**No. 2:11-CV-00084**

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**In the United States District Court**
**Southern District of Texas –**
**Corpus Christi Division**

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**M.D.; bnf Stukenburg, et. al.,**

**Plaintiffs**

**v.**

**Greg Abbott, et. al.,**

**Defendants**

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# AMICUS BRIEF OF TEXAS LAWYERS FOR CHILDREN IN SUPPORT OF PLAINTIFFS, MINOR CHILDREN IN THE PERMANENT MANAGING CONSERVATORSHIP OF THE TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

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## Identity and Interest of Amicus Curiae

Texas Lawyers for Children ("TLC") is a 501(c)(3) nonprofit organization with the mission of improving court case outcomes for abused and neglected children. Through an online system, TLC provides free resources, communication tools, access to pro bono attorneys, and low-cost training to attorneys and judges who handle cases involving children in the Texas child welfare system. TLC also advocates on behalf of foster children's legal rights. The views expressed in this brief are solely those of the nonprofit itself and are not intended to represent the views of the judges and attorneys who use TLC's services.

**Argument**

In the December 2015 Memorandum Opinion and Verdict of the Court, this Court concluded that Texas currently violates the substantive due process rights of children in the permanent managing conservatorship of the State ("PMC") to be "free from an unreasonable risk of harm caused by the State." *MD v. Abbott*, 152 F.Supp.3d 684, 828 (S.D. Tex. 2015). In an effort to address this violation of children's constitutional rights, this Court specified certain Goals and outlined an Implementation Plan to overcome practices that create unconstitutional harm for children in the Texas foster care system. *Id.* at 823-825. In addition to these Goals, this Court explicitly required the Special Masters to "recommend any provision beyond the Court's [stated] Goals that are deemed necessary to cure the State's constitutional violations outlined in th[e] Opinion." *Id.* at 826.

In March 2016, two Special Masters were appointed. *See* Appointment Order, Doc. 379, Case No. 2:11-cv-00084. After eight months of study related to the Texas foster care system, the Special Masters presented their recommendations. *See* Special Masters Recommendations to Judge Jack, Doc. 471, Case No. 2:11-cv-00084 (November 4, 2016) ("Recommendations"). Their review of the Texas foster care system revealed two areas beyond the stated Goals that must be addressed to cure the State's violation of PMC children's constitutional rights:

(7.1) Because the Court observed that "'rape, abuse, psychotropic medication, and instability were the norm' for PMC children, and many children's records. . . were missing important medical information . . . [the Special Masters] recommend[ed] that DFPS develop and implement a Health Care Plan for PMC children," and the Health Care Plan should include "(F) [t]he provision of mental health assessments by a qualified professional for all PMC children within 60 days of entry to the PMC

class, and the delivery of necessary follow up care, as needed" ("Health Care Plan"); and

(7.2) The Special Masters recommended "to reduce the risk of harm to PMC children that DFPS propose a plan, with specific timeframes and activities, to identify and address PMC children's exposure to traumatic events such as, for example, abuse, neglect, removal from their birth families, placement moves and sibling separation." ("Trauma Plan").

On December 4, 2017, the Special Masters filed an Implementation Plan, which represents the Special Master's final report to the Court. *See* Implementation Plan, submitted by Special Master Kevin M. Ryan, at 2 ("Implementation Plan"). The Special Masters were correct that identification of trauma, and treatment that addresses trauma, are necessary to reduce the risk of harm to PMC children. Amicus recognizes, however, that the most recent Implementation Plan does not include any specific guidelines to address the issue of trauma for children in the PMC of the State. Amicus respectfully requests that the Court's final order include the requirement that medical and mental health professionals who provide mental health services to children in the PMC of the State are trained in trauma, as outlined in this brief.

In the Implementation Plan, the Special Masters highlight evidence from the record that support the idea that children who age out of care experience "serious, and often disabling, physical and mental health issues" due to trauma. *Id.* at 19. Amicus agrees and asks the Court to include these provisions in her final order, in light of recent research that shows how a system that does not address the needs of traumatized children, especially those in the PMC of the State, creates for them an unreasonable risk of harm.

In their Recommendations, the Special Masters conclude that "abuse, neglect, and removal from [the child's] birth families" are traumatic events. Therefore, *every* child in the PMC of the State has been impacted by *one* underlying affliction that affects the mental, emotional, behavioral, and physical needs and responses of the child – mainly trauma. Given the repeated sexual abuse, rejection, instability, and turnover of adults that children in PMC face, it is likely that these children face numerous traumatic experiences throughout their childhood. Yet, the State of Texas does not require medical or mental health professionals who make decisions for children in the PMC of the State to have any training in trauma. Instead, the State continues to contract with and pay professionals that do not have training in trauma for the mental health services they provide to traumatized children, which include assessment of the child's overall mental health needs, diagnosis of mental conditions, provision of treatment and therapies, prescription of psychotropic medications, and referral to residential treatment centers ("RTCs") and psychiatric hospitals (collectively, "Mental Health Services").

This practice of contracting with and paying professionals who do not have any training in trauma to evaluate, diagnose, treat, and/or prescribe psychotropic medication that can have life-altering, permanent consequences for PMC children and to make referrals to RTCs and psychiatric hospitals causes an unreasonable risk of harm to these children. Lack of proper training regarding the impact of trauma results in these children being misdiagnosed, overmedicated, institutionalized, and never receiving the actual help they need—trauma-informed interventions and therapies. The harm that results from this practice can be directly linked to the downward spiral children in the PMC of the State experience (including, but not limited to, placement disruption and constant instability, unsubstantiated changes in children's levels of care, and a

failure to develop necessary life skills), which causes these children to "almost uniformly leave State custody more damaged than when they entered." *M.D. v. Abbott*, 152 F.Supp.3d at 828.

The State is aware of the need for trauma training to protect children in its care. State statutes require foster parents, adoptive parents, kinship caregivers, department caseworkers, and department supervisors to be trained in trauma; in addition, children's advocacy centers who contract with the State must have "specialized trauma-focused mental health services that are designed to meet the unique needs of child abuse victims." *See* Tex. Fam. Code § 264.015, § 264.411(10)(F). Yet, medical and mental health professionals who contract with and are paid by the State to provide Mental Health Services to children in the PMC of the State only have to be "offered" training on trauma. *See* Tex. Gov't Code § 533.0052.

In light of the staggering support for the need for trauma-informed Mental Health Services, this deliberate choice not to require or fund trauma training for medical and mental health professionals directly harms foster children, as evidenced by the experiences of the representative PMC children identified in this Court's opinion. Therefore, Amicus respectfully urges this Court to order that the State is prohibited from contracting with and/or paying medical and mental health professionals to provide Mental Health Services to children in the PMC of the State unless these professionals have had adequate and appropriate training in trauma. Amicus further respectfully urges this Court to order that the State, through the Texas Department of Family and Protective Services ("Department"), provide this training, free of charge, to ensure that there are enough qualified medical and mental health professionals to protect children in the PMC of the State from an unreasonable risk of harm and to carry out the provisions of the Special Masters' Health Care Plan and Trauma Plan. These professionals must understand the impact of trauma on children, the overlap of symptoms related to trauma and various mental health disorders, the availability of

trauma-informed treatments and therapies, and the potential risk of harm to these children caused by misdiagnosis, unnecessary medication, and institutionalization. Medical and mental health professionals who have not been provided with this training do not have the information necessary to reduce the risk of harm to children in the PMC of the State by identifying trauma, addressing trauma, conducting accurate mental health assessments, and providing delivery of necessary follow up care to traumatized children, as required by the Health Care Plan and Trauma Plan. This current structural deficiency in DFPS policy and practice causes unreasonable risk of harm to children in the PMC of the State and must be resolved. *See M.D. v. Abbott,* 152 F.Supp.3d at 822.

**A. The trauma that abused and neglected children experience affects their physical, emotional, and mental health needs, and because of the nature of prolonged substitute care, PMC children face an unusually high risk of long-term harm when the effects of trauma are misunderstood, go untreated, or when children continue to be exposed to additional traumatic experiences.**

The Substance Abuse and Mental Health Services Administration of the United States ("SAMSHA") defines trauma as the result of "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." 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 7, available at: http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf. Children in the PMC of the State have often been exposed to "multiple traumatic events over time that are severe, pervasive, and interpersonal in nature (such as repeated abuse and neglect)." *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 Brief"). When a child is exposed to prolonged activation of stress hormones in the absence of a protective adult relationship, the stress can become toxic. *See* "Adverse Childhood Experiences and the Lifelong Consequences of Trauma." American Academy of Pediatrics (2014), available at: www.aap.org/traumaguide ("AAP Trauma Guide"). A growing national study highlights the overwhelming evidence of the effects of trauma and identifies numerous negative outcomes that stem from adverse childhood experiences ("ACEs") (traumatic or stressful events that take place in childhood), and to date, has found that the more ACEs a person experiences, especially if the trauma is not addressed, the more likely that child will exhibit health problems (obesity, diabetes, depression, suicide attempts, STDs, heart disease, cancer, stroke, COPD, broken bones), behavioral problems (smoking, alcoholism, drug abuse), and loss in life potential (graduation rates, academic achievement, lost time from work). *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. In fact, the American Academy of Pediatrics states in its guide on trauma that "[n]ever before in the history of medicine have we had better insight into the factors that determine the health of an individual from infancy to adulthood." AAP Trauma Guide at 2. As evidenced by these research findings, children in the PMC of the State, who have been exposed to years of traumatic experiences without the opportunity for healthy child development, are highly and uniquely susceptible to suffer long-term negative consequences associated with trauma. *See id.* at 4-5 (describing healthy attachment relationships, the ability to regulate emotions and behavior, and supportive environmental systems as related to counterbalancing the negative effects of toxic stress and trauma experienced in childhood, all factors lacking in the experience of many

children in the PMC of the State); *see also* Bath, H. "The Three Pillars of Trauma-Informed Care." Reclaiming Children and Youth, 17(3), 17-21 (2008) (stating that the three pillars of trauma-informed care that lead to healing for children are safety, connection, and the learned ability to regulate emotions). Notably, Dr. William Lee Carter, the plaintiffs' child psychology expert whose testimony was accepted as relevant, reliable, and admissible by this Court, drew haunting conclusions about the psychological decline children in PMC experience that mirror the harms that develop when a child does not receive trauma-informed services: the children do not feel safe, they are not connected to those who make direct decisions about their lives, and, therefore, the negative feelings that they already feel from "disruption[s] in their personal relationships" become compounded, especially for a child in the PMC of the State. *M.D. v. Abbott*, 152 F.Supp.3d at 789.

**B. The State's decision to contract with and pay medical and mental health professionals who do not have any training in trauma for the provision of Mental Health Services to children in the PMC of the State creates an unreasonable risk of harm to PMC children in violation of their constitutional rights.**

When professionals within the foster care system are not trained about the needs of traumatized children and how systemic practices can trigger traumatic memories for abused and neglected children or cause children to be re-traumatized, the system itself increases the child's exposure to trauma and directly causes harm to the children the State has a duty to protect. *See* Children's Bureau Brief, at 3. When medical and mental health professionals are allowed to provide and are even paid for Mental Health Services to traumatized children without any training in trauma, the State creates an unreasonable risk of harm for foster children because this failure leads to misdiagnosis of mental conditions and disorders, misuse of harmful psychotropic medications, and lack of access to adequate care, so that children in the PMC of the State suffer from a lack of adequate treatments and therapies, inappropriate treatments and therapies, placement disruptions, unnecessary institutionalization, and life-long negative outcomes.

One of the most notable harms traumatized children in long-term foster care face is one of misdiagnosis. A review of the Diagnostic and Statistical Manual, Fifth Edition ("DSM-5"), which is the current diagnostic tool published by the American Psychiatric Association and serves as the universal authority for psychiatric diagnoses, reveals that the symptoms of many psychiatric disorders overlap with symptoms related to trauma. *See* Diagnostic and Statistical Manual, Fifth Edition (2013); *see also* Exhibit A (showing a visual depiction of the overlap between symptoms related to trauma and symptoms related to other diagnosable mental conditions); *Children's Mental Health: Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care,* United States Government Accountability Office GAO-13-15 (2012), 15, available at: http://www.gao.gov/assets/660/650716.pdf ("[C]hild mental health experts have stated that the traumatic stress symptoms foster children may experience are often the same as symptoms that can indicate other mental health conditions, which may lead to misdiagnosis and inappropriate treatments") ("GAO Report"). In fact, according to the American Academy of Child and Adolescent Psychiatry, "there is clinical consensus that children with severe PTSD may present with extreme dysregulation of physical, affective, behavioral, cognition and/or interpersonal functioning that is not adequately captured in current descriptions of PTSD diagnostic criteria. Some of these children may be misdiagnosed with bipolar disorder because of severe affective dysregulation related to PTSD; others may have true bipolar disorder but also need attention to their trauma symptoms." *AACAP Official Action: Practice Parameters for the Assessment and Treatment of Children and Adolescents With Posttraumatic Stress Disorder*, 49(4) Journal of the American Academy of Child & Adolescent Psychiatry 414, 415-416 (April 2010); *see id.* at 420 (discussing how PTSD symptoms also may be confused with symptoms of ADHD, oppositional defiant disorder, panic disorder, anxiety disorder, obsessive-compulsive disorder, or major

depressive disorder) ("AACAP Practice Parameters"). The American Academy of Pediatrics agrees, suggesting that "[a] high index of suspicion for trauma should be maintained to avoid diagnostic errors," including depression, ADHD, developmental delay, oppositional defiant disorder, conduct disorder, and bipolar disorder. *See* "Helping Foster and Adoptive Families Cope with Trauma," American Academy of Pediatrics, at 8, available at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Guide.pdf) ("Helping Foster Families, AAP"). Not only do these overlapping symptoms carry the unreasonable risk of harm that a foster child will be incorrectly diagnosed by a medical or mental health professional that is not adequately trained in trauma, a child in long-term foster care can also receive an incorrect diagnosis of several different psychiatric disorders, as the child's symptoms do not clearly fit in the diagnostic criteria of any specific disorder. Unfortunately, the threat of misdiagnosis is real, not theoretical. In a recent national study, 80% of children who age out of foster care have received a psychiatric diagnosis, compared with 22% of young adults in the general population who will be diagnosed with a mental health condition. *See* Helping Foster Families, AAP, at 2; *cf.* "Any Mental Illness Among Adults," National Institute of Mental Health, available at: https://www.nimh.nih.gov/health/Statistics/prevalence/Any-mental-illness-ami-among-us-adults.shtml. The difference between the two statistics is staggering. Children do not enter foster care because they have a mental illness; they enter foster care because they were abused and neglected by those closest to them. These children, dependent on the State to be free from State action that causes psychological deterioration, continue to suffer in foster care because they do not have access to trauma-informed Mental Health Services. The negative effects of misdiagnosis on the child's adolescent experience and future life cannot be overstated. When medical and mental health professionals do not have training in trauma related to abuse and

neglect, they are not aware of the need to take trauma into account when assessing, diagnosing and treating a child, and psychological harm results in any number of ways.

One of the psychological harms that results from misdiagnosis is unnecessary use of psychotropic medication on children. The overuse of psychotropic medication among children in foster care has been well documented. In a study of the use of psychotropic medication among foster children, the GAO cited research that indicates that foster children take psychotropic medication at a rate that is much higher than the rate of other children on Medicaid in a given state population (21% to 39% for foster children, 5% to 10% for other children on Medicaid). *See* GAO Report, at 10 (Texas was one of the states studied as the basis of this research). A recent update by the Texas Department of Health and Human Services confirms that these alarming numbers are still accurate for adolescent children in the Texas foster care system: 36% of foster children in Texas, aged 13-17, remained on psychotropic medication(s) for more than 60 days. *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/default/files/documents/services/health/other/update-on-psych-meds-in-tx-foster-children.pdf. While sometimes needed to address an emergency situation or diagnosis of a concurrent mental health condition, unnecessary use of psychotropic medication is not a benign error: these drugs can cause harmful side effects and, if used incorrectly due to misdiagnosis of a mental health disorder, these drugs can make the child's behavior and condition worse. *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).

According to the GAO Report, of the children on Medicaid who took psychotropic medication, 61% of those children did not receive any other type of mental health services or therapies. *See* GAO Report, at 19. Recognizing the harms of sole reliance on pharmacological interventions to control children's behavior, Texas has created clear directives against this practice. The Parameters, developed by the Texas Department of Family and Protective Services, states that "[g]iven the history of trauma, unusual stress and change in environmental circumstances associated with being a child in foster care, psychotherapy should generally begin before or concurrent with prescription of a psychotropic medication. Referral for trauma-informed, evidence-based psychotherapy should be considered when available and appropriate." *See* Parameters, at 3. In addition, according to Texas statute, a judge must review non-pharmacological interventions made available to the child, and the person responsible for consenting to a foster child's use of psychotropic medication should ensure that the child has been provided appropriate non-pharmacological interventions prior to or concurrent with the use of psychotropic medication. *See* Tex. Fam. Code §§ 266.007(4)(a), 266.004(h-1). This follows the advice of the American Academy of Child & Adolescent Psychiatry, which has determined that "[t]rauma-focused psychotherapies should be considered first-line treatments for children and adolescents with PTSD." AACAP Practice Parameters, at 421.

Unfortunately, it is nearly impossible for children in the PMC of the State to access trauma-informed, non-pharmacological treatment services because lack of training also means lack of a qualified pool of medical and mental health service providers. GAO Report, at 14 (While not

specifically referring to trauma-informed therapies, the GAO Report states, "finding a mental health professional who has been trained to provide a specific EBT [evidence-based therapy] can be a challenge because training in EBTs is not uniformly required in medical and professional schools."). Even as late as 2014, researchers found that instruction regarding the impact of trauma on children was not extensive in a survey of graduate-level mental health curricula. *See* Cook, J. and Newman, E. "A Consensus Statement on Trauma Mental Health: The New Haven Competency Conference Process and Major Findings." Psychological Trauma: Theory, Research, Practice & Policy. 6:4, 300 (2014). In 2015, the American Psychological Association created guidelines to improve education and training for entry-level psychologists, recognizing the unmet need for therapists to be adequately trained in trauma-informed therapies. *See* American Psychological Association, "Guidelines on Trauma Competencies for Education and Training" (2015), available at: https://www.apa.org/ed/resources/trauma-competencies-training.pdf. Furthermore, a recent survey in Texas revealed that many mental health practitioners are not certified in any trauma-informed modalities. This same survey concluded that "increased access to trauma-focused treatments for children in the child welfare system" was one of the most important steps policy makers could take to help make the child welfare system more trauma-informed. *See* Crockett, S. & Torres-Garcia, A. "Understanding Trauma-Informed Care in the Texas Child Welfare System: Data and Recommendations from the Field." Texas CASA (October 2015), available at: http://texascasa.org/wp-content/uploads/2015/10/FINAL-Trauma-Survey-Report-10.5.15.pdf.

The failure to provide minimal treatment that addresses a child's trauma history causes multiple harms to children within the PMC of the State. Adolescents in the PMC of the State who have experienced trauma throughout their childhood think, feel, and act differently than other

children; failure to understand these distinctions results in a failure to respond appropriately to the child's behaviors. *See* Children's Bureau, "Understanding the Effects of Maltreatment on the Brain," Child Information Gateway Network (Issue Brief, April 2015), at 12-13, available at: https://www.childwelfare.gov/pubPDFs/brain_development.pdf. When a traumatized child does not receive the appropriate therapies and interventions for the trauma he or she has experienced, the child's behavior becomes worse, making the child more susceptible to placement disruptions, which can lead to feelings of shame and additional loss of attachment. *See* "Using Trauma-Informed Child Welfare Practice to Improve Placement Stability Breakthrough Series Collaborative: Promising Practices and Lessons Learned," National Child Traumatic Stress Network (2013), 1, available at: http://www.nctsn.org/sites/default/files/assets/pdfs/using_ticw_bsc_final.pdf. An understanding of trauma, however, recognizes that involving parents (biological, foster, and adoptive, as appropriate) in evidence-based therapy interventions is an important first step in resolving trauma-related symptoms and results in a decrease in child-reported depression and foster parent-reported behavior problems. AACAP Official Action at 421.

A review of the record in *M.D. v. Abbott* highlights the psychological decline that PMC children face when medical and mental health professionals who are not trained in trauma misdiagnose, overmedicate, institutionalize, and fail to provide adequate trauma-informed services. For example, M.D.'s story was full of sexual abuse and placement disruptions, followed by "intensifying behavioral issues," a predictable pattern for children who have experienced trauma and who do not receive trauma-informed Mental Health Services needed to prevent harm. *M.D. v. Abbott*, 152 F.Supp.3d at 719. Yet, trauma was never addressed during her repeated stays in psychiatric hospitals, even as she continued to decline in response to the traumatic events in her life. She received no therapy or treatment related to trauma and quickly declined from a basic to

intense level of care within her first seven months in the PMC of the State. *Id.* at 725. In fact, the staff at the RTCs and mental health institutions where she lived compounded her trauma through physical restraint, incorrect diagnoses of mental illness, overmedication, and even abusive punishment. *See id.* at 727 (As the plaintiffs' child psychology expert concluded, "M.D.'s problems are likely not solvable by medication . . . the State over-relied on psychotropic drugs and overmedicated M.D.").

When D.I. entered the State's care, the psychologist noted emotional and behavioral problems, aggressive behaviors, attention problems, conduct problems, social problems, and rule-breaking behavior—all classic symptoms of a child dealing with the effects of unresolved trauma. *See id.* at 728. While a trained psychologist could have prevented D.I. from experiencing years of harm by identifying and addressing D.I.'s needs in light of the trauma he experienced, D.I. did not have that opportunity. Instead, it was suggested that he had symptoms of ADHD, oppositional defiant disorder, affective/depressive disorder, and anxiety. *Id.* Nine months later, after enduring the additional trauma of sexual abuse, again without access to trauma-informed Mental Health Services, he was severely anxious, depressed, suicidal, and admitted to hearing voices. Now, after the notable absence of any therapy for the trauma he endured or the traumatic symptoms he exhibited, he is seriously "disturbed" and "at a high risk for sexually abusing other children." *Id.* at 730.

S.A. began exhibiting "frequent, uncontrollable, & extreme tantrums" after enduring the trauma of sexual abuse at the age of 5. *Id.* at 732. As a child in the PMC of the State, there is no indication that she received any therapy for the trauma she endured either; instead, she faced 45 placement changes, including stays in psychiatric hospitals, where she was restrained and heavily medicated. One psychologist who identified her for self-abusive and suicidal behavior stated that

she was dangerous and "had a history of not getting along with other children," without any noted reference to the trauma she had experienced. *Id.* at 734. Instead of trauma-informed interventions, her list of psychiatric diagnoses grew, and it was ultimately determined that she would need "long-term psychiatric care." *Id.* at 736. Z.H.'s record indicates no trauma-informed therapy in response to the sexual abuse he endured at the hands of two adult men, but it does indicate four psychiatric hospitalizations with the diagnoses of "several significant psychological disorders" and his adolescence was spent in RTCs where he was heavily medicated. *Id.* at 758-759. Unfortunately, these stories are "typical of the entire foster care system in the state of Texas." *Id.* at 727-728, 731, 737, 765, 760.

While the record includes numerous examples of psychological evaluations, diagnoses of various psychiatric conditions, rampant use of psychotropic medication, and an almost endless cycle of treatment at RTCs and psychiatric institutions, one element that is notably absent is the presence of any evidence-based, trauma-informed treatments and therapies, especially those directed at the children continuing to decline into a psychological abyss. Notably, with the actions found in the record, these children did not get better. In fact, they systematically declined. Instead of feeling safe, becoming connected, and learning to cope with their emotions, these children were subjected to the State's practice of contracting with and paying medical and mental health professionals who do not have any training in trauma to treat traumatized children, which led these children through a gauntlet of placement changes, increased levels of care, increased institutionalization, increased diagnoses and prescription drug use, until they became so damaged they will never be adopted or find a permanent home.

Trauma training likely would have led to decisions that could have prevented the cycle of unreasonable risk of harm to these children, and it will prevent other children in the PMC of the

State from experiencing similar outcomes. Medical and mental health professionals who understand the effects of trauma and appropriate responses for addressing trauma will be more likely to recognize the symptoms of trauma, educate and engage foster families in caring for the child in a way that is trauma-informed to improve placement stability, recognize that the child's behavior is a result of trauma and not evidence of a newly developed mental health disorder, and seek out trauma-informed, non-pharmacological treatments and interventions, instead of prescribing psychotropic medication or referring the child to an RTC or psychiatric facility. An understanding of trauma enables medical and mental health professionals to make decisions that prevent harm to and psychological deterioration of children in the PMC of the State—which would have life-changing consequences for these children.

**C. Adequate training in trauma for medical and mental health professionals who provide Mental Health Services for children in the PMC of the State is necessary to diminish the unreasonable risk of harm identified by this Court and can be accomplished through a relatively small investment of time and resources.**

In order to carry out its duty to prevent an unreasonable risk of harm to children in the PMC of the State, all of whom have experienced trauma, the State must require that medical and mental health professionals who contract with the State and are paid to provide Mental Health Services to children in the PMC of the State are trained in trauma. In addition, the State, through the Department, must provide this training, free of charge, to ensure that children in the PMC of the State are free from an unreasonable risk of harm and that there are enough qualified medical and mental health providers to carry out the provisions of the Special Masters' Health Care Plan and Trauma Plan. Texas already has an online training portal for mental health professionals and could add appropriate courses to this portal at no significant additional cost to the Department. In addition, Texas has several institutes and consortia devoted to meeting the needs of traumatized children that could be consulted in further development of this training program. To minimize

unreasonable risk of harm, the State must require that all medical and mental health professionals who contract with and are paid by the State to provide Mental Health Services for children in the PMC of the State receive six to eight hours of training that addresses the following topics (or show a knowledge of these topics through alternate means):

(1) Overview of trauma and how it affects the child;

(2) Overview of attachment theory and how it relates to trauma;

(3) Risk of misdiagnosis, placement breakdown, overmedication, and unnecessary institutionalization due to the overlap of symptoms of trauma and mental disorders;

(4) Availability and benefits of trauma-informed treatments and therapies.

Without a requirement that medical and mental health professionals have this knowledge, the State continues to be deliberately indifferent to its violation of the constitutional rights of children in its permanent managing conservatorship, seriously impairing their mental health and overall life outcomes.

Respectfully submitted,

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**CERTIFICATE OF SERVICE**

I hereby certify that on the 15th day of December, 2017, I electronically filed this Amicus Brief of Texas Lawyers for Children in Support of Plaintiffs with the Clerk of Court using the CM/ECF system, which will send a notice of electronic filing to all CM/ECF participants, and that I have mailed by United States Postal Service the brief to all non-CM/ECF participants.

/s/ William R. Thompson, II
William R. Thompson, II

**Appendix**

**Exhibit A**

# 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.