

**TRAUMA-INFORMED ADVOCACY:
A LAWYER'S ETHICAL DUTY
INVOLVING A CHILD'S
CONSTITUTIONAL RIGHTS**

Presented by:

BARBARA ELIAS-PERCIFUL, J.D.
Director, Texas Lawyers for Children

OCTOBER 27, 2017

Recognizing & Meeting the Needs of Traumatized Children Within Our Systems of Care

Barbara J. Elias-Perciful, J.D.
Director, Texas Lawyers for Children
Kristen A. Bell, J.D., M.Ed.
Program Attorney, Texas Lawyers for Children

We are at an important moment of opportunity for the future welfare of children in our State's care. Over the past decade, a great deal of research has shown the devastating effects trauma has on children and the need for trauma-informed care and services. Professional organizations, administrative leadership, and state and federal lawmakers have begun to push for substantial changes to occur in our child-serving systems that embrace trauma-informed care. Therefore, the time is ripe for practitioners, administrators, and advocates who work with and on behalf of traumatized children daily to learn about trauma and identify ways we can meet the needs of the traumatized children we serve, to begin restoration from a system that harms these children, to one of healing.

I. Children within our educational, juvenile justice and child welfare systems have often been exposed to multiple traumatic experiences and, therefore, are deeply and globally affected by the effects of trauma.

Nearly all children in our child welfare and juvenile justice systems, and many children in our educational systems, have experienced some form of trauma. Events such as abuse, neglect, loss of a parent, sexual assault, removal from the home, and witness to violence can all be traumatic. For children who have spent any time in the foster care system, or in unstable or violent homes or communities, it is likely the child has experienced *complex trauma*, where repeated exposure to traumatic events can have serious and long-lasting effects on the child's physical, mental and emotional well-being. See Children's Bureau, "Developing a Child-Informed Child Welfare System: Implementing Trauma-Informed Practice in Child-Welfare Systems", Child Information Gateway Network (Issue Brief, May 2015), at 2, available at: www.childwelfare.gov/pubs/issue-briefs/trauma-informed ("Children's Bureau Issue Brief"). A national study (known as the Adverse Childhood Experiences, or ACEs, study), as well as a growing body of scientific data, has shown that increased exposure to trauma increases the likelihood an individual will suffer from numerous chronic health conditions; engage in risky behaviors such as alcoholism, drug use, and sexual promiscuity; and struggle to graduate, hold a job, or maintain healthy relationships. See Center for Disease Control. "Association Between ACEs and Negative Outcomes," Injury Prevention & Control: Division of Violence Prevention, (Retrieved September 29, 2016) available at https://www.cdc.gov/violenceprevention/acestudy/about_ace.html ("ACEs Study") (for statistics showing similar effects for children in long-term foster care in Texas, see Texas Appleseed. "Improving the Lives of Children in Long-Term Foster Care." (November 2010), at 48-52, available at <http://texaschildrenscommission.gov/Media/1209/appleseedstudy.pdf>).

For many children, the trauma they have suffered has been relational, so that a person they trusted is the source of their harm. See "Effects of Complex Trauma", The National Child

Traumatic Stress Network, available at <http://www.nctsn.org/trauma-types/complex-trauma/effects-of-complex-trauma>. When children experience relational trauma, their entire perception of the world shifts from what we expect of children (comfort and trustful dependence) to anxiety, fear, doubt, dissociation, and dysregulation. These differences mean that the child will *think* differently, *act* differently, *respond* differently—and therefore—need a completely *different* kind of care. These children are not willfully disobedient; their underdeveloped brains are seeking to survive. Yet, despite these needs, many of our current child-serving systems *compound* the trauma children face by failing to understand the needs of traumatized children and employing traditional disciplinary practices that can re-traumatize the child. At the time a child experiences trauma, the survival mechanisms in the brain take over, prohibiting the cognitive and emotional development that should occur at each stage of growth. For a young child, trauma could negatively affect the child’s ability to process sensory input, access parts of the brain necessary for language acquisition, and develop healthy attachments to caregivers. For school-age children, traumatic events can affect the child’s ability to concentrate, learn required information, connect ideas and form rational conclusions, so that the child may no longer recognize that certain behaviors are linked to consequences, positive or negative. Adolescents tend to internalize these deficiencies, leading to withdrawal, self-harm, violence and aggression, failed relationships, and engagement in dangerous behaviors. In addition, trauma turns on the stress chemicals in the brain, which can increase children’s feelings of agitation and frustration, and can lead to a myriad of destructive behaviors when the child’s brain is triggered by something that is a reminder of the trauma, reigniting the brain’s ‘survival mode’. *See* ACEs Study; *see also* Children’s Bureau, “Long-Term Consequences of Child Abuse and Neglect”, Child Welfare Information Gateway (July 2013), available at https://www.childwelfare.gov/pubPDFs/long_term_consequences.pdf. Recent findings have even shown that prolonged exposure to trauma can affect portions of an individual’s DNA. *See* Zhao, Roseanne. “Child abuse leaves epigenetic marks”, National Human Genome Research Institute (July 2013), available at <https://www.genome.gov/27554258/child-abuse-leaves-epigenetic-marks/>. Complex trauma can pervade into every biological system, causing global harm to the child, and must be fully understood and addressed to meet the needs of traumatized children in our state’s child protection, juvenile justice, and educational systems.

II. If those who serve traumatized children do not fully understand the effects of trauma and appropriate ways to meet the needs of traumatized children, their responses to trauma-related symptoms can cause further harm to the child.

Because those who work with traumatized children evaluate their behaviors and then make decisions for the child based on this evaluation, “[p]rofessionals who work within child-serving systems *must* be aware of a child’s trauma history and its effects, or **their actions and responses to the child may inadvertently trigger trauma memories, worsen symptoms or further traumatize the child.**” Children’s Bureau Issue Brief, at 3 (emphasis added). Unfortunately, our current educational, juvenile justice, and child protection systems, often employ traditional discipline practices that can be the catalyst for a potentially harmful downward spiral when a traumatized child’s misbehavior is incorrectly viewed as ‘willful disobedience’, instead of a survival response. When faced with traumatic situations, or when an occurrence triggers memories of traumatic events, those who have experienced trauma will often ‘fight, flight or

freeze'. If these reactions are misunderstood and blamed, instead of understood and treated, individuals who work with traumatized children may enforce punitive consequences on a child. Frequent teacher conferences, suspensions, referral to an alternative school setting, increased levels of care, or increased consequences within the juvenile justice system can all work to heighten feelings of frustration and hopelessness in traumatized children, leading them to exhibit increasing levels of misbehavior or emotional instability. In addition, the child may face academic challenges because his or her heightened state of anxiety can lead to decreased cognitive ability. If cognitive and emotional deficiencies are viewed as willful behavior, and not actual deficiencies in the child's brain function, caregivers, teachers, and institutional staff are likely to employ external motivators, both in the form of punishment and reward, which can exacerbate the child's stress reactors. Instead, relational trauma must be healed by relationships, where the child feels safe, connected, and is taught how to handle emotional responses and build resiliency. *See* Bath, H. "The Three Pillars of Trauma-Informed Care." Reclaiming Children and Youth, 17(3), 17-21 (2008); *see also* Hodas, Gordon R., M.D., "Responding to Childhood Trauma: The Promise and Practice of Trauma Informed Care (Feb. 2006), available at <http://www.childrescuebill.org/VictimsOfAbuse/RespondingHodas.pdf>.

In addition, when traditional discipline measures do not work, it is common for families or practitioners to seek the advice of mental health professionals. While this can be a helpful resource, untrained practitioners may not be aware of the extensive effects trauma can have on a child or may not have access to available trauma-informed treatments and interventions. Therefore, one of the most notable harms traumatized children face is misdiagnosis from professionals untrained in brain research related to childhood trauma. Because the symptoms of trauma and the symptoms of mental disorders often overlap, children are routinely misdiagnosed with a mental disorder for symptoms that may be healed through a trauma-informed approach. *See* **Appendix B** (Overlapping Symptoms of Child Trauma and Psychiatric Disorders); *See also* Layne, C. M., Kaplow, J. B. & Youngstrom, E. A. (in press). "Applying Evidence-Based Assessment to Childhood Trauma & Bereavement: Concepts, Principles, and Practices." In M.A Landholdt, M. Cloitre & U. Schynder, Evidence-Based Treatments for Trauma-Related Disorders in Children and Adolescents. Cham, Switzerland: Springer International Publishing AG. Dysregulation, problems with attention/concentration, hyperactivity, negative self-image, attachment issues, and behavioral problems are all prevalent in children who have experienced multiple traumatic experiences. Children can also exhibit outbursts of anger, sexual reactive behavior, sensory issues, and dissociation, among a host of many other symptoms. In fact, studies have shown that the more trauma a child has experienced, the more likely the child will show notable symptoms affecting the child's cognitive processing, emotional well-being, or physical health. *See* Kiesel, C. "Constellations of Interpersonal Trauma and Symptoms in Child Welfare: Implications for a Developmental Trauma Framework". *Journal of Family Violence* 29:1-14 (2014), at 2, DOI: 10.1007/s10896-013-9559-0. Many of these same symptoms also manifest in individuals with mental illness. For example, children who have experienced trauma could exhibit symptoms that correlate with findings of ADHD, Bipolar Disorder, Major Depressive Disorder, Panic Disorder, Oppositional Defiant Disorder, and Psychotic Disorder. *See* Griffin, Gene. "Addressing the Impact of Trauma Before Diagnosing Mental Illness in Child Welfare," *Child Welfare*, 90(6): 69, 74 (Jan. 2011). As children get older, the overlap increases: in one study, 54% of children aged 13-16 years old exhibited overlapping trauma and mental health symptoms, and for children aged 17 and older,

that percentage increased to 62% of children in the child welfare system. *See id.* at 83; *See Appendix C* (Increase of Overlapping Symptoms as Child's Age Increases). Not only do these overlapping symptoms often lead to a misdiagnosis of a psychiatric disorder when the child is instead exhibiting a myriad of traumatic symptoms, they can lead to a diagnosis of several different psychiatric disorders, as the child's symptoms do not clearly fit into the diagnostic criteria of a specific disorder. Kiesel, at 4.

Misdiagnosing a child's response to trauma as mental illness is not a benign error. A failure to understand the child's underlying condition leads to a failure to treat it properly. One of the most damaging harms of misdiagnosis is unnecessary use of prescription psychotropic medications. These drugs do not always have FDA approval, especially for use with children, and can include harmful side effects that cause the child to exhibit even more concerning behavior. *See Texas Department of Family and Protective Services and University of Texas School of Pharmacy. "Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care (5th Version)." (March 2016), available at https://www.dfps.state.tx.us/Child_Protection/Medical_Services/documents/reports/2016-03_Psychotropic_Medication_Utilization_Parameters_for_Foster_Children.pdf ("Parameters")* (hallucinations, mania, aggression, decreased appetite, delusional thinking, sleep disturbance, psychiatric adverse effects, seizures, and suicidal ideation are all listed as potential side effects of commonly-used psychotropic medications); *see also* "Foster Children: HHS Could Provide Additional Guidance to States Regarding Psychotropic Medications", GAO Highlights (May 29, 2014), available at: <http://www.gao.gov/assets/670/663662.pdf>. For children who do not have a stable caregiver, caseworker, or mental health practitioner able to properly oversee and manage their medication use, these side effects can even lead to multiple or a more severe mental health diagnosis. *See Parameters* (warning against poly-pharmacy of psychotropic medication in patients without proper monitoring and established need). The Parameters, coauthored by DFPS, advise that a thorough assessment of the patient, including the patient's trauma history, and nonpharmacological approaches to treatment, should be investigated by mental health professionals before psychotropic medications are prescribed, except in the case of an emergency. *See id.*, at 4. Laws in both the Family Code and Administrative Code also have certain requirements before a child in the State's care can receive psychotropic medications. *See Appendix D*. Unfortunately, a recent report by Texas House Human Services stated that almost 50% of 13-17 year-old children in foster care are still prescribed psychotropic medications. *See Smith, Charles, Executive Commissioner. "Update on the Use of Psychotropic Medications for Children in Texas Foster Care: Fiscal Years 2002-2016." Texas Health and Human Services Commission. Available at :<https://hhs.texas.gov/sites/hhs/files/documents/services/health/other/update-on-psych-meds-in-tx-foster-children.pdf>. These children did not enter care because they had a mental disorder; they entered care because they were abused, neglected, and abandoned. Therefore, advocates and system administrators have an important role to ensure that appropriate nonpharmacological efforts and protective measures are put into practice before a child takes psychotropic medications for symptoms that may be healed through a trauma-informed approach.*

In addition to the long-term effects of taking psychotropic medications, an assumption that a child's reactions and behavior are due to the effects of mental illness instead of trauma can mean that the child will spend more time in mental health institutions, where harmful seclusion and

forceful restraints may be used. *See* Cooper, J. “Facts About Trauma for Policymakers”, National Center for Children in Poverty (July 2007), available at http://www.nccp.org/publications/pub_746.html. Finally, the child may not improve because the child is receiving treatment that does not meet the child’s need. Not only does this lead to waste of time and the State’s resources, it can also damage the child by increasing the child’s feelings of frustration, shame, and hopelessness, as even professionals are unable to “fix” the child’s “bad” behavior. *See* Hodas, at pp. 24-27. Because of the myriad of harms discussed above—ranging from a misapplied label of mental illness, to placement in facilities that actually increase harm for children who have experienced trauma, to potentially life-altering side effects of unnecessary psychotropic medications—all professionals working with traumatized children in the State’s care must know to ask the right questions to ensure that mental health professionals who diagnose or treat a child in foster care understand and have addressed the possible impacts of trauma on a child’s behaviors and overall treatment plan. *See* Griffin, at 71.

III. Because of the potential to harm traumatized children in our systems of care, it is imperative that these systems (especially, systems of child protection, juvenile justice, and special education services) become trauma-informed systems of care.

This downward spiral of harm does not have to be the answer. Every choice made on behalf of a child in the child welfare system must come from a place of understanding the child’s experiences, or that choice has the potential to cause long-term harm to the child’s emotional and psychological health. “Care” in a system of blame shatters these children who have already been traumatized and breeds distrust, shame, and fear. Developing resiliency is key to a child’s ability to overcome traumatic experiences. To build resiliency, those who work with children should focus on ensuring that the child is *safe* (both real and perceived), *connected*, and *able to regulate emotions*. *See* Bath, H., at 17-21; *see also* **Appendix A** (Reactive Systems that Harms Children vs. Proactive Systems that Heals Children). Traumatized children are not without hope; with appropriate support and interventions, these children can heal. Substance Abuse and Mental Health Services Administration, “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”, HHS Publication No. (SMA), 14-4884 (2014), at 8, available at <http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf> (“SAMSHA Trauma Guidance”). Trauma-informed care leads to a different cycle: one that reduces frustration, increases the child’s self-awareness, leads to the development of skills and autonomous coping strategies, and enhances the child’s ability to form and maintain interpersonal relationships. In addition, a culture of trauma-informed care creates a cycle that improves our child-serving systems in the following ways:

- Decision makers work collaboratively and in a common language to truly understand the child and the true cause of the child’s behaviors;
- Caregivers, educators, and staff of child placing agencies and correctional or residential treatment facilities are provided tools to address the relational harms these children have experienced;
- Biological parents are viewed through a lens that recognizes the trauma they have faced, and meaningful service plans give them a real opportunity to successfully parent;

- Caseworkers, correctional officers, and behavioral specialists are not just a cog in a hopeless cycle, but truly have a role in changing the life of a child, which allows them to see their work as valuable, and therefore, improves worker retention;
- Caseworkers, therapists, educators, and correctional officers are given the tools to identify traumatic triggers and are given the power to make choices and changes in practice and policy that prevent re-traumatization of the child;
- Steps are taken to ensure a child who was sexually assaulted will never be placed in a situation that would trigger a traumatic response or risk further victimization;
- Appropriate therapies and sensory integration tools are provided for children who have developed sensory processing disorder in the womb or early in life due to trauma;
- A child who exhibits violence or aggression develops a plan for calming, and caregivers are given appropriate tools to understand the child's survival behaviors and prevent a power struggle;
- Judges and attorneys can seek placements that meet the child's individualized needs and promote connection to caregivers, as well as develop a service plan that applies to the needs of the family as discovered in an individualized assessment;
- Judges and district administrators are given flexibility to determine appropriate outcomes for a child's misbehavior that is responsive to the child's exposure to trauma; and
- Appropriate non-pharmacological therapies are available and can be utilized to address a child's failure to attach to caregivers, helping the child reorganize mental processes and preventing the development of dissociative disorders.

A. There is an expanding framework for advocates to seek trauma-informed care and services for their clients.

Judges, attorneys, and systems administrators who work with traumatized children should be encouraged that there is an increasing body of support for responding to traumatized children within our child-serving systems with care that is trauma informed. The Substance Abuse and Mental Health Services Administration, the Children's Bureau (a section of the Administration for Children and Families), the American Bar Association, the American Association of Pediatrics, the American Psychological Association, the National Council of Juvenile and Family Court Judges, and the Office of Juvenile Justice and Delinquency Prevention have all spoken about the need to understand the effects of complex trauma in children. In addition, the Texas Education Agency has begun to track discipline practices and is exploring ways to promote 'restorative discipline' to decrease suspensions, especially for at-risk youth, so that they can continue to learn. *See* Commissioner Michael Williams, "Texas Focusing on Restorative Discipline," Texas Education Agency (June 2015), available at http://tea.texas.gov/Home/Commissioner_Blog/Texas_Focusing_on_Restorative_Discipline/.

Advocates may also utilize existing laws to seek appropriate services for traumatized children and to promote trauma-informed systems of care. *See* **Appendix D** (Relevant Federal and State Statutes). In addition to state statutes that can be applied to minimize traumatic practices within our child-serving systems, federal law may also help provide funding for evaluation, diagnosis,

and treatment for traumatized children in the foster care system today. For example, Medicaid, operated under the STAR Network in Texas, allows for reimbursement of “diagnostic, screening, preventive and rehabilitative services, including . . . any medical or remedial services (provided in a facility, home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.” 42 U.S.C. § 1396d (a)(13)(C); *see also* 25 Texas Administrative Code § 416.3, § 416.5, § 416.10 (Under STAR Network, a child is eligible for mental health services and skills training and development services, if the child has a “serious emotional disturbance”, defined as ‘a diagnosed mental health disorder that substantially disrupts a child’s or adolescent’s ability to function social, academically, or emotionally’”). The Department of Health and Human Services, in a letter dated July 11, 2013, urges state directors of child welfare systems to adequately understand the presence of complex trauma for children in foster care, provide screenings to adequately assess the effect of trauma in the children under its care, and coordinate treatment through evidence-based, trauma-related services. *See* Sheldon, G., Tavenner, M. and Hyde, P., *State Director Letter*, Department of Health and Human Services (July 11, 2013), available at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf> (discussing a myriad of sources of federal funding to meet the needs of children who have experienced trauma and outlining an expansive list of trauma-informed treatments that can qualify for reimbursement under federal statute). The letter concludes that effective screening, assessment and treatment for incidences of complex trauma can reduce the use of psychotropic medications, reduce the need for emergency services or long-term residential care services, and reduce instances where children who have ‘clinical levels of need’ are not receiving any care, as well as ultimately lowering long-term costs for administration of the child welfare system. *Id.* at 15. In addition, the Every Student Succeeds Act (ESSA), which passed in 2015, allows grant funding for local school districts that seek to train faculty and staff in trauma-informed practices for classroom management, decrease shaming and isolation-based discipline practices, and promote educational stability.

B. Resources are available to learn more about trauma, so that child-serving organizations can promote and implement changes in policy and practice to transform traditional systems into systems that are trauma informed.

Trauma training is a necessary first step, but a training slideshow alone will not change policy or practice. There must be a change in the entire structure for trauma-informed practices to truly take hold. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), a trauma-informed approach includes four key components:

- *Realization* of the widespread impact of trauma and understanding of potential paths for recovery;
- *Recognition* of the signs and symptoms of trauma in clients, families, staff and others involved within the system;
- *Response* by fully integrating knowledge about trauma into policies, procedures and practices, and
- Seeking to actively *resist re-traumatization*.

We would add a fifth ‘R’ to the formula for a trauma-informed system of care, which is probably implied, but cannot be overstated: that of *relationship-building*. Trauma-informed care does not alleviate accountability for the child, but shifts the focus from blaming and punishing the child to educating and preparing the child for success. Instead of assuming that a traumatized child can be responsible for his or her actions without intense help and instruction, trauma-informed care assumes that the child has a need for adult mentors to invest in understanding the child through his or her experiences; helping the child find his or her voice; helping the child understand the effects of trauma, as appropriate; building relationships to mentor and counsel the child through development; breaking down barriers that prevent the child from receiving proper treatment and healing for trauma; and working with others in the system to help the child develop and practice coping strategies for appropriate responses to traumatic triggers that may decrease frustration, anxiety, or anger. Texas practitioners have the added benefit of several organizations in our state that are experts in promoting practices that address trauma and building children’s capacity to cope with difficult experiences in their lives. These include, but are not limited to, the TCU Institute of Child Development, specifically, Trust-Based Relational Intervention, founded by Drs. Karyn Purvis and David Cross; the ChildTrauma Academy in Houston, founded by Dr. Bruce Perry; the Travis County Collaborative for Children; and the UT School of Social Work—Institute for Restorative Justice and Restorative Dialogue.

In addition, the Texas Lawyers for Children Online Legal Resource and Communication Center (“Online Center”) has a large collection of articles related to trauma, searchable by topic, and access to discussion boards and communication tools to connect practitioners who want to learn more about trauma with experts and colleagues in several different fields. The Online Center also includes over twenty hours of digital training devoted to helping practitioners and advocates understand trauma and develop competency in meeting the needs of traumatized children. For more information, please register at www.texaslawyersforchildren.org.

As a practical matter, there are many steps attorneys and system administrators can take to advocate for a child who has experienced trauma. The following list names a few:

- **Learn about trauma and the effects trauma has on a child, especially children in substitute care or in our juvenile justice systems.** As an adult invested in a system of care that serves traumatized children, it is important to recognize instances of trauma in a client’s file; recognize when symptoms of trauma have been overlooked, especially when this oversight leads to negative outcomes for your client; and have sufficient knowledge to advocate for trauma-informed services.
- **Be aware of how you interact with a child client who has experienced trauma.** Avoid forcing your client to speak about traumatic experiences, especially when the information can be gathered from other sources. In addition, work towards a relationship where your client feels safe, heard, and connected.
- **Be an advocate for stability in the child’s life.** Unless a placement change is at the request of the child, require those advocating for a placement change to prove why one is needed. Their reason should always focus on the child. Placement changes can be traumatic for a child in substitute care, especially if the change removes the child from a family setting. If the foster family has expressed difficulty meeting the child’s needs,

advocate for the child and foster family to receive trauma-informed services. In addition, utilize presumptions in the law that promote educational stability.

- **Ensure that your child client has received a trauma screening and trauma-informed services before taking psychotropic medications.** Judges, court advocates, DFPS employees, and medical decision makers have a duty to ensure the use of any psychotropic medication is necessary and beneficial to the child. Request an explanation of a diagnosis of mental illness and the need for psychotropic medication, especially when there has not been a screening for trauma, an attempt to utilize trauma-related interventions, or sufficient follow-up on the effect the psychotropic medication has had on the child's condition.
- **Request evaluations and services from trauma-informed specialists. Advocate for payment of these trauma-informed care and services.** There are counselors, therapists, and other medical professionals who specialize in modalities and treatments targeted at healing the effects of trauma. In addition, attorneys may have grounds to advocate for these services to be paid under the state's Medicaid provisions (Star Health).
- **Help schools or juvenile justice systems develop responses to the child's behavior that are appropriate and likely to lead towards healing, instead of harm.** There are many avenues where schools have begun to investigate alternative methods for addressing a child's misbehavior or academic struggles. Response to Intervention, Positive Behavior Strategies, and Restorative Discipline, as well as assessment for special education services, should be explored.
- **Utilize existing laws to advocate for decisions that protect your child client from repeated exposure to trauma and advocate for additional legislative and policy changes that promote trauma-informed systems of care.** While laws may not explicitly address trauma, many laws that promote stability for children, reduce the use of punitive practices, and require strict review and oversight of medical and mental health services can work to the benefit of traumatized children. In addition, judges, attorneys, and child-serving system administrators can advocate for laws and policies that promote the development of a trauma-informed workforce and increased understanding of the needs of traumatized children.
- **Explain to older youth what you know about trauma and how it affects them.** This can help youth understand why they react in certain ways, recognize changes in moods and feelings, identify traumatic triggers, and develop plans for calming and handling emotional responses.
- **Believe healing is possible.** Those who serve children that have been traumatized have an extremely important role, both for the individual child and for future generations. The rewards, however, are not always immediate, and our investment must have a long-term vision. We must believe that positive change is possible, and we must commit to doing all we can to help these children heal, seeking to find creative solutions within our existing child-serving systems that increase safety, connection, and emotional regulation and improve lifelong outcomes for our State's most vulnerable children.

Appendix A:

Reactive System That Harms Children vs. Proactive System That Heals Children

The left column in the chart below highlights several areas where traditional systems could be harmful to traumatized children. The right column discusses how each issue might be handled differently by employing the foundational principles and practices of trauma-informed care.

<p align="center">Reactive System: Utilizes Punishment and Consequences -- Harms Traumatized Children</p>	<p align="center">Proactive System: Utilizes Trauma-Informed Care -- Heals Children</p>
<p>Employee Overload & Turnover: Children are Lost in the System</p> <p><i>This harms children by increasing their feelings of isolation. In addition, there is no one within the system who knows their history or needs, so misdiagnosing and mislabeling the child's behavior is common.</i></p>	<p>Building safety, connection and coping strategies through relationship is the priority of trauma-informed care. In a trauma-informed system, employee: child ratios must be manageable to meet the child's needs, and procedures must be put into place to improve the transitions a child must experience.</p> <p>In addition, employees and caregivers will have tools and access to services that actually help children. This allows the adults who work with traumatized children to see growth and progress in the child, instead of increasing harm, and adds intrinsic value to the employee's role.</p> <p>Finally, a trauma-informed system of care also decreases employee turnover by recognizing the issue of <i>secondary trauma</i> and <i>burn-out</i>. Those who work with vulnerable children must also have access to care and treatment to deal with the trauma they face daily.</p> <p><i>This helps children heal because those who work within these systems are served by a healthy organizational structure, and the children have adult mentors who understands their needs and increases their feelings of safety and connection.</i></p>
<p>Lack of Interest in Determining and Maintaining Documentation of Child's Traumatic History</p> <p><i>This harms children because the system is likely to re-traumatize children if there is not a complete understanding of the child's experiences and triggers of traumatic memories.</i></p>	<p>In a trauma-informed system of care, interested parties must have access to information about the traumatic events that form the child's "trauma narrative". The child's file becomes a necessary part of each decision and action taken on behalf of the child because those in a trauma-informed system of care recognize that the only way not to re-traumatize the child is to understand the child's past experiences, including events that may trigger the child's traumatic memories, as well as coping strategies that have helped the child in the past. Any trauma that the child has experienced in foster care—including child-on-child abuse—also becomes part of each child's trauma narrative.</p> <p><i>This helps children heal because informed decisions are made in light of the child's history and triggers, and future traumatizing events are avoided.</i></p>
<p>Focus on Documentation/Correction Rather Than Education/Connection:</p>	<p>In a trauma-informed system of care, focus is placed on providing care to the child. Taking the time, energy and resources to meet a child's needs early can create long-term improvements for a child's</p>

<p>Majority of employee’s time is spent documenting misbehavior or proving the need for punishment/rewards, instead of caring for and mentoring the child</p> <p><i>This harms children because this focus fails to meet the child’s needs. In fact, a focus on behavioral modification often means decreased stability for the child, as well as an increased likelihood that the child’s behaviors will be treated as “willful disobedience”, rather than a need for healing.</i></p>	<p>personal and inter-relational stability, leading to an eventual decrease in the need for documentation and correction.</p> <p><i>A decrease in correctional practices (and related documentation) helps children heal because time can now be spent understanding the child and finding the best way to meet the child’s specific needs. The caseworker is able to help the child identify triggers, develop a plan for responding to emotional and trauma-informed services that will promote stability and healing in the child’s life.</i></p>
<p>Punitive Practices that Blame and Isolate the Child</p> <p><i>Corrective practices that isolate the child harm the child by increasing the child’s feelings of rejection and decreasing the child’s ability to develop relationships and trust. In addition, children who are removed from learning environments miss out on credits, continuity in their learning, and the activities that increase normalcy. Increasing the child’s “level of care” means that the child is more likely to be exposed to violence and sexual deviation while in care. In addition, the further the child moves into an institutional care setting, the less equipped the child becomes for forming healthy relationships.</i></p>	<p>Caregivers are equipped with the tools to form attachment, provide security, and develop strategies to help the child minimize emotional deregulation. When these caregivers know the child well, and understand the child’s reactions to trauma, they begin to recognize how the misbehavior is really a cry for safety, connection, or help in regulating emotions. Then, the caregiver can meet these needs and de-escalate the situation. This response alleviates the need for increasing the child’s “level of care” or placement changes, and increases stability in the child’s life.</p> <p><i>Because connection is the core of a child’s ability to become resilient, caregiver stability helps children heal in all areas of the child’s life, and is even proven to help a child overcome traumatic experiences. In addition, caregiver stability means that the child will develop friendships and achieve “normalcy” more quickly. Finally, the child will be able to grow in a family setting where healthy relationships with foster parents and siblings can be formed.</i></p>
<p>Overuse of Debilitating Psychotropic Medication</p> <p><i>Misuse of psychotropic medications hurts the child in multiple ways: the child is labeled by a diagnosis of mental illness, which affects others’ expectations of the child; and the side effects of the medication can increase a child’s troublesome behaviors or have long-term negative consequences on a child’s physical or emotional health.</i></p>	<p>A quick-fix or behavior-management approach is replaced with long-term connection and mentorship, where children learn to identify and manage emotional or behavioral triggers, and medication is used only to treat illness, not manage behavior.</p> <p>Caregivers and other stakeholders can truly assess the needs of the child in their care, instead of misunderstanding symptoms that are caused by harmful side effects of medication.</p> <p><i>Trauma-informed care helps to ensure that the treatment the child receives is appropriate to that child’s experiences and the specific effects the child is experiencing from trauma. Trauma-informed care seeks to repair the global damage that trauma has had on the way a child thinks and behaves.</i></p>

<p>Increase in Child’s Shame and Lack of Trust for the ‘System’</p> <p><i>This harms the child because internalized shame affects the child’s overall outlook of his/her abilities, value, and place in the system of care. In addition, lack of trust in the system means that resources are wasted, as the child has learned that services and programs do not meet his/her needs, and the child disengages.</i></p>	<p>The child begins to understand that his/her responses to the trauma he/she has faced are normal reactions, and the child can begin to manage these reactions and develop trust through strong connections and mentoring relationships. The child can also practice coping strategies in a safe environment.</p> <p><i>This helps the child heal because he/she learns to seek appropriate help. The child feels safer in a system that understands the effects of his/her experience, and therefore, the child no longer has to rely on fear-driven survival strategies. Once the “fight, flight, or freeze” instinct is calmed, the child can begin to develop coping strategies and cognitive growth.</i></p>
<p>Aging Out of “the System” Without Healing</p> <p><i>The harm can be devastating at this stage of the child’s life, where repeated misguided attempts to provide care means that the child enters adulthood unable to manage the responsibilities of keeping a job, handle interpersonal relationships, and cope with different emotions and experiences. If misdiagnosed, the child must live with the label of mental illness, as well as the harmful side effects of psychotropic medications. In addition, the child who is now an adult believes that the harms he/she has experienced in foster care have no hope for healing, and he/she enters adulthood expecting continued trauma.</i></p>	<p>Children learn positive coping strategies for managing their emotions, they learn to express their needs, and they develop long-term connections to aid in the transition to adulthood. In addition, children have been properly diagnosed and have received a treatment plan that adequately meets their long-term needs.</p> <p><i>This helps the child develop into a functioning adult and one that contributes to society. With trauma-informed therapies and treatments, the child is able to work through his/her traumatic experiences, learn appropriate ways of handling emotions, and identify sensory or physical events that may trigger feelings of panic. The child has also learned to form connections with others and has several mentors to seek for advice. Finally, a proactive approach has helped the child’s “fight, flight, or freeze” survival portions of the brain rest, so that the child has made use of the higher-level functions in the brain and has had successful experiences in language development, decision-making, and emotional regulation.</i></p>

Appendix B:

Overlapping symptoms of child trauma and psychiatric disorders

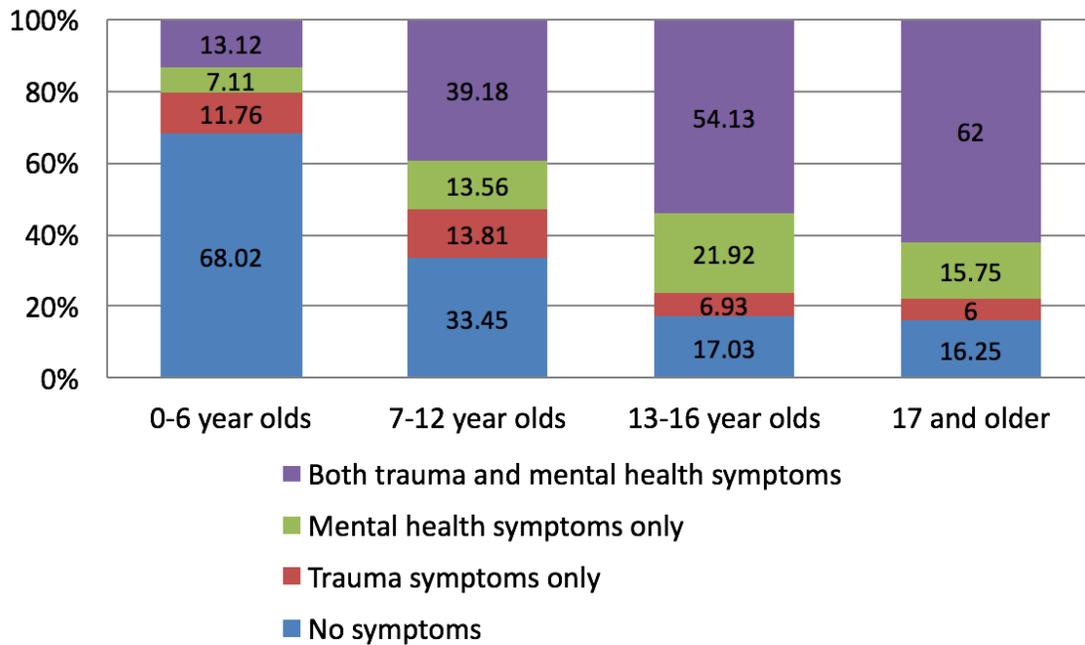
Psychiatric Disorder	Overlapping Symptoms
Anxiety Disorders	avoidance of feared stimuli, physiologic and psychological hyperarousal upon exposure to feared stimuli, sleep problems, hypervigilance, and increased startle reaction
ADHD	restless, hyperactive, disorganized, and/or agitated activity; difficulty sleeping, poor concentration, and hypervigilant motor activity
Bipolar Disorder	hyperarousal and other anxiety symptoms mimicking hypomania; traumatic reenactment mimicking aggressive or hypersexual behavior; and maladaptive attempts at cognitive coping mimicking pseudo-manic statements
Major Depressive Disorder	self-injurious behaviors as avoidant coping with trauma reminders, social withdrawal, affective numbing, and/or sleep difficulties
Oppositional Defiant Disorder	a predominance of angry outbursts and irritability
Panic Disorder	striking anxiety and psychological and physiologic distress upon exposure to trauma reminders and avoidance of talking about the trauma
Psychotic Disorder	severely agitated, hypervigilance, flashbacks, sleep disturbance, numbing, and/or social withdrawal, unusual perceptions, impairment of sensorium and fluctuating levels of consciousness
Substance Abuse Disorder	drugs and/or alcohol used to numb or avoid trauma reminders

Source: Griffin, Gene. *A Trauma-Informed Approach to Diagnosing Children in Foster Care*. Presented on August 28, 2012 at Because Minds Matter: Collaborating to Strengthen Management of Psychotropic Medications for Children and Youth in Foster Care.

Appendix C:
Overlap of Trauma and Mental Health Symptoms as Children Age

As the chart below indicates, children exhibit both trauma and mental health symptoms at an increasing rate as they age. By the age of 17, 83.75% of children in foster care are exhibiting mental health symptoms, trauma symptoms, or both. Given that a substantial majority of these children exhibit symptoms that could be either mental illness or trauma, and these children are only one year from aging out of care, we have an imperative and an urgency to use evidence-based practices that ensure we have correctly diagnosed and have an accurate comprehensive treatment plan for these children. Otherwise, they have no hope for functioning as adults and will continue to cycle into destructive patterns of behavior.

Overlap of Trauma and Mental Health Symptoms



Source: Griffin, Gene. *A Trauma-Informed Approach to Diagnosing Children in Foster Care*. Presented on August 28, 2012 at Because Minds Matter: Collaborating to Strengthen Management of Psychotropic Medications for Children and Youth in Foster Care.

Appendix D:
Table of Federal and State Statutes

(could be used as basis of argument to advocate for trauma-informed care)

*All laws are subject to change. Please ensure that each law is still valid before using as legal authority. Because of time constraints, this has not been updated to reflect changes from the 2017 Texas Legislative Session. A few notable amendments or additions to current law include:

- HB 7 (change in role for attorney ad litem to review the safety and well-being of the child, including the effects of trauma, and take appropriate action, including requesting a review hearing);
- SB 179 (increases likelihood that educators receive more training in trauma and how evidence-based trauma-informed practices can support academic success for students affected by grief or trauma);
- HB 4056 (adds that trauma-informed practices, positive school climates, and positive behavioral supports must be added to the list available to districts for promotion of available programs and best practices);
- HB 1549 and SB 11 (promote community-based practices and early medical review and intervention);
- SB 74 (could increase availability of targeted trauma-informed behavioral therapies for children, adolescents, and their families).

Citation	Relevant Language
42 USC § 622 (Stephanie Tubbs Jones Child Welfare Service Program)	(a) In order to be eligible for payment under this Subpart . . . a State must have a . . . (b)(15) plan for the ongoing oversight and coordination of health care services for any child in a foster care placement, which shall ensure a coordinated strategy to identify and respond to the health care needs of children in foster care placements, including mental health and dental health needs, and shall include an outline of--(ii) how health needs identified through screenings will be monitored and treated, including emotional trauma; . . .and(v) the oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications.
P.L. 114-95, 129 Stat. 1802 (Every Student Succeeds Act) *provides grant funding opportunities for districts that make activities to promote safe and healthy students, including trauma-informed training and care	Section 4108. Subject to Section 4106(f), each local educational agency, or consortium of such agencies, that receives an allocation, under section 4105(a) shall use a portion of such funds to develop, implement, and evaluate comprehensive programs and activities that—(5) may include, among other programs and activities— (B) in accordance with sections 4001 and 4111—(ii) school-based mental health service partnerships that—(II) provide comprehensive school-based mental health services and supports and staff development for school and community personnel working in the school that are—(aa) based on trauma-informed practices that are evidence-based (to the extent the State, in consultation with local educational agencies in the State, determines that such evidence is reasonably available). . . (D) high-quality training for school personnel, including specialized instructional support personnel, related to—(ii) effective and trauma-informed practices in classroom management Section 2102. Subgrants to Local Educational Agencies. Section 2103. Local Use of Funds. (a) IN GENERAL—A local educational agency that receives a subgrant under Section 2102 shall use the funds made available through the

<p>*requires schools that use School Climate as a factor in “School Quality and Student Success” ratings to address overuse of discipline and promote educational stability</p>	<p>subgrant to develop, implement, and evaluate comprehensive programs and activities described in subsection (b); (b) The programs and activities described in this subsection, (5) may include, among other programs and activities—</p> <p>(F) developing programs and activities that increase the ability of teachers to effectively teach children with disabilities, including children with significant cognitive disabilities, and English learners, with may include the use of multi-tier systems of support and positive behavioral interventions and supports, so that such children with disabilities and English learners can meet the challenging State academic standards;...</p> <p>(I) carrying out in-service training for school personnel in—</p> <p>(i) the techniques and supports needed to help educators understand when and how to refer students affected by trauma, and children with, or at risk of, mental illness;</p> <p>(ii) the use of referral mechanisms that effectively link such services to appropriate treatment and intervention services in the school and in the community, where appropriate;</p> <p>(iii) forming partnerships between school-based mental health programs and public or private mental health organization; and</p> <p>(iv) addressing issues related to school conditions for student learning, such as safety, peer interaction, drug and alcohol abuse, and chronic absenteeism.</p> <p>Section 1111 & 1112.</p> <p>1112. (b) PLAN PROVISIONS. To ensure that all children receive a high-quality education, and to close the achievement gap between children meeting the challenging State academic standards and those children who are not meeting such standards, each local educational agency plan shall describe—(11) how the local educational agency will support efforts to reduce the overuse of discipline practices that remove students from the classroom, which may include identifying and supporting schools with high rates of discipline, disaggregated by each of the subgroups of students, as defined in section 1111(c)(2).</p>
<p><u>P.L. 114-95, 129 Stat. 1802</u> <u>(Every Student Succeeds Act)</u> § 1111(g)(1)(E) § 1112(c)(5)(B)</p> <p><u>Texas Education Code</u> §§ 25.001(g), (g-1) § 25.002(g) § 25.007(b)(1)</p> <p><u>Texas Family Code</u> § 264.1072 §264.115</p>	<p>*While not copied in their entirety here, these provisions help promote educational stability, so that the Department and local school district(s) should work together to help a foster child remain at his or her school of origin if it is in the child’s best interest to do so. If it is better for the child to be moved, these provisions also require prompt enrollment and prompt transfer of records for foster children.</p>
<p>42 USC § 1396d(a)(13)</p> <p>*Medicaid: broad</p>	<p>The term “medical assistance” means payment of part or all of the cost of the following care and services –</p>

<p>coverage that could be interpreted to include trauma-related care, especially when practitioners are properly trained to recognize the need for screening, assessment and treatment in the children they serve</p>	<p>(13) other diagnostic, screening, preventive and rehabilitative services, including—</p> <p>(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.</p>
<p>25 Texas Administrative Code § 416.3</p> <p>25 Texas Administrative Code § 416.5</p> <p>25 Texas Administrative Code § 416.10</p> <p>*State statutory provisions allowing STAR Network (Medicaid) funds for treatment of trauma-related services to the child and his/her caregivers</p>	<p>(47) Serious Emotional Disturbance or SED—A diagnosed mental health disorder that substantially disrupts a child’s or adolescent’s ability to function socially, academically or emotionally.</p> <p>(31) Mental Health Disorder—Health conditions involving changes in thinking, mood, and/or behaviors that are associated with distress or impaired functioning.</p> <p>An individual is eligible for MH rehabilitative services if—the individual is . . . a child or adolescent with a serious emotional disturbance (SED)</p> <p>(1) Skills training and development services is training provided to an eligible individual or the LAR (legally authorized representative) or primary caregiver of an eligible adult, child, or adolescent. Such training:</p> <p>(A) addresses serious mental illness or SED and symptom-related problems that interfere with the individual’s functioning and living, working, and learning environment;</p> <p>(B) provides opportunities for the individual to acquire and improve skills needed to function as appropriately and independently as possible in the community; and</p> <p>(C) facilitates the individual’s community integration and increases his or her community tenure.</p> <p>(2) Skills training and development services consist of teaching an individual the following skills:</p> <p>(A) skills for managing daily responsibilities (e.g., paying bills, attending school, and performing chores);</p> <p>(B) communication skills (e.g., effective communication and recognizing or change problematic communication styles);</p> <p>(C) pro-social skills (e.g., replacing problematic behaviors with behaviors that are socially and culturally appropriate or developing interpersonal relationship skills necessary to function effectively with family, peer, teachers, or other people in the community);</p> <p>(D) problem-solving skills;</p>

	<p>(E) assertiveness skills (e.g., resisting peer pressure, replacing aggressive behaviors with assertive behaviors, and expressing one's own opinion in a manner that is socially appropriate);</p> <p>(F) social skills and expanding the individual social support network, (e.g., selection of appropriate friends and healthy activities);</p> <p>(G) stress reduction techniques (e.g., progressive muscle relaxation, deep breathing exercises, guided imagery, and selected visualization);</p> <p>(H) anger management skills (e.g., identification of antecedents to anger, calming down, stopping and thinking before acting, handling criticism, avoiding and disengaging from explosive situations);</p> <p>(I) skills to manage the symptoms of serious mental illness or SED and to recognize and modify unreasonable beliefs, thoughts and expectations;</p> <p>(J) skills to identify and utilize community resources and informal supports;</p> <p>(K) skills to identify and utilize acceptable leisure time activities (e.g., identifying pleasurable leisure time activities that will foster acceptable behavior); and</p> <p>(L) independent living skills (e.g., money management, accessing and using transportation, grocery shopping, maintaining housing, maintaining a job, and decision making).</p> <p>(3) Skills training and development services consist of:</p> <p>(A) assisting the child or adolescent in learning the skills described in paragraph (2) of this subsection; and</p> <p>(B) increasing the LAR's or primary caregiver's understanding of and ability to respond to the individual's needs identified in the uniform assessment or documented in the recovery plan.</p>
<p>Texas Government Code § 533.0052</p> <p>*STAR HEALTH to “offer” training to physicians and providers (may be updated in current legislative session)</p>	<p>STAR HEALTH PROGRAM: TRAUMA-INFORMED CARE TRAINING.</p> <p>(a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients under the STAR Health program must include a requirement that trauma-informed care training be offered to each contracted physician or provider.</p> <p>(b) The commission shall encourage each managed care organization providing health care services to recipients under the STAR Health program to make training in post-traumatic stress disorder and attention-deficit/hyperactivity disorder available to a contracted physician or provider within a reasonable time after the date the physician or provider begins providing services under the managed care plan.</p>
<p>Texas Family Code § 264.015</p> <p>*Required training in trauma-informed program and services (may be updated in current legislative</p>	<p>a) The department shall include training in trauma-informed programs and services in any training the department provides to foster parents, adoptive parents, kinship caregivers, department caseworkers, and department supervisors. The department shall pay for the training provided under this subsection with gifts, donations, and grants and any federal money available through the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Pub. L. No. 110-351).</p> <p>The department shall annually evaluate the effectiveness of the training provided under this subsection to ensure progress toward a trauma-informed system of care.</p>

<p>session)</p>	<p>(b) The department shall require department caseworkers and department supervisors to complete an annual refresher training course in trauma-informed programs and services.</p> <p>(c) To the extent that resources are available, the department shall assist the following entities in developing training in trauma-informed programs and services and in locating money and other resources to assist the entities in providing trauma-informed programs and services:</p> <ol style="list-style-type: none"> (1) court-appointed special advocate programs; (2) children's advocacy centers; (3) local community mental health centers created under Section 534.001, Health and Safety Code; and (4) domestic violence shelters.
<p>Texas Family Code § 263.5031</p> <p>*Responsibilities of the Court at the PMC Hearing</p>	<p>PERMANENCY HEARINGS FOLLOWING FINAL ORDER.</p> <p>At each permanency hearing after the court renders a final order, the court shall . . . review the permanency hearing to determine—</p> <ul style="list-style-type: none"> • the safety and well-being of the child and whether the child's needs, including any medical or special needs, are being adequately addressed; • the continuing necessity and appropriateness of the placement of the child, including with respect to a child who has been placed outside of this state, whether the placement continues to be in the best interest of the child; • if the child is placed in institutional care, whether efforts have been made to ensure that the child is placed in the least restrictive environment consistent with the child's best interest and special needs; • whether the child is receiving appropriate medical care and has been provided the opportunity, in a developmentally appropriate manner, to express the child's opinion on any medical care provided; • for a child receiving psychotropic medication, whether the child: <ul style="list-style-type: none"> ○ has been provided appropriate nonpharmacological interventions, therapies, or strategies to meet the child's needs; or ○ has been seen by the prescribing physician, physician assistant, or advanced practice nurse at least once every 90 days; • whether an education decision-maker for the child has been identified, the child's education needs and goals have been identified and addressed, and there are major changes in the child's school performance or there have been serious disciplinary events
<p>Texas Family Code § 266.007</p> <p>*Judicial Review of Medical Care</p>	<p>JUDICIAL REVIEW OF MEDICAL CARE. (a) At each hearing under Chapter 263, or more frequently if ordered by the court, the court shall review a summary of the medical care provided to the foster child since the last hearing. The summary must include information regarding:</p> <ol style="list-style-type: none"> (1) the nature of any emergency medical care provided to the child and the circumstances necessitating emergency medical care, including any injury or acute illness suffered by the child; (2) all medical and mental health treatment that the child is receiving and the child's progress with the treatment; (3) any medication prescribed for the child, the condition, diagnosis, and symptoms for which the medication was prescribed, and the child's progress with the medication; (4) for a child receiving a psychotropic medication: <ol style="list-style-type: none"> (A) any psychosocial therapies, behavior strategies, or other non-pharmacological interventions that have been provided to the child; and (B) the dates since the previous hearing of any office visits the child had with the prescribing physician, physician assistant, or advanced practice nurse as required by Section 266.011; (5) the degree to which the child or foster care provider has complied or failed to comply with any plan of medical treatment for the child; (6) any adverse reaction to or side effects of any medical treatment provided to the

	child . . .
Texas Family Code § 266.011 *Monitoring Use of Psychotropic Medications	MONITORING USE OF PSYCHOTROPIC DRUG. The person authorized to consent to medical treatment for a foster child prescribed a psychotropic medication shall ensure that the child has been seen by the prescribing physician, physician assistant, or advanced practice nurse at least once every 90 days to allow the physician, physician assistant, or advanced practice nurse to: (1) appropriately monitor the side effects of the medication; and (2) determine whether: (A) the medication is helping the child achieve the treatment goals; and (B) continued use of the medication is appropriate.
Texas Family Code § 266.012 *Requirements for Comprehensive Assessments: Trauma-Focused	COMPREHENSIVE ASSESSMENTS. (a) Not later than the 45th day after the date a child enters the conservatorship of the department, the child shall receive a developmentally appropriate comprehensive assessment. The assessment must include: (1) a screening for trauma; and (2) interviews with individuals who have knowledge of the child's needs. (b) The department shall develop guidelines regarding the contents of an assessment report.
Texas Family Code § 266.004 *Training Required for Medical Consenter	CONSENT FOR MEDICAL CARE. (a) Medical care may not be provided to a child in foster care unless the person authorized by this section has provided consent. A person may not be authorized to consent to medical care provided to a foster child unless the person has completed a department-approved training program . . . The training required by Subsection (h) must include training related to informed consent for the administration of psychotropic medication and the appropriate use of psychosocial therapies, behavior strategies, and other non-pharmacological interventions that should be considered before or concurrently with the administration of psychotropic medications.
Texas Family Code § 266.0042 *Requirements for Consent for Psychotropic Medications	CONSENT FOR PSYCHOTROPIC MEDICATION. Consent to the administration of a psychotropic medication is valid only if: (1) the consent is given voluntarily and without undue influence; and (2) the person authorized by law to consent for the foster child receives verbally or in writing information that describes: (A) the specific condition to be treated; (B) the beneficial effects on that condition expected from the medication; (C) the probable health and mental health consequences of not consenting to the medication; (D) the probable clinically significant side effects and risks associated with the medication; and (E) the generally accepted alternative medications and non-pharmacological interventions to the medication, if any, and the reasons for the proposed course of treatment.
Texas Family Code § 107.002 *Relevant Roles & Responsibilities of Guardian ad Litem	POWERS AND DUTIES OF GUARDIAN AD LITEM FOR CHILD. A guardian ad litem appointed for a child under this chapter is not a party to the suit but may: <ul style="list-style-type: none"> • conduct an investigation to the extent that the guardian ad litem considers necessary to determine the best interests of the child; and • obtain and review copies of the child's relevant medical, psychological, and school records. A guardian ad litem appointed for the child under this chapter shall within a reasonable time after the appointment, interview the child in a developmentally appropriate manner . . .and seek to elicit in a developmentally appropriate manner the child's expressed objectives. A guardian ad litem appointed for a child in a proceeding under Chapter 262 or 263

	<p>shall</p> <ul style="list-style-type: none"> • review the medical care provided to the child; and • in a developmentally appropriate manner, seek to elicit the child's opinion on the medical care provided
<p>Texas Family Code § 107.003</p> <p>*Relevant Roles and Responsibilities of Attorney ad Litem (may be updated in current legislative session)</p>	<p>POWERS AND DUTIES OF ATTORNEY AD LITEM FOR CHILD. An attorney ad litem appointed to represent a child or an amicus attorney appointed to assist the court shall . . .</p> <ul style="list-style-type: none"> • interview the child in a developmentally appropriate manner. . . and seek to elicit in a developmentally appropriate manner the child’s expressed objectives of representation. • investigate the facts of the case to the extent the attorney considers appropriate; and • obtain and review copies of relevant records relating to the child as provided by Section 107.006. <p>An attorney ad litem appointed to represent a child . . . must be trained in child advocacy or have experience determined by the court to be equivalent to that training.</p> <p>An attorney ad litem appointed for a child in a proceeding under Chapter 262 or 263 shall:</p> <ul style="list-style-type: none"> • review the medical care provided to the child; • in a developmentally appropriate manner, seek to elicit the child's opinion on the medical care provided; and • for a child at least 16 years of age, advise the child of the child's right to request the court to authorize the child to consent to the child's own medical care under 266.010.

<p>Training Requirements & Movement Toward a Trauma-Informed System of Care in the Texas Juvenile Justice System</p>	<p>Texas Government Code § 244.0106 (b) The rules adopted under this section must require the department and the Department of Family and Protective Services to cooperate in providing appropriate services to a child for whom the Department of Family and Protective Services has been appointed managing conservator while the child is committed to the department or released under supervision by the department, including: (7) trauma informed care.</p> <p>Texas Human Resources Code §221.002 (a) The board shall adopt reasonable rules that provide: (3) appropriate educational, preservice, and in-service training, and certification standards for probation and detention officers or court-supervised community-based program personnel;</p> <p>(c-1) In adopting rules under Subsection (a)(3), the board shall require probation officers, juvenile supervision officers, and court-supervised community-based program personnel to receive trauma-informed care training. The training must provide knowledge, in line with best practices, of how to interact with juveniles who have experienced traumatic events.</p> <p>Texas Human Resources Code §221.0061. TRAUMA-INFORMED CARE TRAINING. The department shall provide trauma-informed care training during the preservice training the department provides for juvenile probation officers, juvenile supervision officers, juvenile correctional officers, and juvenile parole officers. The training must provide knowledge, in line with best practices, of how to interact with juveniles who have experienced traumatic events.</p> <p>Texas Human Resources Code §242.009 (b) The department shall provide competency-based training to each juvenile correctional officer employed by the department, which must include on-the-job training. Each officer must complete at least 300 hours of training in the officer’s first year of employment, with at least 240 hours of training before the officer independently commences the officer’s duties at the facility. The officer must demonstrate competency in the trained subjects as required by the department. The training must provide the officer with information and instruction related to the officer’s duties, including information and instruction concerning: (19) trauma-informed care.</p>
<p>Psychopharmacology for Children in the Juvenile Justice System</p>	<p>Texas Administrative Code §380.9191 (b) Under no circumstances are tranquilizers, psychostimulants or psychotropic medications administered: (1) for discipline, security, or control purposes</p>



Texas Lawyers for Children

- Protecting Abused Children from Further Harm -

3131 Turtle Creek Blvd., Suite 1018 • Dallas, Texas • 75219

P: (214)-219-5TLC (5852) • F: (214)-219-5851 • www.TexasLawyersforChildren.org

A Girl's Story

A Child's Experience in a Foster Care System That Is Not Trauma Informed

by

Kristen A. Bell, J.D., Program Attorney, Texas Lawyers for Children

Imagine a 10-year-old girl who wakes each morning, tiptoeing to the kitchen, only to hear her stepfather whisper her name, wave her into the family's small bathroom, his finger across his lips to say, "Shhhh!!" She timidly enters, the smell of bacon follows her inside, and he motions for her to shut the door. He pulls her close, playing with the hair that reaches the small of her back. Her heart begins to beat rapidly, but she knows there is no escape. She has said something to her mom before, and it only got worse.

After two and a half years of being raped by her stepfather, she finally finds a friend she trusts enough to tell what has happened. When the investigator shows up, she is surprised. She doesn't know if she should tell the truth or not—if she tells the truth, and they don't believe her, what will happen to her then? She knows that the investigator's presence will already create trouble, so she decides to try the truth. She is given a few minutes to pack a small bag while her mother yells at her for ruining her life. She can hear the sirens as they blare down the street, her stepfather's face growing more and more angry and unpredictable. Her little sister is crying because she has to leave, too, and doesn't understand why. Neighbors start to pile outside, while the girl and her sister are both loaded into the backseat of an investigator's car. They sit in silence for hours, driving away from anything familiar.

Eventually, they arrive at a home. It is already dark outside, and they are greeted by an older man and woman. The woman reaches around and touches her back, running her fingers through her hair, just like her stepfather used to do. The girl quickly looks down, unable to make eye contact, and her back bristles. That evening, when it is time to use the restroom, her memories emerge and she is too frightened to go. Because she shares a room with her sister, who is asleep from exhaustion, and another girl she doesn't know, she must stifle her emotions and spends much of the night staring at the ceiling. She finally falls asleep but wakes a few hours later to wet sheets and clothing and the smell of bacon wafting into the room. The young girl begins to cry, pulls the sheets frantically off the bed, and refuses to eat. She remembers the last time she smelled bacon, and her heart races uncontrollably. She can hear the older woman on the phone, "I thought these girls were at a Basic level of care. The little one can stay, but the older one has to go."

A few days later, another worker arrives and gives her five minutes to pack up her things. Her sister stares ahead, sad to see her go but also angry that she put them in this situation. The worker is taking the girl to another home, for children "more like her". On the way, the worker stops at an appointment where the girl and the worker are given hundreds of questions to mark "Never", "Sometimes", "Always". *Depression and Anxiety Disorder*, she hears. The doctor writes a few prescriptions and says, "This should help."

At the new home, there are more kids. They stare at her when she enters with her small bundle wrapped in her arms; two girls groan when they find out they have a new roommate. She is told that the bus will arrive at 7:10 to take her to her new school. She only has the clothes on her back. She wakes the next morning, sweating and her heart pounding. Then, she smells it: bacon. She runs to the restroom, but in her panicked state, she cannot make herself shut the door. When she exits the bathroom, her new foster mother puts her arm around the girl,

playing with her hair, “Honey, you have to close the door when you use the restroom. There are other children here. Now, come in the kitchen and eat.” Remembering his hand on her hair and the closed bathroom door, the girl is consumed with an overwhelming urge to flee and runs out the front door.

The police are called, and they bring her back. “Sorry, Officers, we haven’t tried her medication yet. Hopefully that will help.” She is given two pills that day and the next morning before school. On the bus, she notices that she is extremely drowsy and unable to concentrate. After four weeks at the new home, she is still eating very little, unable to close the bathroom door, and occasionally wetting the bed. Her foster mom is fed up with her “unwillingness” to follow the rules of the house and feels she is creating a bad influence on the other children. Then, her first progress report comes home, and she is failing three out of four core academic classes. When her foster mother asks why she is failing, the girl only responds with, “I don’t know.” She used to make A’s and B’s at her old school; she doesn’t know why she can’t pay attention here.

On to a new home and then another, and another, and another, and another, and another. One night, one of the teenage girls in her room puts her finger up to her mouth to say “Shh!!” and motions for the girl to come sit on her bed. Before even being aware of her own actions, the now 12-year-old girl has run through the front door and down the street. After the police have returned the girl again, the foster mother makes a call, and later that night, another worker arrives. “It looks like you may do better in a more secure facility,” the worker says and drives her to a place that looks more like a hospital than a home.

The doors clang shut behind her. Within the first 24 hours, she meets with several counselors and doctors. She is given hundreds of more questions to answer “Never”, “Sometimes” and “Always”, and she answers a bit differently this time, unable to think clearly and less sure of herself than before. *Bipolar Disorder* and *Severe Depression*. She now has a handful of different medications to take to make her “feel better”, but a few days after she starts them, her mind is racing, and she feels agitated all the time. Now, when she smells bacon cooking in the morning or someone brushes up against her hair or skin, she is filled with uncontrollable panic which makes her cry and thrash and kick. Once, when she bit at the workers as they tried to hold her down, two huge male staff threw her to the ground and restrained her for hours as she shrieked for help, tears streaming down her face. This awakened new fears and a rage she has never experienced before. She cannot learn, and she cannot focus. She asks where her sister is, and no one can tell her. She grows more and more distrustful of the adults around her and seeks anything to quiet the constant humming inside of her. She just wants to get outside of these walls, and occasionally, the now 16-year-old girl is able to escape, where she finds momentary comfort in sex with people she does not know and escape through a cocktail of drugs she buys on the street. She returns, only to have her medications altered and restrictions increased.

The facility counselors start to talk with her about life when she “ages out” of foster care and becomes responsible for herself. Although she has been passed from grade to grade, she does not have a workable reading comprehension level above 3rd grade and can only perform the most basic of math computations. She has never prepared a meal, filled out an application, or even made a handful of decisions for herself. They ask, “What training do you think you might need to function as an adult?” She doesn’t know how to respond; she has not ever really *functioned* before. A few months after turning 18 and leaving care, she is homeless and selling her body for drugs. By the age of 19, she is pregnant, and the cycle continues.

At each level of the girl’s journey in the story above, the girl was harmed by caregivers and professionals within the child protection system. She was harmed when she experienced a traumatic removal from her home. She was harmed when her caregivers did not understand the events that triggered traumatic memories, and therefore, saw her response as “willful disobedience” and asked her to be moved because they did not know how to handle her. She was harmed when each transition brought a new caseworker, so that she felt alone when she left her family, alone when she left her sister, and alone when she was institutionalized. She was harmed when counselors and doctors failed to properly screen for trauma or recognize her need for trauma-informed therapy and, instead, labeled her with mental illnesses and placed her on multiple psychotropic medications that

decreased her ability to behave within “normal” expectations. She was harmed when she was placed with an older child in the Residential Treatment Center, without any regard for that child’s past history, or the girl’s susceptibility to re-traumatization. The six years she spent in the PMC of the State heaped trauma upon trauma on an already fragile child until, eventually, she shattered.

Unfortunately, for far too many children in Texas, this story is not the script of a tragic movie, but their horrifying reality. At each point of harm, a trauma-informed system of care could have responded differently, with more informed decisions and more responsive care. To change the story for this girl, and the thousands of children who will enter foster care in years to come, the State must adopt and make investments in a trauma-informed system of care that leads to healing for children, instead of harm.