.
- It is thus my hope that stakeholder agencies and administrators can recognize the obvious needs of this specific population, grasp the evidence for this need and for the interventions that have been effective thus far, and work synchronously and diligently to further develop and provide these resources in a timely and accessible manner.