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Alternative Parent Support Services

Network

Helping to Heal ~ Providing to Thrive

S U M M A R Y P R O P O S A L

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Presented to:

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INTRODUCTION

As a competent, dedicated adoptive parent to three special children, all with individually unique, special needs I have learned through experience that the State of Connecticut, and the Nation as a whole, do not make available insightful, fundamental services essential to addresses the vital needs of the alternative parent community and their families. Well-intentioned individuals selflessly invest themselves every day in this country, in the role of caring for, raising and adopting children who are in need of good, loving, safe homes. When these same individuals, now committed parents or legal guardians, seek services in response to serious and troubling behavioral patterns they face with their child, they are first suspected of mistreatment, investigated and judged by social services workers and accused of poor parenting. This is my experience.

Families formed through State agency adoptions are provided full medical insurance benefits for their placed child until that child is of the age of eighteen. If that family chooses to leave the State where the adoption(s) originated, coverage is said to transfer, in its full capacity, to the new state of residence. This is not the case. State insurance coverage benefits for placed children vary from state to state. Each State sets and administers coverage based on several factors. As a result, at-risk adopted children are often denied potentially life changing mental health services rooted in undisclosed criteria. This is maddening and provoking for committed parents, harmful to the suffering child in need, and dangerous to the immediate community. This is my experience.

Resources, information, education and enforcement are all critical components of a well-designed program of any kind, but if those charged with administering enforcement are not provided with the tools, knowledge, budgets and protocols to safely and effectively respond to, in this case, the unique conditions that exists in alternative family households; that system runs the risk of further traumatizing those already at-risk, attachment-challenged, troubled children and their fragile families. This is my experience.

If speaking out in support of legislative change and advocating loudly for the health and well-being of distressed children makes one appear ‘crazy’; how do parents of traumatized, psychologically impaired children address this crisis and remedy the service void? This is my experience. APSS will change this experience.

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The goal of APSS:

1. To engage a **common-sense tool** to the Department of Child and families, the Department of Social Services and private clinicians. Involving the APSS team immediately following an in-take on those cases where 'placed' children are involved, will decrease DCF worker case loads, reduce the risk of agency district offices mishandling 'special cases', minimize the drain on State Family Court systems, and increase early intervention in those cases that pose a risk to the community, now and in the future.

2. **Reduce the burden on taxpayers** by spending valuable budgets more wisely. First, by eliminating the impulse investigation and prosecution protocol of baseless family neglect and abuse cases, relative to alternative parent families. Second through early intervention and targeted family services, thus reducing the rate of crime and incarceration costs. Minimize the risk attachment impaired children and young adults bring to the community and through the timely and appropriate utilization of State insurance benefits.

3. Become a **valuable source**, an advocate, an in tune voice, and **first responder to overwrought parents** of children with disrupted attachment behavioral patterns, by intervening with families who require 'real' support, real help. An accessible, compassionate, skilled, point-of-service coordination and information network, for families seeking help with their at-risk, troubled, placed children.

4. **Lobby Washington** to establish health **insurance coverage uniformity**, state to state; providing treatment access, choices and options, without restriction, to all children being raised by alternative parents.

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Scope of Client Services:

APSS will provide:

- Specialized case management for alternative parents of at-risk children i.e. permanently removed from the care of biological parent(s), fostered in the past, adopted or being raised by family-members or legal guardians.

- Case origination through direct contact from an alternative parent or family member, as a school referral, through a public or private clinician, through a DCF or 211 inquiries and through any first responder investigations.

- Specialized case workers will be comprised of a team of relevant individuals whose posses both training and significant experience working with attachment-challenged clients and their families. These case workers will include individuals with degrees in social work, child psychology and intra-personal relationship building. Others with special training in the field of attachment and domestic violence; those with family advocacy training and securing insurance benefits, and those familiar with the unique manifestation of trauma-rooted behaviors. The 'team' will include parents of adopted children who have themselves gone through similar situations in their own homes; providing encouragement, support and situation familiarity to those who are in need.

- Tangible support service coordination and management, including but not limited to, individual out-patient therapy, family out-patient therapy, intense in-home therapy, crisis response coaching, acute hospitalization, residential care, etc. Most services will be provided in conjunction with existing State services, already in place. Some services will be provided or facilitated by APSS staff.

- In-tangible support service network facilitation will include youth oriented physical therapy programs i.e. art, dance, drama, music, sports, scouting, etc., therapeutic child sitting services, therapeutic summer camps and after school programs, a coordinated respite service and attachment challenged parenting classes.

- Revenue generation services: Clinician & service provider, training and certification programs.

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The administration of APSS:

Since the root of the issues that impact the families that APSS will service is mental health in nature, I would encourage the creation of an APSS pilot program to fall under the administration of the Department of Mental Health; with coordination of program elements to be in orchestra with the Department of Children and Families and the Department of Social Services.

The cost of implementing and funding the program is to be considered and drafted by State of Connecticut legislators. It is the position of the individual who drafted this proposal, that several State agencies will realize reduced costs and miscellaneous spending, over time, as a result of this new, pilot program.

Operations:

Operate under the oversight of the Department of Mental Health. Administrative office based at a Department of Mental Health field office. Field office locations mirror DCF districting. See Excel Operations Flow Chart.

Total initial staff members:	Twenty (20)
Administrative: Director Marketing Service Network Coordinator	Three (3)
Clerical support: Office & in-take Point-of-contact	Three (3)
Case managers: LCSW / MSW RAD trained clinicians	Eleven (11)
Advocates: Insurance, Family & legal oriented	Three (3)

Relevance:

The timing for engaging an APSS program could put Connecticut in the National spotlight as a State 'leading the intended action' behind Attorney General Eric Holder's National Task Force on Children Exposed to Violence. Since the task force was formed to examine ways to prevent, treat and heal children with exposure to trauma and violence, Connecticut could be seen, and position itself as, the State that cares enough to act.

The 2007 Cheshire Connecticut home invasion case rocked the country, traumatized a community and destroyed a family. The horrific nature of the crime is unfathomable to most people yet, at the hands of an adopted, traumatized, sexually assaulted youth, who was previously incarcerated and who never received appropriate intervention and attachment healing as a youth, took the lives of three lives beautiful, productive, engaged, loving people. Who can commit such a crime? An individual who is emotionally numb can. Early intense therapeutic intervention, before the age of eleven years old, is an essential ingredient to combat events like this.

With the abolishment of the death penalty in Connecticut, many tax payers perceive a correlation between housing criminals and the escalating costs to do so, and balancing the State budget. The APSS program, if structured, positioned and administered effectively, could assist the State on many fronts: It could prove to reduce our inmate population. It could over time reduce the corrections department budget in the future, and thus provide the current administration with a valuable campaigning platform.

At-risk children tend to have problems both at home and in school. For a state that used to boast of its exceptional educational system producing a higher number of college graduates then most, Connecticut's drop out rate no longer supports this image. APSS services will make the difference that will set the stage for improved graduation rates and elevated family effectiveness and values.

Getting the word out:

Marketing APPS can be done through either overt or covert practices. Due to matters of sensitivity and anonymity, some may feel that the exposure of this program should be administered discreetly, through agencies and clinicians. As an alternative parent myself, I do not support that way of thinking.

In our home we communicate and celebrate the fact that our children are adopted. Faced with troubling behavior patterns for many years, we've actively sought out therapeutic services and would have embraced knowledge of such a resource. Therefore, I support a more overt approach by which to introduce such a potentially valuable service to clinicians, residents and families.

An effective marketing program should include, but not be limited to, the following:

- An informational website linked to ALL State of Connecticut departments and agencies, and further exposed through social networking.
- Media releases and story idea for extended media coverage.
- Brochures and flyers to adoption agencies and adoption attorney's to be distributed to their new families and registered alumni; agencies serving the victims of domestic violence, and all services and activities that are oriented towards children and family participation; and family advocacy organizations.
- Emails to clinician networks for further email distribution
- Direct mail to private practices that specialize in children, adolescent and family therapy
- Community relations: Distribute brochures at area events.
- Circulate flyers through local school boards and school PTO organizations.
- Promotion: Run an ad campaign via PSA media inventory.

Together, State and local providers and families can

Help to Heal and Provide tools to Thrive

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The personal experience of the proposal author:
Maureen A. O'Neill – Davis and her family

My family's journey raising an adopted child with diagnosed severe RAD, PTSD and depression, arising from witnessing her birth mother's murder when she was 13-months old and disrupted attachments, is numbing. It's bewildering, complicated, emotional, scary, unpredictable, frustrating and sometimes unsafe. Our entire family has been affected, including our other two adopted, relatively well-adjusted, thriving children. While working full time to support our family and relocating out of Florida in response to issues of family safety and our children's medical needs, and despite years of tireless effort and research to identify and engage appropriate, effective services, CT-DCF was alerted to a possible issue of neglect and/ or abuse in our home. Their involvement in our unique dynamic has further disrupted our efforts to foster attachment and help our child heal.

The issue is childhood mental illness brought on by early childhood trauma, access to timely, appropriate, proven and cutting-edge treatment modalities; and healthy intervention programs. Reactive Attachment Disorder (RAD) is an attachment-rooted mental illness gaining in popularity. It is highly misunderstood, varies in severity and umbrellas several sub-sectors of psychological dysfunctions. A predominant number of adopted and foster children suffer from it, as do children from disrupted home environments. Even professionals who treat RAD and PTSD in children disagree as to the best treatment protocols. RAD can be a precursor to sociopathic tendencies, personality disorders and more. The impaired tend to gravitate towards antisocial thoughts and behaviors. Untreated, treated inappropriately or misdiagnosed, trauma-based mental illness often leads teens and adults to challenging life patterns such as general crimes, drug use, prostitution, unwanted pregnancy, incarceration, psychiatric hospitalization, suicide and homicide. The '07 Cheshire, CT home invasion, recent school shootings and heinous youth-committed crimes are perfect, high profile example of what can happen when a child with RAD/ PTSD does not get early, attachment-based, effective treatment and emotional nourishment.

Living with a child with mental illness in ones immediate environment, every day, is profoundly difficult. It's physically, mentally and emotionally exhausting, painful, distracting and incredibly disruptive. Everyone is affected. The primary caregiver(s) distributes attention in an effort to ensure that everyone gets 'enough', but it's never enough. The impaired individual can't be trusted, left unattended or expected to follow simple instruction. They are emotionally starved and thrive in chaos, which they generate with ease. Family stressors breed more disruptive behaviors, and disruptive patterns of behavior breed more stressors and create strain on marriages. Parents walk a daily tightrope between panic and calm, parental nourishment and survival, anxiety and empowerment. This family experience is 'normal' for families that parent children with RAD, PTSD and other childhood, trauma-based disorders.

DCF workers are largely uninformed when it comes to the 'real' impact of RAD and early childhood trauma (0-3 years of age) on the brain and how behaviors and emotional instability manifest later in life i.e. over the age of five. Due to protocol and uninformed investigators, they tend to lump these cases into standard neglect, abuse, maltreatment criteria. It is often speculated that the unstable behaviors at hand must be relative to something happening in the child's immediate environment now. In these cases, their efforts are often counterproductive and cost good families and committed parents obscene sums of money, valuable time, recourses, embarrassment and tons of energy. Further, everyone's attention is diverted 'off the ball' - the child who is suffering. Their misguided efforts also cost taxpayers in a variety of ways.

In our case, after years of effort and based on the direction of a clinician, we sought out the assistance of DCF's Voluntary Services to help us secure residential care, which was recommended by her then therapist. In turn, we were subjected to humiliating, rude investigator conduct and harsh accusations. We were treated with complete disrespect. Based on statements made solely by our impaired child, not by any other member of our family; claims of neglect and abuse were deemed substantiated. We've had to borrow money to fund attorneys to defend ourselves against faults claims and forced to redirect our limited resources.

All of our family's statements and actions, including those supported by current, self secured clinicians involved with our family, have been judged, twisted and misrepresented by the Torrington, DCF case workers and their superiors, to support the original DCF findings and position. These efforts led to the removal of our impaired child on March 6th, 2012.

Since then, our troubled child has been moved to three separate foster/ safe home placements, taken to the ER for a psychiatric consult, and treated like a child who was removed from an abuse, neglectful home. Her troubling behaviors at school have escalated dramatically. Her placements have been in geographical areas that are in contrast to her rural home environment. Our attachment work with her has been severed and set back years and the challenging primary caregiver bond has once again been severed. The deliberate effort to obtain an OTC has further harmed and traumatized our already hurting child.

Despite numerous psychiatric professional documents to support our claims that our child is impaired, rooted in events that occurred prior to final adoption placement with u and that her condition(s) produce illogical and troubling behavioral and emotional patterns, our impaired daughter remains in the care of DCF. Per standard DCF case protocol, the Court, under the direction of Judge Thomas Upson, ordered child and family psychiatric evaluations. That's where we sit today. No other competent, engaged, struggling alternative parent, seeking help, should ever have to endure this type of treatment again.

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REFERENCES:

The following is a 'short list' of resources that support the relevance, objectives and scope of services APSS proposes to provide. Several psychiatric professionals, who specialize in treating children with disrupted attachment histories, endorse the dyer need for support services and social understanding of these serious conditions.

Terry M. Levy, Ph D., Director of Evergreen Psychotherapy Center; and Michael Orlans, M. A.
Authors of many relevant releases including 'Attachment, Trauma, and Healing; Understanding and Treating Attachment Disorder in Children and Families'
www.attachmentexperts.com

Dr. Michael Pines, Private practice clinician, Glastonbury, CT
Attach.Org
www.ATTACH.org

Dr. Peg Kirby, Director of the Attachment Institute of New England
The Attachment Institute of New England
www.attachmentnewengland.com

The Mayo Clinic
www.mayoclinic.com/health/reactive-attachment-disorder/DS00988

Heather T. Forbes, LCSW & B. Bryan Post
Authors of 'Beyond Consequences, Logic, and Control'
www.beyondconsequences.com

Dr. Karyn B. Purvis, Dr. David R. Cross and Wendy Lyons Sunshine
Authors of 'The Connected Child'
www.hugthemonkey.com/reactive_attachment_disorder_rad/page/2/