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Binny Miller

American University Washington College of Law, bmiller@wcl.american.edu

Maya Coleman

contact@mayacolemanphd.com

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“Everything you need is in here”¹: Missing Elements in a Trauma-Sensitive, Multiracial Framework for Foster Parenting

Binny Miller and Maya Coleman*

INTRODUCTION

We offer a story about the experience we had as a foster family to a nine-year-old African-American girl with severe mental health needs. We will refer to her as “T.” in this essay. One of us is a law professor and a clinical teacher who represents young people in the juvenile delinquency system. The other is a clinical psychologist who works with children who have experienced trauma. We are white women who are parents of an African-American girl whom we adopted as an infant. Our daughter was nine when we became foster parents to another nine-year-old. We came to the experience of foster parenting with what we thought was a deep awareness of the dysfunction of the foster care system overall, but especially for children of color with severe mental health needs. Nothing, though, had prepared us for the complete dysfunction that we encountered during the two-month period that we were T.’s foster parents in Washington, D.C. This dysfunction had myriad effects, the most important of which was the denial of appropriate mental health services to T. The system failed T., time and again, and failed us as foster parents desperately seeking mental health services for her.

Foster care in D.C. is largely managed by the Child and Family Services Agency (CFSA).² The CFSA is a cabinet-level agency that oversees the safety, permanence, and well-being of children and families residing in D.C.³ As of August

* Binny Miller is a Professor of Law and the Co-Director of the Criminal Justice Clinic at American University’s Washington College of Law. She received her J.D. from the University of Chicago Law School and her B.A. from Carleton College. Maya Coleman is clinical psychologist in private practice who works with families of young children who have experienced adversity in early childhood. Dr. Coleman has a Ph.D. in clinical psychology from The Catholic University of America, a master’s degree in special education from American University, and an A.B. from Bryn Mawr College. We first presented the ideas in this essay at the 21st Mid-Atlantic People of Color Legal Scholarship Conference in Washington, D.C. We thank the attendees for their valuable feedback. We appreciate the outstanding research assistance provided by Dan Gestal, Sarah Goggans, and Alanna Kennedy.

1 The first part of the title is a quote from the foster care caseworker who brought our foster child to our home for the first time. The foster care worker was referring to a binder that she gave us that evening. We use the phrase ironically because in fact nothing we, or our foster child, needed was in the binder. See the discussion *infra* Part I.A.

2 See Child and Family Services Agency, *Frequently Asked Questions*, DC.GOV, <http://cfsa.dc.gov/page/faqs-cfsa> [hereinafter CFSA, *Frequently Asked Questions*] (last visited Oct. 7, 2017).

3 Child and Family Services Agency, *CFSA Policy Unit and Policy Development*, DC.GOV, <http://cfsa.dc.gov/page/cfsa-policy-unit-and-policy-development> (last visited Oct. 7, 2017). The overarching statutory scheme governing CFSA related activities is found in Chapter 13 of Title 4 of the D.C. Statutes and Court Rules. CFSA is governed by D.C. Code § 4-1303.01a and the applicable regulations under D.C.M.R. Title 29 relating to public welfare. See generally D.C. CODE § 4-1303.01a;

2016, CFSA was actively serving approximately 2,500 children.⁴ Of those, 62% were served in their homes and 38% were served in out-of-home care.⁵ CFSA can take custody of a child only when she is in immediate danger of abuse or neglect.⁶ In our case, we worked with a private agency licensed by CFSA to provide foster care services, including recruiting and training foster parents.

Our story follows in the footsteps of other first-person accounts of the foster care system written by parents and other caregivers.⁷ In an essay published in *The Guardian*, a British foster parent describes the trials and tribulations (and some triumphs) of being a foster parent.⁸ While the essay is not specifically about children diagnosed with a mental health condition, many of the themes were common to our experience: emergency referrals where little information is available about a child,⁹ the challenges of dealing with a child who becomes angry and destructive,¹⁰ anger toward other actors in the system,¹¹ feelings of being overwhelmed and drained,¹² and feelings of disappointment and grief when a placement is disrupted.¹³ The author’s experience was different than ours—she described a year of fostering children coming from very difficult circumstances, and had been fostering children for five years—while we were new to foster parenting and describe one very intense experience. Still, many of the themes in the *Guardian* piece resonated with us.

The fact that children in foster care have significant developmental, behavioral, and emotional problems is well documented.¹⁴ By definition, children in out-of-home care have experienced at least one potentially traumatic attachment

D.C. Mun. Regs. Tit. 29, <http://www.dcregs.dc.gov/Gateway/TitleHome.aspx?TitleNumber=29>.

4 CFSA, *Frequently Asked Questions*, *supra* note 2.

5 *Id.*

6 See D.C. CODE § 16-2301(9)(A) (2017) (statutory definition of a neglected child and factors the government must prove to adjudicate a child neglected); D.C. CODE § 16-2301(14) (2017) (statutory definition of shelter care, a child’s placement prior to a neglect adjudication); D.C. CODE § 16-2301(28) (2017) (entry into foster care after a neglect adjudication).

7 We use the term “we” in describing the experiences that both of us had, or views that both of us shared. We use our first names separately for experiences that only one of us had. This creates a somewhat awkward disjunction between the use of the first person (“we”) and the third person (“Maya” or “Binny”), but we believe it is important to keep the first-person flavor while also acknowledging our different experiences.

8 *A Year in the Life of a Foster Parent*, THE GUARDIAN (Nov. 26, 2010, 7:04 PM), <http://www.theguardian.com/society/2010/nov/27/diary-of-a-foster-parent>.

9 *Id.* (describing eight-year-old Dan).

10 *Id.* (describing Tom, who had been sexually abused by his birthparents, broke toys, and harmed the pets in his foster family’s household).

11 *Id.* (describing the author’s feelings about a “frazzled-looking” emergency foster care worker).

12 *Id.* (describing Sarah, a rebellious teenager).

13 *Id.* (“This ending leaves us traumatised and, without wanting to sound melodramatic, grieving.”).

14 See Peter J. Pecora, Peter S. Jensen, Lisa Hunter Romanelli, Lovie J. Jackson & Abel Ortiz, *Mental Health Services for Children Placed in Foster Care: An Overview of Current Challenges*, 88 CHILD WELFARE 5, 6 (2009) (“Studies also suggest that of the 40% of youth in foster care, up to about 80% of these children exhibit a serious behavioral or mental health problem requiring intervention.”). This report cites studies conducted by Aubyn C. Stahmer, Laurel K. Leslie, Michael Hurlburt, Richard P. Barth, Mary Bruce Webb, John Landsverk & Jinjin Zhang, *Developmental and Behavioral Needs and Service Use for Young Children in Child Welfare*, 116 PEDIATRICS 891 (2005); June M. Clausen, John Landsverk, William Ganger, David Chadwick & Alan Litrownik, *Mental Health Problems of Children in Foster Care*, 7 J. CHILD & FAM. STUD. 283, 292 (1998).

disruption.¹⁵ The lack of access by youth in foster care to high-quality mental health services is also well documented.¹⁶ There are also racial disparities in the provision of mental health services to children in foster care.¹⁷ Our story endeavors to put a face on the problems identified in these studies and to offer some suggestions for systemic changes that would support critical members of the team caring for children in the system

T. first came to live with us in the middle of the academic semester. When Binny told one of the law student teams that she was supervising that we had become foster parents, one of the students exclaimed, “You’re the dream team, a lawyer and a clinical psychologist who work with kids!” While we would not have called ourselves a dream team, our professional backgrounds in many ways had uniquely prepared us for the challenges of foster parenting. But in the end, our experiences and our commitment were not enough to meet T.’s needs. Nor was the work of a seasoned and committed social worker, the energy and enthusiasm of two guardians ad litem, and many other caring professionals.¹⁸

The story we tell here is not just one about unmet mental health needs. It is also a story about the difficulty of forging connections across the lines of race, class, and sexual orientation. It is also a story about the challenges that we experienced in navigating our roles as parents against the backdrop of our professional experiences. While we hope to explore these topics in more depth in a future essay, the mental health story is not entirely separate from these other stories, so we include them here.

We offer some policy suggestions to address the problems of severely inadequate trauma-sensitive mental health services for children in the foster care system. What can be done in a system that uses the language of trauma but in fact does not provide mental health services, let alone trauma-informed services? And when systems are inadequate to the task at hand, what can individuals do?

We saw a system that was so flawed that it could not provide the basic services that children and their families are entitled to, and we attempted interventions on an individual level. We tried to make the system work for T. by pushing the system to do its job, through hundreds of phone calls and letters, and in-person meetings. We

15 See generally *Removal from the Home: Resulting Trauma*, UPENN COLLABORATIVE ON CMTY. INTEGRATION (April 6, 2017), <http://tucollaborative.org/wp-content/uploads/2017/04/Trauma-The-Impact-of-Removing-Children-from-the-Home.pdf> (exploring the trauma resulting from a child’s removal into foster care).

16 See JOHN LANDSVERK, BARBARA BURNS, LEYLA FAW STAMBAUGH & JENNIFER A. ROLLS REUTZ, *MENTAL HEALTH CARE FOR CHILDREN AND ADOLESCENTS IN FOSTER CARE: REVIEW OF RESEARCH LITERATURE* (2006) (report developed for Casey Family Programs); John Landsverk, Ann F. Garland & Laurel K. Leslie, *Mental Health Services for Children Reported to Child Protective Services*, in *THE APSAC HANDBOOK ON CHILD MALTREATMENT* (John E.B. Myers, Lucy Berliner, John Briere, C. Terry Hendrix, Carole Jenny & Theresa A. Reid eds., 2002).

17 See Ann F. Garland, John A. Landsverk & Anna S. Lau, *Racial/Ethnic Disparities in Mental Health Service Use Among Children in Foster Care*, 25 *CHILD. & YOUTH SERV. REV.* 491 (2003); Ann F. Garland, Richard I. Hough, John A. Landsverk, Kristen M. McCabe, May Yeh, William C. Ganger & Beth J. Reynolds, *Racial and Ethnic Variations in Mental Health Care Utilization Among Children in Foster Care*, 3 *CHILD. SERVS. SOC. POL’Y, RES. & PRAC.* 133 (2000).

18 See generally Yael Zakai Cannon, *There’s No Place Like Home: Realizing the Vision of Community-Based Mental Health Treatment for Children*, 61 *DEPAUL L. REV.* 1049 (2012) (finding evidence that the United States severely lacks the infrastructure to help children with mental disabilities in the foster system).

implemented trauma-informed practices in our home. But ultimately these strategies were inadequate in providing the support that T. needed as a foster child and that we needed to help her as her foster parents.

Instead, we and T. needed access to real trauma-informed resources and practices. These kinds of services can support foster parents who are parenting in the context of trauma and are supporting children affected by trauma. We also needed to be who we were not; we needed one of us to work full-time as a foster parent.

We offer two proposals. The first is that in order to create a truly trauma-sensitive child welfare system, all foster care must be conceptualized as treatment foster care or therapeutic foster care. By definition, children in the system have experienced a potentially traumatic disruption in caregiving simply by being brought into the system. Foster parents are caring for children at risk of trauma. This doesn't even address the potentially traumatic conditions that may have existed before entry into the system, that may have prompted entry, or anything that may happen as the result of involvement in the system.

Our second proposal is that foster caregiving should be conceptualized as professional care work rather than substitute parenting and that foster caregivers should be paid for their labor, not just inadequately reimbursed for expenses incurred. Payments should be at the level at which one caregiver would be compensated for full-time work. So, foster caregiving should not be conceived of as ordinary parenting, or even as only therapeutic parenting, but as professional care work with caregivers playing a central role in the larger professional support team. This latter proposal builds on the excellent article by Hannah Roman,¹⁹ although our proposal differs in some respects from hers.

In writing this essay, we first understood T.'s situation as a problem of inadequate mental health services. If she had only been able to receive this service or that service or more services, she would have been able to function better at home, at school and in the larger world. No doubt that was true. But the real failure of the system is its failure to conceptualize all foster care as therapeutic foster care and all foster parents as providing professional care.

I. T.'S STORY

A. *Joining the Family and the Community*

We had been licensed foster parents for several months when we received a call one afternoon from our agency about T. T. was scheduled to be released from a psychiatric hospital that night, and she was coming into the foster care system because her mother refused to accept her when she was discharged. T.'s mother did not feel that she could keep T. from hurting herself or others. Our agency knew very little about T.'s “case.” The staff at our agency had attended a meeting of foster care providers where some details about T. were discussed, including the fact that she had

19 Hannah Roman, *Foster Parenting as Work*, 27 YALE J.L. & FEMINISM 179 (2016).

a diagnosis of post-traumatic stress disorder (PTSD) and had suffered severe abuse and neglect as an infant. Her birthmother's rights had been terminated, and T. had at some point been adopted by her mother. Because of the nature of the incidents that had led to T.'s hospitalization, the other providers did not have foster parents in their organizations that they felt were a good match for T. The staff at our agency thought of us and called.

We hesitated at first because we had become foster parents for the purpose of providing "respite care," which is short term relief for other foster parents who needed to leave town and couldn't take a child with them, had medical emergencies, or simply needed a break from parenting. But as we talked, it became clear that T. had nowhere else to go, at least in the short term; that we were not committing to a long-term placement; we had experience in working with children with her diagnosis in our professional lives; and we had a daughter of the same age who we thought could help T. feel more comfortable joining our family. The day we said "yes" was Binny's birthday, so we switched gears from preparing the birthday dinner to preparing for T.'s arrival.

A staff person at our agency told us that a staff person from D.C.'s CFSA would bring T. to our home that evening. She didn't know when T. would arrive, but thought it might be around 6:00 p.m. T. arrived at our house around 10:00 p.m. She was carrying a small backpack and a plastic bag with a few items of clothing and a tattered Bible. We had heard stories about children in foster care arriving with so few possessions, but it was shocking to see firsthand. Even more shocking was the fact that T. had been released from the hospital with no medications, and CFSA had provided her with none, despite the fact that she had been to CFSA for a medical screening after her release from the hospital.²⁰

The psychiatrist at the hospital had written prescriptions for psychiatric medications, which the CFSA worker gave us. She also gave us a binder which included a document with a few sentences about T.'s situation, and an admonishment not to lose the important paperwork provided. She stated in no uncertain terms, "Everything you need is in here." Indeed, nothing we needed was in the binder. Ironically, the remainder of the paperwork consisted of blank forms that we were to bring to T.'s various appointments. The CFSA worker knew nothing more; it was clear that her job was simply to transport T. from one place to another, not to know anything about T.'s personal situation or circumstances. The worker left after less than five minutes.

T. was a strikingly beautiful child. Her hair was closely cropped and her complexion was dark. We would soon learn all of T.'s struggles with negative feelings about her appearance, but when we looked at her we saw a beautiful child. T. was very talkative, and very open and forthcoming. One of her first questions (we can't remember whether it was directed to Binny or Maya) was, "Can I call you mom?"

20 See NAT'L COUNCIL ON DISABILITY, *YOUTH WITH DISABILITIES IN THE FOSTER CARE SYSTEM: BARRIERS TO SUCCESS AND PROPOSED POLICY SOLUTIONS* (2008), <http://www.ncd.gov/publications/2008/02262008> (noting the inability of the health care system and foster care system to successfully share data on foster children with mental disabilities).

Maya responded, “You have a mom, why don’t you call us Binny and Maya?”

T. was charming and funny and really likeable. She also seemed immediately interested in our daughter and in our three dogs. She ran up to the dogs and tried to throw her arms around them. This was fine for our two elderly coonhound labs, but our very skittish whippet-cattle dog recoiled. We explained that this dog didn’t like being approached by people she didn’t know because she had been mistreated before she joined our family. While she was fine being in the same room with gentle people, she shouldn’t be approached suddenly. Even the two coonhounds weren’t used to that level of physical activity.

T. was very high energy with somewhat jerky movements and she spoke rapidly. None of this was particularly surprising, given that she came directly to us from a psychiatric hospital, and in the context of all of the turmoil in her life.²¹ We spent some time that night just talking and trying to get to know each other, showing T. the house and the room she would be sharing with our daughter. We made the decision not to go to the 24-hour pharmacy to get her prescription filled. We worried that there might be a problem with the Medicaid number provided that couldn’t be sorted out until the morning when we could obtain her physical card and we thought our time would be better spent connecting with T.

As it turned out, T. was up all night. She had tried to go to bed, but we could hear that she was up and down and wandering to the bathroom, so Maya got up with her, made a middle of the night breakfast and she and T. drew pictures for each other at the dining room table. We later learned that one of her medications functioned as a sleep aid, even though that was not its intended use, so without it T. could not fall asleep. T. arrived on a Thursday night, and we assumed she wouldn’t go back to school the next morning, but by morning she said that she didn’t want to miss school the next day. She was one of the top students in her class, and she was very proud of her academic skills. Transportation arrangements had not been made so Maya drove T. over to her school in southeast Washington so that she could reconnect with her friends and teachers. Maya checked her in at the front office, and T. was able to go to her classroom. Surprisingly, there was no contact with the school counselor and no plan for helping her reintegrate back into the school environment after her hospitalization and placement with us. Maya gave the front desk attendant her name and phone number so she could be reached if T. needed anything during the day, but there was no established protocol for communicating with the school about her new guardians.

Neither of us is naïve, so we knew there would be cultural, racial, and class differences between us. We weren’t entirely prepared, though, for our interactions and conversations on some issues. One of our earliest conversations was about sexual orientation and identity, and different ways of forming families. We don’t know if anyone told T. that we were a lesbian couple, but it was probably fairly obvious, and T. asked us if we were gay.

T. had been raised in a homophobic environment. When we look back on our

21 See Cannon, *supra* note 18, at 1049-1052 (noting that Mary, a foster child, who also suffered from PTSD, exhibited similar behavioral symptoms).

experience with T., it is surprising that we never asked T. where her attitudes and beliefs came from. Was this homophobia a product of family, school, neighborhood, church, or the larger community? It was less a conscious decision than a sense that we didn't want to be conducting an "investigation" into her life (her family was already being investigated by the state), and that doing so could drive a wedge between her and us. And it may not have mattered where her attitudes came from; they were her attitudes, and we were who we were.

Within a day of meeting us, T. was talking about gay people burning in hell. She said that gay people "had the devil in them." This was almost a daily topic of conversation in the first few weeks of our relationship. We listened, and we explained that we didn't believe in hell, and we didn't believe that anyone would burn in hell. We said that people can love people of any gender, choose to live with them, form partnerships or get married, and raise families. These conversations were fascinating, although it was disconcerting to be having such extended conversations on this topic with a child that we were parenting. Our decisions about what to say and what not to say were obviously framed by our role as foster parents. We were her temporary family and expected that she would return to her mother and to her community. But it was clear that she was experiencing quite a bit of conflict and anxiety. As she grew more connected to us, she seemed to become more worried about us, and told us that she would pray for us.

In reflecting on the experience, there was value in hearing how T. felt about gay people. We knew what we were up against. It is also rare to engage with such raw unfiltered feelings. Perhaps this is only possible with children, or in intimate family settings. Homophobia, of course, is all around us. It is one thing to observe this phenomenon vicariously, watching media or anti-gay protests in person. It is quite another to engage with such deeply held beliefs on a daily basis.

There was also the fact that we were white parents. T. had lived in highly segregated neighborhoods, both in Maryland and in D.C. She attended an elementary school where she said there was only one student who was not African American, a student from Central America. T. said that only one teacher in her school was white. She had travelled very little, only once or twice by car to visit family in a nearby state.

Northwest D.C. felt like a very strange place to T. Our neighborhood is diverse, but also gentrifying and a majority of our neighbors are white. The majority of the students at the public school that our daughter attended were African American, but the school was in an almost all-white neighborhood. When T. was upset she would shout "I hate northwest D.C., I want to go back to southeast." We don't suggest that this desire was all about race. T. missed her family and her life, which were themselves bound up with race, and we believe that the racial differences made her transition even more difficult.²²

We had many incredible moments with T. She was a wonderful conversationalist and a deep thinker, and we would spend several hours every day talking, longer on weekends. At one point, T. asked our daughter what it was like to

22 See *A Year in the Life of a Foster Parent*, *supra* note 8 (noting that a family was denied two Afghani asylum seekers for caregivers that the system felt were more culturally appropriate).

live in a white family. Our daughter responded that we were not a white family because she is African-American. It was heartening to hear that our daughter felt as we do that we are a multiracial family, and we appreciated the opportunity to hear from both T. and our daughter about their experiences with and thoughts about race.

We also had some amazing moments outdoors. As T. described her life in southeast D.C., she went from home to school and back without spending much time outdoors. Some part of this seemed to reflect the reality of safety in her neighborhood, while some part of this seemed to reflect her mother’s preference for being indoors. T. said she did not play with other children in her neighborhood and spent a lot of time inside her apartment.

Within a week of T. arriving at our house, Binny took our daughter and T. ice skating at an outdoor rink near our house. T. had never skated before, and at first was terrified to move. But with the help of two teenagers who were working at the rink, T. gained confidence and by the end of the afternoon she was off-balance but skating on her own, and not afraid to fall. Binny saw joy in T.’s face.

Binny will never forget her hike with T. in Rock Creek Park. Twenty years ago, Binny had hiked on the Appalachian Trail for four months. Binny talked to T. about that experience, and T. was fascinated by the story. We like to think she was drawn to the sense of freedom and adventure reflected in that hike. T. said she wanted to go on a hike and one weekend Binny and T. went into the woods and walked along a small creek. T. said that she had never been on a walk in the woods before. She absolutely loved the walk. We have two pictures from that time. One shows T. wearing her neon-green Batman shirt, standing on a log, arms outstretched, grinning from ear to ear. The other shows her with arms outstretched and bent at the elbow, flexing her muscles, making a silly face. On the way home, T. asked Binny if this was what it was like to hike the Appalachian Trail.

B. Interacting with the Child Welfare System

We experienced the foster care system as a system in complete disarray. We met many wonderful, caring professionals, and yet, we found that the system presented insurmountable barriers to parenting a foster child, particularly a child who had experienced as much trauma as T. had experienced. The system’s complete failure to provide her with appropriate mental health services was the most appalling. But even the logistics of daily life were exhausting.²³

As two working parents with a child, it was impossible to parent a second child in a foster care system that lacked appropriate services. In the process of becoming licensed foster care parents, we had received training in how the system works.²⁴ Although the training addressed the challenges of parenting children who had experienced trauma in their lives, both while living with their families and in the

23 *Id.* (explaining that finding a school for a foster child is part of the endless daily stress that comes with being a foster parent).

24 *See, e.g.,* Sandra Stukes Chipungu & Tricia B. Bent-Goodley, *Meeting the Challenges of Contemporary Foster Care*, 14 *CHILD. FAM. & FOSTER CARE* 75, 86 (2004) (noting that less than one-third of foster parents feel adequately trained for the role they are taking on).

process of being removed from their families, we didn't get much of a picture of the nuts and bolts of daily life. If we had known then what we came to learn as foster parents, we would have hesitated to become foster parents. In retrospect, we concluded that even under the best of circumstances one of us would have needed to take a leave from work to foster parent effectively.²⁵

The day after T. came to live with us, we learned that we were expected to drive her to school every day. Her school, in southeast D.C., was a forty-five minute to an hour drive in rush hour traffic from our house. Round trip travel was 1 and ½ to 2 hours, twice a day. There was no before school care, so T. couldn't be dropped off early, and even if there were, we wouldn't have gotten back in time to take our daughter to school. We also learned that T. was not enrolled in aftercare, so she would need to be picked up at 3:15 p.m., the end of the school day. We pushed back on this plan and learned that CFSA had a transportation service to take kids to and from school, but that it would take a week to set up.²⁶ Apparently, this was something "extra" that foster parents weren't expected to request but that could be provided when it was requested.²⁷

We were able to drive T. back and forth to school until CFSA transportation started. Fortunately, both of us have some flexibility in our schedules and don't answer to a "boss." Maya is self-employed as a child psychologist, and Binny is a law professor who teaches in a clinic. Some of Binny's work occurs at fixed times (class time and court time), but other work can be done early in the morning or late at night. Maya limited her client work and did not take on new clients as it became clear that T. would need a great deal of logistical support and emotional care, and that it would take quite some time to arrange for and coordinate to have any of that support or care provided by others.

Even after CFSA transportation started, there were bumps in the road. The driver would arrive at our house anywhere between 6:45 a.m. and 8 a.m. We wanted T. to sleep as late as she could but this was impossible with the uncertainty about the schedule. Also, because the agency was charged for each ride, transportation had to be stopped during the days we were out of town for a family funeral, and when T. was hospitalized again during her stay with us. Each time transportation was restarted there was a problem with the schedule, and we had to be ready to take T. to school or pick her up.

The foster care model seemed to be built on the assumption of a nonworking parent in a household who was available every weekday outside of the six and a half hour day when a child was in school. The free aftercare at T.'s school had no room, and there were no funds for aftercare, or for care during the week when T. was not in school, on an extended break, or on days when school was not in session. One of us

25 See *A Year in the Life of a Foster Parent*, *supra* note 8 (highlighting the seemingly impossible responsibility foster parents are asked to take on for children who are left broken by the system).

26 See, e.g., CHILDREN'S LAW CTR., CLC TIP SHEET: FOSTER CHILDREN'S RIGHT TO SCHOOL STABILITY (2016) (explaining CFSA's responsibility to ensure youth in care have educational stability).

27 See Sue Coyle, *Children with Intellectual Disabilities in Foster Care*, 14 SOC. WORK TODAY 22 (2014) (explaining that foster parents of special needs children rarely receive adequate support from the foster care system, leaving the caretaker with few options).

could leave work at 5 p.m. to pick up our daughter from the aftercare program at her elementary school, but we needed a place where T. could be between drop off of the van (as early as 4 p.m.) and our arrival more than an hour later.

The situation was untenable, so we took matters into our own hands. This was one of many situations where the system was not working or was in disarray, when we came up with solutions on our own, or we relied on the kindness of other people in our lives. After some hesitation, Binny approached the aftercare supervisor at our daughter’s school to see if T. could be enrolled in the fee-based program as a student from a different school. He offered to keep an eye on her after the van dropped her off and before we picked her up. This solution was better than the stopgap measure it appeared to be. The aftercare supervisor had a master’s degree in counseling and in his “day” job worked at an alternative school for teenagers with emotional disabilities. It was an incredible act of generosity for him to assume responsibility for her along with the other kids in the program.

We arranged for other care in exchange for three packages of hot dogs. We are not kidding. We needed to plan ahead for T. to be enrolled in camp while school was not in session over spring break and while we were travelling to attend a family funeral. At this point in T.’s stay with us, it was clear that she needed some specialized supports and it would have been untenable to bring her with us on this trip, given that the recent death of one of T.’s close family members had affected her deeply. CFSA had no budget for camp or other activities during these days off, and we also wanted to keep T. in familiar surroundings rather than placing her in basketball camp with our daughter. A city recreation center was located near our daughter’s elementary school, and T. knew some of the children who planned to attend camp there. I asked the generous director of the camp if we could enroll T. and pay the fee, and she said, “Don’t worry about that; just bring me some hot dogs” for the cookout planned later in the week.

C. Interacting with the School System

An immediate consideration was whether the school that T. was attending was, at a minimum, failing to address her trauma, or perhaps worsening it. It appeared to us that some of the incidents that we observed when T. arrived home from school were correlated with T.’s reports of being taunted, bullied, and physically assaulted at school. She was taunted constantly at school for having dark skin and short hair. T. was called racial epithets by other African-American children. She reported being hit and pushed by other children, and she reported some incidents that were sexual in nature.

T.’s situation at her elementary school exacerbated her ongoing mental health challenges, and it was an impediment to us effectively foster parenting her. Some of T.’s reports included behavior towards her that could be characterized as sexual assaults. There was no communication between the school and us about T. during the entire time that she lived with us, with the exception of a report card that came home in her backpack. Bizarrely, that report card indicated no behavioral challenges at

school despite the fact that T. reported that she had been disciplined many times for disruptive behavior.

We called T.'s school counselor many times and never received a return phone call. Without talking to school personnel, we had no way of understanding the many troubling incidents that T. reported to us, and the school counselor had no way of coordinating her care with us.

Although school personnel welcomed T. warmly when we dropped her off at school in the morning, nothing that T. told us about her school day suggested that it was a trauma-sensitive environment. One troubling example was what she called "silent lunch." For the third graders, and perhaps other grades, children were not allowed to speak at lunch. Perhaps this practice meant that the teachers dealt with fewer immediate behavior problems in the short run, but in the long run the practice was counterproductive. The children were deprived of important learning opportunities for social and emotional development.

We looked into other school options for T. We weren't sure what the best course of action was, given that she had already experienced so many disruptions in her life. Also, we had no way of knowing the length of her stay with us. We questioned whether we should pull her from a problematic setting when disruption might compound her difficulties, and it was not clear how long she would be at the new school. If she left our home, would she then be faced with going back to her old school, or perhaps face starting at yet another school?

We tentatively explored the possibility of enrolling T. at our daughter's school. The results were not encouraging. As a foster child, T. might have a right to attend our neighborhood school, but our daughter was attending a highly desirable, out-of-boundary school. Our neighborhood school was a bilingual school, which would not have been appropriate for T., given the fact that she spoke only English. It was not clear what right she would have to attend any other school near our home. In the end, we left the school situation alone, fearing that it was too complicated to unpack, and focused our efforts on advocating in other forums.

D. Interacting with the Medical and Mental Health System

Medical appointments posed another logistical challenge. Within a week of T.'s arrival we were expected to find medical care providers and make medical and dental appointments. T.'s social worker referred us to excellent providers who took Medicaid. When we went to see a pediatrician, we learned that T. needed glasses. This explained her squinting, and she then mentioned that she had worn glasses for a long time but had lost them a few months ago and had never replaced them. That meant a trip to the optometrist for glasses and another trip to pick them up.

Every parent knows that these logistics are simply a part of parenting. But in the case of foster parenting they can feel overwhelming. The visits need to happen quickly, providers need to be found, and new relationships need to be built. A very efficient nurse from CFSA would call or email us frequently to inquire if we had set up the appointments, to question who the appointments were with, and to ask us to

provide her with paperwork from the appointments. T.’s social worker already had received these documents from us and had uploaded information to a CFSA database. The nurse was often dissatisfied with the paperwork provided, despite the fact that Binny told her many times that we had provided everything that we had received.²⁸

We were also working with a huge void of information. No records were furnished concerning T.’s medical visits before she came to live us, or her medical needs. T. did tell us that she hadn’t been to the dentist in several years, a fact which was confirmed when the dentist told us that she had many cavities that needed to be filled. Thus, the providers, like us, had an incomplete picture of her physical and mental health needs. In some respects, we felt as if we were just checking off things on a to-do list rather than getting a complete picture of T.’s needs.

One of the more frightening events involving T.’s physical health involved an all-night visit to the emergency room at a local hospital. One late afternoon on the way to choir practice (T. participated in our church choir along with our daughter), T. complained of feeling lightheaded and dizzy. Binny stopped in front of the church and dropped our daughter off at practice and T. got out of the car. She collapsed into Binny’s arms. Binny called Maya, who felt that T. needed to be taken for a medical examination, given the medications she was taking. Because we had such limited information about her medical history, Binny took T. to the emergency room, calling the social worker on the way. The social worker joined Binny and T. at the hospital. The hospital was an all-night ordeal. The doctors ran many tests, but in the end, the doctors were unable to diagnose the problem. No doubt they were hampered by Binny’s ability to provide only the most basic medical history. We left the hospital at 6 a.m. the next morning, no wiser as to what had happened or why.²⁹

It was not long before we realized the depth of the trauma that T. had suffered, both as an infant and while living with her adoptive family. While living with us, there were weekly—and sometimes daily—threats of harm to herself, threats of harm to others, and harmful actions. The details are alarming and frightening; we have left most details out because they are intensely personal and private to her. Some of the milder occurrences included opening the car door and attempting to jump out of the car in traffic and running out of the house late at night and hiding in the neighborhood. Maya vividly recalls one time when she ran up and down the block looking for T., carrying a flashlight in the dark, peering under cars, and calling her name. We found her a hundred yards from our house, crouched next to a car on the street side, completely panicked and hysterical. Maya spoke to her calmly and was able to coax T. away from the car. Maya walked back to our house holding T.’s hand. These episodes were often accompanied by severe sweating and shaking, crying, and at times apparent anger, which actually seemed to be fear and panic.

T.’s mother had told T. about the trauma that T. had experienced living with

28 See generally Joachim Hagopain, *The Failures of America’s Foster Care System*, GLOBAL RESEARCH (July 19, 2014), <http://www.globalresearch.ca/the-failures-of-americas-foster-care-system/5392130> (explaining the corrosive behavior of employees within the foster system).

29 See Pecora, et al., *supra* note 14, at 6 (noting recent studies that estimate “one out of every two children in foster care has chronic medical problems unrelated to behavioral concerns,” and that “[e]vidence suggests that these chronic conditions increase the likelihood of serious emotional problems”).

her birth mother. There were nights after dinner when T. would relive the trauma she experienced as an infant and as a very young child, describing these events in vivid and painful detail. She also recounted incidents from much later, describing the trauma from living in poverty and from the harsh physical discipline practices used in her home. Our view was that these disciplinary practices might have been used in any event, but they likely at least in part stemmed from trying to control a child whose PTSD was associated with severe regulatory challenges. T. reported that she thought she had bipolar disorder; others had said that she had the devil in her. This explanation does not justify these practices, but it does put them in context.

We did what we could to help T. deal with the feelings that she experienced during these episodes. Maya is a professional who works with traumatized children. Binny has no professional expertise in helping children heal from trauma but has years of experience working in the often highly emotionally charged world of criminal defense, much of it in interactions with children and their families in the juvenile justice system. We called on these experiences in trying to figure out an approach to helping T. In the aftermath of frightening incidents we would sit next to T. on the couch. We would hold her while she screamed and shook and cried. We tried to keep our talking to a minimum. When we talked, we spoke softly and quietly and simply. In time, T. would relax a bit and return to a calmer state.

While T. lived with us she received outpatient services through a community mental health organization, which included meeting with a psychiatrist twice a month for medication management and seeing a caseworker, both of whom worked for the same agency. The caseworker saw T. once or twice a week; sometimes this involved taking T. to appointments or just hanging out in the caseworker's office. We were told that these meetings with the caseworker were an upgraded level of service that was not available to most children in the foster care system.

In our view, these services were insufficient for T., and likely insufficient for any child with a mental health diagnosis, let alone a child with severe PTSD. The caseworker had no advanced mental health training and did not provide counseling. To her credit, she listened well and seemed to sincerely care about T. as a person, so we felt that this relationship was an important resource, but additional trauma treatment was not provided.

The visits with the psychiatrist were particularly troubling. Maya asked for and received special permission to attend the sessions; typically, foster parents are not expected to play this role. T.'s mother also attended some of the sessions. Although the sessions were only about medication management, they were too short to be useful. T. had seen this psychiatrist before she entered the foster care system, likely as a result of the hospitalization that occurred before the one that led to her placement with us. T.'s cursory responses to the questions the psychiatrist asked did not give the psychiatrist an accurate picture of T.'s daily functioning. There was no built-in opportunity for the psychiatrist to obtain information from her daily caregivers.

Maya had to request to meet with the psychiatrist without T. present as well. It would not have been therapeutically appropriate to contradict what T. herself

reported to the psychiatrist, or to describe in front of a nine-year-old child the concerns we had. Maya was also hesitant to report some of what had been happening for T. in front of T.’s mother, given the concerns about harsh disciplinary practices T. might face upon returning home. Some adjustments were made to T.’s medications, but it wasn’t always clear why, or what we should be looking for in terms of positive effects or concerning side effects.

A few weeks after she arrived at our house, T.’s situation worsened and she had to be hospitalized again. One evening, T.’s behavior escalated to the point where we were not able to guarantee her safety or ours. We called her social worker, and she explained that the city had a mobile crisis unit³⁰ that was available for situations like this. This was the first that we had heard of it. This was our first of two encounters with the mobile crisis unit, and this time we found the personnel to be compassionate and helpful.

After spending several hours at our home that night, the crisis unit personnel determined that T. needed to be hospitalized. Earlier that evening, we had sent our daughter over to a neighbor’s house when T.’s behavior began to escalate, and the neighbors said that our daughter could sleep over at their house. We accompanied T. to the hospital, Binny in the ambulance and Maya in our car. We arrived at the same hospital where T. had been discharged several weeks earlier. This time, T. stayed at the hospital for ten days. One or both of us visited her every day on the children’s unit.

There were many disturbing aspects of her hospital stay. During the ten days that we visited her, we saw no white children on the unit. The vast majority of the children were African American, with a few biracial or Latino children. In Binny’s experience in the juvenile delinquency system, she had become accustomed to seeing only African-American children in residential placements, but we somehow thought it would be different in this hospital because it was open to children citywide, not just children involved in the juvenile justice system or the foster care system. We also were struck by the age of the children. Many were younger than T.; the youngest child we saw was six years old.

There was a lack of coordination and information sharing between the hospital and other involved parties: foster parents, T.’s mother, T.’s social worker, and the guardian ad litem. There was one meeting during her stay organized by the social worker at the hospital, which basically turned into a meeting where T.’s mother recounted early difficulties raising T. when she was a toddler. This was not the purpose of the meeting, but it was incredibly useful because it was the first time that

30 See, e.g., D.C. DEPARTMENT OF BEHAVIORAL HEALTH, CHILDREN, YOUTH AND FAMILY SERVICES, <https://dbh.dc.gov/service/children-youth-and-family-services> (last visited July 16, 2017) (“The Children and Adolescent Mobile Psychiatric Service (ChAMPS) provides on-site immediate help to children facing a behavioral or mental health crisis whether in the home, school or community. Services are geared toward children and youth 6-21 years of age. The goal is to stabilize them and avert inpatient hospitalization or placement disruptions in the case of foster children. The mobile crisis teams also make follow up visits and connect the family to needed support services.”).

we had met or spoken to T.'s mother, and she provided a detailed narrative of T.'s mental health difficulties, beginning with the abuse she suffered at the hands of her birth mother, whose parental rights were eventually terminated.

According to T.'s mother, T. had experienced difficulties from the day she came to live with her. All of her babysitters had quit because they couldn't cope with T.'s emotional difficulties. T.'s mother also provided documents on random pieces of paper from various specialists she had visited beginning when T. was a toddler. They included a wide variety of DSM-IV diagnoses, many of which were conflicting and none of which mentioned trauma. It was at this meeting that we first realized that T. had been hospitalized at least three other times in the past eighteen months prior to the hospital stay from which she was discharged to our care. At least one of those times was at the same hospital where she was currently placed. Altogether, T. had been hospitalized at least five times, including this hospitalization, in the past eighteen months.

At this point, T. had been living with us and in the foster care system for almost four weeks. It was alarming that none of this information had been shared with us before we agreed to the placement, and perhaps even more alarming that no one in the room knew most of the information. It seemed that some of the professionals may have heard bits and pieces from T.'s mother before, but not in this level of detail, and not in a way where the information was shared with others involved in T.'s case.

We made several efforts to reach T.'s psychiatrist at the hospital and finally received a return phone call. We were desperate for some information on what in her view might help prevent a return visit. The psychiatrist had no suggestions and explained that the purpose of hospitalization was short-term stabilization. Being approved for release does not mean that a patient won't be back; it only means that for the moment the person is not a danger to herself or others. We already knew about the purpose, and limitations, of hospitalization because of our work experiences in the mental health system, but we were trying to figure out what we might be able to do to advocate on T.'s behalf.

The psychiatrist did say that based on the number of times that T. had been hospitalized she likely needed to live in a structured residential treatment center or group home. When Binny asked the psychiatrist if she knew of any options, she said, "No." Thus, it was not entirely surprising that when T. was released from this hospital stay she was released with no recommendations for services upon discharge.

Hospitalization made the situation with T.'s medication go from bad to worse. Before she was hospitalized, she was on such a high dosage of a particular sedating medication that she needed to sleep for an hour mid-morning. We were able, with her mother's permission, to reduce T.'s dosage by a small amount to lessen the sedating impact of this medication and improve her ability to engage in her classroom. When T. was hospitalized, her medications were increased again but were different than her prescribed dose at the point when she came to live with us. It seems that decisions were made about her medication without information from her caregivers about her daily functioning. To make matters worse, there was no coordination between the psychiatrist that she saw on an outpatient basis and the psychiatrist at the hospital.

We assumed that they would at least talk briefly, but that was not the case. Both professionals were working in a vacuum, from each other and from the people providing her daily care.

There was a particularly dangerous episode at the hospital where the doctor on call that weekend felt that T. needed an additional medication because of symptoms that she was experiencing. Her mother, however, refused to agree to the medication because she felt that she had not been properly consulted about changes in medication on a previous stay. When we saw T. that weekend she was literally bouncing off the walls: highly agitated, pressured speech, running from room to room. She told us that she had not slept in thirty-six hours and hospital staff confirmed this. Whether this was because of too much medication, too little medication, or the wrong kind of medication, we will never know. But it was clear that these decisions were poorly thought out without appropriate input from other professionals.

During her hospitalization, T. lived in a highly-structured environment under close watch by the staff. She attended what she referred to as a “fake” school, worked on arts and crafts projects, and received medication. There were things that T. liked about being in the hospital. She was surrounded by other children all of the time; she had grown up essentially as an only child because her mother’s adult children were much older than she was. T. talked a lot about wanting to have siblings and really wanted to be close to our daughter. She also knew the staff well because of her frequent visits to the hospital, and she enjoyed talking with them. T. was an extroverted child who knew how to talk to adults. T. seemed not to have any anger toward us for setting in motion the events that led to her hospitalization; instead, she seemed to view hospitalization as something that occurred in the normal course of things. The hospital had become T.’s world, and, in some ways, it was a more welcoming world than the one she faced on the outside. However, the continuity of care between the stabilization services provided while T. was hospitalized and appropriate trauma-informed outpatient services was non-existent.

One positive development was that T.’s hospitalization prompted the agencies involved to seek additional services for her. While she was hospitalized, her social worker submitted a referral packet for residential diversion services; the name seemed to indicate that these services were designed to avoid a residential placement where it seemed that one might be imminent. T. was assigned a care coordinator with an organization that provides wraparound services for youth who are experiencing difficulties stabilizing in the community. This organization was a source of funding for services that could not be provided in the normal course of foster care, and as the care coordinator described it to us, she could “assist with out-of-the-box interventions that may help to stabilize” T. Monthly team meetings were designed to discuss the services that were currently being provided and those that were needed but not being provided.

We went to the first meeting with a list of services that we felt that T. needed, which could keep her from being institutionalized. At the top of the list was appropriate therapy for a child suffering from trauma. Also included were a visit to a nutritionist, because we felt that T.’s diet was having an effect on her behavior and

emotional state, and therapeutic horseback riding, which has been shown to be helpful to children with a wide range of mental health challenges. We also felt that T. would benefit from a mentor, a young adult who could spend time with her and take her on outings.

The team was open to these services, but progress was slow in actually obtaining them. Because none of the providers that we or the team identified had contracted with the agencies involved, these relationships needed to be explored. We bore the brunt of actually getting these services in place.

Therapeutic horseback riding is a case in point. Therapeutic riding was on the list of approved services from the outside funding organization, but all of the providers were located a long distance from D.C. in Virginia or Maryland. When we asked about the Rock Creek Park stables, centrally located in D.C. and a ten-minute drive from our home, no one on the team had heard of it. We knew a child who had participated in their therapeutic riding program and really benefitted from it.

Equine-assisted activities and equine-assisted therapies have been used for individuals with attention deficit disorder, anxiety, autism, dementia, cognitive delays, Down syndrome and other genetic syndromes, depression, trauma and brain injuries, behavioral challenges, and other mental health issues.³¹ Therapeutic riding is an equine-assisted activity that teaches people with special needs about horsemanship and how to ride. It can promote emotional, social, or physical well-being of participants. Therapeutic riding programs are often a component of trauma treatment. Horses are seen as good for people who have experienced trauma because they are patient, cooperative, and receptive to people.³² The results of one study suggest that the relationships participants had with their horses contributed significantly to their healing from trauma.³³ While therapeutic riding is therapeutic, it is not a form of psychotherapy.³⁴

We spent many hours researching the services available and learned that the stable had a well-regarded therapeutic riding program. Binny spoke to the woman who ran it and got the information necessary for the agency to arrange services. One evening after school, we took T. to the stables for a visit. There, she met a boy with autism who participated in the therapeutic riding program. His dad told us that the riding program was the best thing that had happened to his son. We didn't mention the program to T. because we wanted to make sure that it was actually happening before getting her hopes up.

As it turned out, T. never had the chance to ride horses. Her placement with us was disrupted 10 weeks after she came to live with us. We discuss the disruption, the difficulty of obtaining other trauma-informed services and some of the role

31 Keren Bachi, *Equine-Facilitated Psychotherapy: Practice, Theory, and Empirical Knowledge*, in ANIMAL-ASSISTED PSYCHOTHERAPY 221 (Nancy Parish-Plass ed., 2013); *What is Equestrian Therapy?*, EQUESTRIAN THERAPY, <http://www.equestriantherapy.com>

32 Jan Yorke, Cindy Adams & Nick Coody, *Therapeutic Value of Equine-Human Bonding in Recovery from Trauma*, 21 ANTHROZOOS 17, 18 (2008) (citing T.F. Garrity & L. Stallones, *Effects of Pet Contact on Human Well-being: Review of Recent Research*, 3 COMPANION ANIMALS IN HUMAN HEALTH 22 (1998)).

33 *Id.* at 25.

34 Bachi, *supra* note 31, at 222; *but cf. id.* at 221–22 (stating that equine facilitated psychotherapy employs a licensed mental health professional to work with a horse, a client, and an equine professional).

challenges that we faced as foster parents, in the next section.

II. OUR STORY: ROLE AND ROLE CHALLENGES

It is difficult to convey the experience of living with a child with severe mental health needs. It is even harder to fathom the failure of the system to respond to the needs of a child whose struggles stem in part from involvement in the system itself. Both of us, from the work we did in our professional lives, were well aware of the limited availability of mental health services for poor children (and adults) and the often poor quality of the services that were available. Even with this perspective, we were shocked by what T. experienced. We believed, mistakenly, that between us we could get her some of the services that she needed. We had too much faith in our ability as parents with professional expertise in advocacy, mental health, and navigating complex systems, and it became clear that systemic deficiencies could not be overcome with our experience and advocacy alone.

As two working parents with a child, it was impossible to parent a second child in a foster care system that lacked appropriate services. In the process of becoming licensed foster care parents, we had received training on the role of foster parents, the needs of foster children, and how the system works.³⁵ D.C. regulations require child-placing agencies to provide orientation and preservice training to the foster care system, to prospective foster parents, and annually to foster parents, to improve their parenting skills.³⁶ Foster parents must complete thirty hours of preservice training offered by the agency.³⁷ CFSA may accept training provided by another child-placing agency, as was the case in our situation, if the training and participation is properly documented and covers required areas.³⁸ This training must encompass, among other things, the developmental needs of children in foster care and the availability of supportive services in the community for foster children and foster parents and their families.³⁹ This training reflects the underlying criteria for foster parents in D.C.,

35 See Chipungu & Bent-Goodley, *supra* note 24, at 86 (noting that less than one-third of foster parents feel adequately trained for the role they are taking on).

36 D.C. Mun. Regs. tit. 29, §§ 1641.1–.2 (1990). Foster care generally, and the standards of placement, care, and services for child-placing agencies, can be found in the D.C. Municipal Regulations, Title 29, Chapters 16 and 60.

37 D.C. Mun. Regs. tit. 29, § 6026.2 (2001).

38 *Id.* § 6026.4.

39 *Id.* § 6026.3. The complete list of training requirements includes:

- (a) Role and relationships in foster care between CFSA, agency personnel, the foster parent, the foster child, and the foster child's family;
- (b) The importance of the foster child's family and the foster child's relationship with them;
- (c) Developmental needs of children in foster care;
- (d) Awareness of cultural and religious differences;
- (e) Child management and discipline techniques;
- (f) Child abuse and neglect, including prevention, reporting, investigation, and services;
- (g) Supportive services available in the community for foster children and foster parents and their families;
- (h) Self-awareness;
- (i) Communication skills;
- (j) Problem solving;

which require that foster parents understand the principles of good child care, have the ability to “meet the needs of a foster child, notwithstanding any employment outside the home,” and have “the stamina to meet the demands of caring for growing foster children.”⁴⁰

None of these criteria, either the criteria for individuals’ suitability for foster parenting or the training criteria, specifically mention mental health, or even trauma. Nonetheless, the training addressed the challenges of parenting children who had experienced trauma in their lives, both while living with their families and in the process of being removed from their families. What we didn’t get was a full picture of the demands of the nuts and bolts of daily life. If we had known then what we came to learn as foster parents, we would have hesitated to become foster parents. In retrospect, we concluded that even under the best of circumstances, one of us would have needed to take a leave from work to foster parent effectively.⁴¹

We also experienced role challenges in navigating our multiple roles as foster parents, as mental health advocates, and as white foster parents to an African-American foster child. It also required significant thought and energy to navigate the differences between our beliefs and T.’s beliefs about religion and sexual orientation.

We did not begin advocating for trauma-informed services as early as we might have because it took us some time to clarify our role. The fact that we were trying to be parents to T., knowing that her mother was the decision maker in all important

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- (k) This chapter of the D.C.M.R.;
 - (l) The licensure process, including the agency's internal processes; and
 - (m) The procedures and practices of the Family Division of the District of Columbia Superior Court related to children in foster care.

40 *Id.* § 6001.1(g), (j). The complete list of criteria includes:

- (a) Knowledge of, interest in, and regard for the principles of good child care and understanding of the foster parent's responsibility in providing care for a foster child;
- (b) The willingness to work with CFSA and agency personnel in the best interest of the foster child;
- (c) Maturity and personality characteristics which:
 - (1) Make it possible to provide an emotional climate in which a foster child can benefit during temporary care;
 - (2) Create an atmosphere in which social skills can be enriched;
 - (3) Help a foster child to understand placement in foster care and the child's own feelings about the placement; and
 - (4) Help maintain family ties through regular and consistent family contact in accordance with a foster child's case plan;
- (d) The flexibility to understand and work with lifestyles different from the foster parent's;
- (e) The capacity to value, respect, appreciate, and educate a foster child regarding the child's racial, ethnic, religious, and cultural heritage;
- (f) The capacity to understand that it is in the best interest of a foster child of mixed racial parentage to have healthy multiracial experiences;
- (g) The suitability and stamina to meet the demands of caring for growing foster children;
- (h) The willingness to support and encourage a foster child's educational progress, and take an active role by attending school conferences and similar activities whenever possible;
- (i) The ability to give a foster child the needed care and attention;
- (j) The ability to provide a nurturing family life and meet the needs of a foster child, notwithstanding any employment outside the home; and
- (k) Awareness of the way in which a child needs family life to grow and learn, and the ability to provide a foster child with the skills and values which a parent customarily provides.

41 *See A Year in the Life of a Foster Parent, supra* note 8 (highlighting the seemingly impossible responsibility foster parents are asked to take on for children who are left broken by the system).

aspects of T.’s life, in some way delayed our advocacy efforts. Had T. been Maya’s client, as a mental health professional, Maya would have moved quickly to obtain the necessary services. But T. was not Maya’s client, she was our foster child, and the parameters of our role unfolded over time.

One example of this role confusion is the fact that for some time Maya was concerned about T.’s reaction to changing medications and felt that T. should be screened to see if she was suffering from medication-induced manic episodes. But it was not until T. was hospitalized that Maya wrote a memo to the key members of T.’s team requesting this screening. Professionalizing the foster parent role, and conceiving of the role as a parent-professional, would make it clearer that advocacy on this front was appropriate.

Hovering over us always was the belief that T.’s needs were more than we could meet—more than anyone could meet—without some significant services being provided. This left us torn and confused. Our experience with group homes and residential treatment centers for youth was mostly negative. Those placements didn’t seem to be the answer. T.’s own home was the wrong place for her now, and perhaps in the future. Our placement was dangling by a thread; we wanted to make it work, but it was taking a huge toll on us and our family, and T. was clearly struggling.

As foster parents, our feelings about T.’s hospitalization were incredibly mixed. On the one hand, it seemed to be the only option available for keeping her safe. Also, T.’s hospitalization gave us a break from parenting a child with severe, unaddressed mental health needs. After three weeks, we were exhausted from working, parenting our daughter, parenting T., managing the incredible logistics of T.’s life as a foster child, caring for three geriatric dogs, and handling the daily tasks of running a household. We were emotionally spent, and we realized it during T.’s hospitalization when we could go home after visiting hours and watch television without keeping an ear tuned to T.’s fragile emotional state. We weren’t sure that we could provide a home for T. when she was released from the hospital, but after many conversations we decided to continue to try to parent her and to obtain services. We told the social worker that T. could live with us when she was discharged.

When we began to advocate for trauma-informed services, first with our social worker and then with others, everything moved very slowly and required multiple emails, phone calls, and meetings. Many individuals that we worked with were responsive and diligent and had a great deal of experience navigating the system. But the ultimate decision-makers didn’t seem to understand the severity of T.’s mental health needs.

To begin with, there were many, many people to coordinate with: the social worker assigned to T., the guardians ad litem, doctors, psychiatrists, staff at the psychiatric hospital, staff at the community mental health organization that contracted with CFSA to provide services, workers who came to our home with the mobile crisis intervention van—the list goes on and on. Not only did we have to contact the individual providing direct services, we often had to contact that person’s supervisor. At one point, Maya compiled a list of all of the people we came into contact with, and it numbered over sixty people. Moreover, the identity of two important

players changed during the ten weeks that T. lived with us. Her first guardian ad litem was promoted to a supervisory position in the organization, and a second guardian ad litem replaced him. Her case coordination was also in the process of being transferred from a very experienced social worker to a new social worker when our placement was disrupted.

Our effort to enroll T. in therapeutic riding is an example of a situation where services were theoretically available but hard to obtain. Even when people were on board, it could take weeks to arrange the services and many hours of research and leg work to find an appropriate version of the service. So, this was different than the situation with hotdogs and summer camp, or prevailing on the kindness of the aftercare supervisor at our daughter's elementary school. The service was available, and there was money to pay for it. But still, the role for parents was huge. This was not time that any one person in the system had to devote to one child and one service. It fell on parents to make it happen, and that was difficult on top of the challenge of dealing with a child with severe mental health needs.

On the surface, the division of roles between T.'s mother as her parent and our role as T.'s foster parents was clear. Our job was to provide a home for T. and daily financial and emotional support. We knew, and were told many times, that T.'s mother would make all medical decisions, including decisions about whether her medications should be changed or her mental health treatment altered. There were times, however, when we had a very different view of the particular service that might benefit T.

But stating this division of responsibilities was different than the reality of parenting in the face of this division of responsibilities. As professionals, we understood that clients (or parents of clients) make decisions after receiving information and advice. Both of us counsel clients: Binny provides legal counsel, and Maya provides information about options for trauma-informed services to her clients' parents. We don't always agree with the decisions that our clients make, but we know that these decisions are theirs to make. But somehow the situation was more complicated when it came to the decisions that T.'s mother was entitled to make on T.'s behalf.

T.'s mother had many understandable feelings of anger at the failure of the system to support her in parenting a child with severe mental health needs. The repeated hospitalizations, the release back into the community with no real aftercare plan or adequate services, and the frequent failure of other actors in the system to communicate with T.'s mother all contributed to her distrust of the system. Despite our knowledge of the system and Maya's mental health expertise, we did not want to directly advocate with T.'s mother for particular services, even when we strongly believed that they would help T.

This all came to a head when Maya proposed that T. receive a sequence of treatments that were specifically designed to treat trauma. Initially, a supervisor at the community mental health organization took the position that T. didn't need *any* therapy because she was spending time weekly with a case worker at the agency. This case worker was not a licensed mental health professional, and while she was

kind and had a good ability to engage with T., we did not feel that their interactions were a substitute for therapy. After much prodding, the supervisor suggested that Trauma-Focused Cognitive Behavioral Therapy could be provided.⁴² We believed that Trauma-Focused Cognitive Behavioral Therapy was suggested because it was the only trauma-informed treatment that the agency had easy access to. Maya felt that this therapy would not be appropriate at that time because T. was too unstable for this intervention. She was having severe regulatory challenges and intrusive memories so Trauma-Focused Cognitive Behavioral Therapy was likely to be destabilizing rather than containing and regulating. Instead, a staged treatment was needed that could take into account how destabilized T. was and could address the regulatory challenges that she was facing. Maya found a service provider that could provide the first stage of treatment, and the team finally agreed that services were needed. But none of the professionals involved had explained the staged treatment or the reason for it to T.’s mother, so when Binny attended a meeting with the treatment team and T.’s mother, T.’s mother refused to give permission for the therapy.

The meeting was another example of confusion about our role with T.’s mother. Was it our role to try to persuade her about the appropriateness, indeed the necessity, of this therapy? By this point we were comfortable, although often frustrated by, advocating with the professionals involved with T. But as foster parents, we weren’t comfortable advocating with T.’s mother about issues within our professional expertise (in this case, Maya’s expertise). We worried about alienating T.’s mother and being perceived as knowing more about mental health services than she did. This was particularly complicated because T.’s mother was the decision maker, but we had to live with the consequences of her decisions and try to parent T. when she was receiving woefully inadequate services. This is not to suggest that we should have been the decision makers, but simply to note the often dire consequences that flowed from the fact that we lacked decision-making authority.

Binny left the meeting angry because the professionals knew so little about appropriate trauma-informed services and had not taken the time to talk to T.’s mother about the services. Had they taken the time, T.’s mother might have been able to overcome her distrust of a therapeutic method that she had not heard of before and did not understand.

Several moments in our conversations with T. involving religion and sexual orientation also stand out in terms of the complexity of navigating our role. The Bible fueled T.’s negative feelings about gay people. On many occasions, one of us would sit with T. in her room in the evening while she flipped through the Bible, citing passages from the Old Testament about hell and damnation; some about gay people, others about other people who had sinned, or the Adam and Eve story. T. took the Bible quite literally. We did not, so we would talk with T. about how these passages might be viewed in light of today’s world. In one bedtime discussion, T. went through two pages of the Bible, asking Maya after each sentence, “Do you believe that’s true?”

It was never our goal to change T.’s mind, even when her views reflected bias

42

See infra notes 65-68 for a discussion of Trauma-Focused Cognitive Behavioral Therapy.

and prejudice. Her views had been formed living with her family and in her community, and it felt wrong, particularly as white foster parents, to disrupt that dynamic entirely. But we did feel okay about sharing our own ways of looking at the world. There was some line between respecting where she came from and altering her world view, and we tried to stay on the right side of that line, however shifting that line might be. We were particularly focused on helping T. with the anxiety that seemed to be triggered by her thoughts that we would go to hell.

T. made her journal available for us to read. One of the most striking moments in our relationship occurred when we read a passage in T.'s journal titled: "Day Three of living with a family that does not believe in hell" in which she expressed her concerns about our welfare and eventual fate. She worried about what would happen to us because we were living in violation of religious guidelines she had been taught. As time went on, though, it sometimes seemed as if T. took some comfort in the fact that we did not believe in hell. If we did not believe in hell, then maybe, just maybe, hell was not real, and she would not burn in hell as she had been told she would from a very early age.

In the last week or two of her placement with us, T.'s situation had deteriorated to the point where we felt that it was no longer safe for her to live with us. Even before that, it felt as if each day was a decision to move forward to another day. It was hard to picture T. not living with us, but it was even harder to picture the energy that it would take to parent a child with such severe mental health needs over the long-term. Our hearts were broken when we realized that we would not be able to provide a home as long as T. needed one.

The situation came to a head one afternoon when T. came home from school, completely dysregulated.⁴³ The situation escalated to the point where we decided to call the mobile crisis unit to evaluate T. for hospitalization. This time, the individuals who came with the mobile crisis van seemed not to comprehend the nature of the crisis. They spent a lot of time talking with T. alone and, at the end of those conversations, believed that she was not at risk. The leader of the team seemed to view T.'s problems as behavioral rather than stemming from mental health needs, and he did not treat her with compassion. At one point he said to T., "You better be nice to these people because they are the only ones who are willing to take you in."

Hospitalization, to be sure, was no long-term answer to T.'s unmet mental health needs. We dreaded the thought of T. being hospitalized, but we also feared that no services were forthcoming to shift what had become a dangerous and volatile situation. Her first hospitalization, while unsuccessful in any long-term way, had given us time to regroup, to reenergize, and to prepare to have her return to our home. Now, the placement was hanging from a thread. That night, we talked about whether we needed to disrupt the placement.

The thread broke the next day, when T. was scheduled to visit her psychiatrist.

43 Emotional dysregulation refers to an emotional response that falls outside the range of an acceptable emotional response and may include outbursts such as destroying objects or aggression towards oneself or others. Daniel Schechter, *Disturbances of Attachment and Parental Psychopathology in Early Childhood*, 18 CHILD & ADOLESCENT PSYCHIATRY CLINICS OF NORTH AMERICA 665, 687 (2009).

Both of us and T.’s mother were scheduled to attend the meeting. T. also had a longer visit arranged with her mother after seeing the psychiatrist. This visit would be T.’s first unsupervised visit with her mother since T. had come to live with us. There was tension in the room. T. was upset that we had called the mobile crisis van, but elated that she was not hospitalized. We sat on one side of the room; T. and her mother sat on the other side.

After the psychiatrist met with everyone, she told us that she was reducing T.’s medication at the request of her mother. This decision appeared not to take into account our feedback about T.’s volatile day-to-day functioning. We were concerned that the medication adjustment would further destabilize T. and make it impossible for us to keep her safe, and to keep our daughter and our dogs safe. Also, T. had always returned from supervised visits with her mother in a very distressed state, and supports were not in place should she return from this unsupervised visit in a similar or more dysregulated state. We talked in the hallway outside of the psychiatrist’s office and decided that we could no longer be foster parents to T. T. left for the visit with her mother, and we called T.’s social worker and told her that we needed to disrupt the placement. This was a heartbreaking decision for us, and we worried about what other placement might be available for T.

III. A WAY FORWARD

During our time with T. and after she left our home, we spent many hours discussing our experiences and seeking to understand what supports might have protected T.’s placement with us. We came to believe that all placements in the foster care system should be treated as therapeutic foster care placements and that foster parenting should be understood as work that requires a full-time, and in many cases, more than a full-time commitment of time and energy. We were not seeking to be paid for parenting T. because we already had full-time work. But if we had known that foster parenting required this expenditure of time, we would have known that we could not make the commitment that foster parenting requires.

A. *Therapeutic Foster Care*

Long before the language of trauma became an important concept in foster care systems, therapeutic foster care has been seen as an alternative to both traditional family foster care and institutional forms of foster care, including group homes or residential treatment. Therapeutic foster care, sometimes referred to as multidimensional treatment foster care, combines family-based care with specialized treatment interventions to create “a therapeutic environment in the context of a nurturing family home.”⁴⁴ “Families are recruited from the community, trained, and

44 U.S. DEP’T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 176 (1999) (quoting Beth A. Stroul & Robert M. Friedman, *Caring for Severely Emotionally Disturbed Children and*

closely monitored to provide [children] with treatment and intensive supervision at home, in school, and in the community.”⁴⁵ It serves high-risk children with behavioral, mental, health, or substance abuse problems.⁴⁶ Where a child is unable to remain in his or her home, a therapeutic foster care placement may provide “the least restrictive alternative” for the child, if the child has “an emotional disturbance or delinquency system involvement.”⁴⁷ High-risk children are placed “in therapeutic settings that mimic a nurturing home,” reflecting the preference that children “be placed in family-like settings, rather than congregate care settings.”⁴⁸

Although therapeutic foster care programs differ in some respects, “all programs share similar core qualities, using specially trained foster parents as the primary intervention.”⁴⁹ Therapeutic foster care parents work with professionals to develop an individualized plan for the child, and they “receive consistent support from clinicians and other mental health professionals.”⁵⁰ Therapeutic foster care shifts the primary interventionist focus from the clinician to the foster parents.⁵¹ Therapeutic foster care is “often funded jointly by child welfare and mental health agencies, [both of which] are responsible for arranging for foster parent training and oversight.”⁵²

Therapeutic foster care focuses on “clear and consistent limit setting, positive reinforcement, relationship building, and separation from negative peer influences.”⁵³ Children remain for approximately six-to-nine months.⁵⁴ Families receive weekly counselling and daily contact about progress, and the biological parents “are given parent training and family counseling to help prepare them for the child’s return.”⁵⁵ In a non-therapeutic foster care situation, such as ours, the contact that we had with the providers in the wider CFSA system was more about providing information to them than getting support for us.

Youth: Principles for a System of Care, 17 CHILD TODAY 11 (1988).

45 Judy L. Estren & Kristin Winokur, *Community-Based Solutions for Delinquent Youth: A Guide for Advocates*, 29 A.B.A. CHILD L. PRAC. 49, 57 (2010).

46 Ericka S. Garcia, *Where Do Foster Children with Disabilities Fit? How the State Legislatures Must Create the Programs for Specialized Services to Ensure the Proper Fit*, 30 U. LA VERNE L. REV. 131, 145–46 (2008); see also Cannon, *supra* note 17, at 1122–23 (citing Estren & Winokur, *supra* note 48, at 57).

47 Cannon, *supra* note 17, at 1123.

48 *Id.*; see also PATRICIA CHAMBERLAIN & SHARON F. MIHALIC, BLUEPRINTS FOR VIOLENCE PREVENTION, BOOK EIGHT: MULTIDIMENSIONAL TREATMENT FOSTER CARE 17 (Delbert S. Elliott ed., 1998) (noting that the goals of multidimensional treatment foster care are to “reinforce youths’ normative and positive behaviors; closely supervise youth at all times; closely monitor peer associations; specify clear and consistent rules and limits; consistently follow through with consequences for both positive and problem behavior; encourage youth to develop academic skills and positive work habits; support family members to increase their parenting skills; decrease conflict between family members; [and] teach youth new skills for forming relationships with positive peers and for bonding with adult mentors and role models” (citation omitted)).

49 Cannon, *supra* note 17, at 1123 (citation omitted).

50 *Id.*

51 LYNNE MARSENICH, EVIDENCE-BASED PRACTICES IN MENTAL HEALTH SERVICES FOR FOSTER YOUTH 36 (2002).

52 U.S. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 47, at 176.

53 Estren & Winokur, *supra* note 48, at 57.

54 Cannon, *supra* note 17, at 1123.

55 *Id.*; see also *Spotlight On: Karl Dennis, Pioneer of Wraparound Services and Chicago’s Kaleidoscope, the Country’s First Wraparound Agency*, 20 CHILD. LEGAL RTS. J. 55, 63 (2000) (describing how one program’s TFC included weekly family visits and 24-hour crisis intervention).

Therapeutic foster care parents are provided with special training that goes beyond the more minimal training often required for regular foster parents.⁵⁶ In most cases, each foster home takes one child at a time, and supervisor caseloads are small.⁵⁷ Therapeutic foster care “is a highly structured program that provides consistent monitoring of the child to ensure that the child does not interact with negative influences and that she instead begins participating in pro-social activities.”⁵⁸ Furthermore, it is often a more cost-effective form of treatment than other institutional forms of foster care.⁵⁹

Even with therapeutic foster care in place, there are still challenges with providing the appropriate services. There is a need to advocate and to educate professionals and laypeople in the system about what trauma-sensitive services mean. Many of the mental health professionals that T. encountered had not heard of many established ways of treating trauma.

It is by now accepted wisdom that for a foster care system to be effective, it must be trauma informed. In 2012, CFSA obtained a five-year grant from the U.S. Department of Health and Human Services “to make trauma-informed treatment the foundation of serving children and youth in the District’s child welfare system.”⁶⁰ CFSA selected the Trauma Systems Therapy (TST) model, “an evidence-based approach shown to dramatically speed and improve healing of child victims of abuse and neglect without relying on medication, hospitalization, or prolonged counseling.”⁶¹ Under this approach, children are assessed for trauma when they enter the system, and any child who has been found to have experienced trauma is referred for “trauma-informed mental health treatment.”⁶²

The trauma systems therapy model is not without its critics. CFSA social workers are case managers, not direct providers of clinical services, so a model designed for clinicians and therapists may not translate smoothly to the work of case managers.⁶³ CFSA social workers have received training in the use of the model,⁶⁴

56 Roman, *supra* note 18, at 192, 221.

57 U.S. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 47, at 176.

58 Cannon, *supra* note 17, at 1123–24.

59 *Id.* at 1120; *see also id.* at 1110 (quoting BAZELON CTR. FOR MENTAL HEALTH LAW, STILL WAITING: UNFULFILLED PROMISE OF *OLMSTEAD 2* (2009)) (“Multisystemic therapy for high-risk youth saves more than \$31,661 in subsequent costs to the criminal justice system, while multidimensional treatment foster care for troubled youth saves \$43.70 in residential treatment costs for every dollar spent.”).

63 Child and Family Services Agency, *Trauma-Informed Practice: Cutting Edge Treatment of Child Victims of Abuse and Neglect*, DC.GOV, <http://cfsa.dc.gov/page/trauma-informed-practice> (last visited Oct. 2, 2017).

64 *Id.*; *see also* Office of the State Superintendent of Education, *Trauma Systems Therapy Training*, DC.GOV, <http://osse.dc.gov/event/trauma-systems-therapy-training-0> (detailing what TST is, training times for TST, and detailing school-based interventions).

62 Marie Cohen, *If Not Trauma Systems Therapy, Then What?*, FOSTERING REFORM (Mar. 26, 2015), [hereinafter Cohen (Mar. 26)], <http://fosteringreform.blogspot.com/2015/03/in-my-last-post-iquestioned-dc-child.html>.

63 *See* Marie Cohen, *Trauma Systems Therapy: Good Idea, Wrong Model, Poor Implementation*, FOSTERING REFORM (Mar. 23, 2015), [hereinafter Cohen (Mar. 23)], http://fosteringreform.blogspot.com/2015/03/trauma-systems-therapy-good-idea-wrong_23.html.

64 *See, e.g.,* Washington D.C. Child and Family Services Agency *Trauma Systems Therapy Training Program*, FREE STATE SOCIAL WORK LLC, http://www.freestatesocialwork.com/?page_id=571 (last visited

but they are not the individuals providing therapy services.

Other actors in the system that provide direct therapy services have adopted other evidence-based methods of therapy focusing on trauma. One treatment in particular, Trauma-Focused Cognitive Behavioral Therapy, is widely accepted.⁶⁵ However, Trauma-Focused Cognitive Behavioral Therapy is not appropriate for all children who have suffered trauma; the appropriateness of this therapy depends on the child's stability and stage of treatment.⁶⁶ CFSA and private foster care agencies contract with private providers that incorporate trauma into their practice.⁶⁷ Not all therapists, however, are well-trained or well-qualified to administer trauma-based therapies.⁶⁸ In T.'s case, sophisticated knowledge of and experience with trauma treatments appropriate for all stages of trauma treatment was clearly lacking.

Moreover, as of 2015, the TST model had not yet been fully implemented.⁶⁹ The first cohort of CFSA employees did not receive training in the model until the fall of 2014,⁷⁰ and it was not until the middle of 2015 that all youths in the system were expected to be assessed for trauma.⁷¹

It is difficult to know what difference, if any, TST would have made to T., or to our experience of being foster parents to a severely traumatized child. We became foster parents in 2015 when the system was still being implemented. Although T. came into our care after children entering the system were supposed to be assessed for trauma, we saw no evidence that she had been assessed for trauma or any other mental health issue. This is not a good sign about the effectiveness of TST in making a real difference in the lives of foster children. And whatever the label or "treatment" modality, it is highly disturbing that T. was not immediately identified as a child in need of an enhanced level of intervention to address her trauma.

The mere fact that T. was being released from an inpatient psychiatric facility should have provided a clue to her severe mental health condition. The fact that her mother had refused to pick her up from the hospital is yet another sign. One explanation is that her mother felt that T.'s needs were beyond her ability to cope with them at home. T.'s history of previous psychiatric hospitalizations raises an even bigger red flag. We did not know whether CFSA was aware of these hospitalizations, but if it was not, it raises serious questions about the agency's responsibility to gather information about the background of a child deemed appropriate for psychiatric hospitalization.

The problem was not that T. was receiving the "wrong" kind of therapy, or that

Oct. 2, 2017).

65 Cohen (Mar. 26), *supra* note 65 (giving the example of D.C.'s Department of Mental Health).

66 *See supra* Part II (for a discussion of why Trauma Focused Cognitive Behavioral Therapy was not appropriate for T.).

67 *Id.*

68 *Id.* (noting the example of therapists who work for D.C.'s Department of Mental Health).

69 *See* Cohen (Mar. 23), *supra* note 63.

70 *Id.*

71 *See Hearing on the Child and Family Services Agency Performance Oversight, Fiscal Year 2015–16 Before the Council of D.C. & Comm. on Health & Human Servs.*, CFSA (2016) (testimony of Raymond Davidson, Director, CFSA) (explaining that CFSA implemented strategies to become more trauma-informed in the summer of 2015).

the therapy was not trauma focused; the problem was that she had received no therapy. In looking back on our experience, it seemed to us that what were described as “out-of-the-box” interventions should instead be inside-of-the-box interventions for any child in foster care.

B. *Recognizing That Foster Care is Full-Time Work*

In a thought-provoking article, Hannah Roman makes the case for why foster parenting should be treated as work: “Imagine a job in which the employee is expected to be on-call twenty-four hours a day.”⁷² As she states, “Foster parents are thus essential members of the ‘team’ responsible for caring for children in foster care.”⁷³ Foster parents’ care work “should be treated as labor and compensated as such.”⁷⁴ This benefits children in foster care by incentivizing and enabling foster parents to give the kind of care these children deserve.⁷⁵ Moreover, if foster care is properly compensated, foster parents could play a key role in facilitating reunification with birthparents.⁷⁶

Foster parents are paid under the current system, but the payments are intended to cover the costs associated with caring for foster children, not compensation for the foster parents’ labor.⁷⁷ Most states have a “therapeutic foster care” or “treatment foster care” system where “foster parents caring for children with special needs are paid significantly more than foster parents receiving the regular subsidy.”⁷⁸ Such higher subsidies are likely due to “the additional time and work involved in caring for children with disabilities or behavioral challenges and as an incentive for foster parents to become licensed as therapeutic foster parents.”⁷⁹ However, compensation is not designed to replace the income of a caregiver.

Roman makes two important points in arguing that foster parenting should be treated as paid work. The first is that “children in foster care are much more likely than other children from a similar socioeconomic background to experience serious emotional and behavioral challenges as well as developmental delays.”⁸⁰ She notes that because of the emphasis on not removing children from their homes who can safely stay there, those children removed from their homes are more likely to be children who are more challenging to parent and who have experienced significant trauma.⁸¹ Roman uses the term “vigilant consistency”⁸² to describe the level of parenting often required of foster parents.

We experienced our time as foster parents as a time requiring extreme

72 Roman, *supra* note 19, at 180.

73 *Id.* at 181.

74 *Id.* at 184.

75 *Id.*

76 *Id.* at 185.

77 *Id.* at 211.

78 *Id.* at 213.

79 *Id.*

80 *Id.* at 189.

81 *Id.*

82 *Id.* at 197.

vigilance; or, perhaps more accurately, we were in an almost constant state of hypervigilance. We were unable to take T. shopping or to most public places unless we were both focused at every moment on how she was experiencing the event. Even then, we would come home exhausted from paying such close attention at every moment, and often the experience of going out was not helpful to T. even with all of our efforts to make it work. At the same time, we could not have friends over to our home, even friends who had significant experience working with children with emotional and behavioral challenges, because T. became very dysregulated and required our complete attention. As a consequence, we became isolated from supportive relationships that would have assisted us in such challenging times.

Second, Roman notes the amount of labor and time involved in meeting with caseworkers and other professionals and implementing the recommended services.⁸³ We certainly spent a lot of time in these endeavors, and our experiences fit Roman's description of the labor involved in foster parenting.

We would, however, reframe Roman's point about labor as not just the labor of time, but also the labor of co-parenting. We were, in fact, co-parenting with a system, not just with T.'s mother, but with the endless series of individuals who we came into contact with. We were co-parenting not with a linear, organized system, but with a diffuse, chaotic system of many actors, many of them unrelated to each other. These included two different assigned social workers, two different guardians ad litem, psychiatrists, medical doctors, a mental health caseworker—the list goes on and on. The list would have included the school system, had the school system chosen to engage with us. This is a full-time job that requires extensive expertise and the right temperament.

Foster parents are trained to support an individual child. But foster parents are not trained to be co-parents with a system. We needed more information about how to navigate all of the new relationships we were going to have to form and the conditions of those relationships. We were not told that we would have to learn about the structures of all these caregiving environments, to figure out how a community mental health system works, and to meet with the front-line worker—the psychiatrist. We had to learn how an inpatient mental health facility worked—from how to talk to the front desk people to how to access the psychiatrist. We had to keep track of everyone's name, position, their ability to make decisions, their supervisor, where they sat in the structure of their organization, what resources were available where, and how their organization worked. A long-term parent of a child since birth would have time to establish these relationships; we had to set these up immediately. We already were parenting a child of the same age, so we could make use of some of those already-established relationships. It is hard to imagine how we would have done this without those relationships and without the excellent social worker that we had the privilege to work with.

Another important point about our co-parenting role, a point which Roman does not make, is the lack of autonomy that is inherent in the role of a foster parent. We did not consent to these relationships; we had no say in whether we wanted to

83 *Id.* at 196–97.

continue co-parenting with the biological family, the guardian ad litem, the psychiatrist, or the nurse who calls. We could not set the conditions of our own parenting, and yet we had to deal with the fallout. We had no control over the medications T. was or wasn't taking, and yet our job required that we deal with the effects of over- and under-medication. We had no control over our own working conditions, and it is this lack of control that is the cornerstone of traumatic stress. In hindsight, we saw clearly the cumulative effects of this vicarious stress on us as individuals and on our existing family system.

Paying foster parents would not solve the tensions inherent in the high-stakes nature of the parenting and the lack of control over the working conditions of foster parents. But it would at least recognize the time and emotional energy required to manage these relationships, and would free up time from other paid work.

Another aspect of viewing foster parenting as paid work is that it would recognize that there are, in fact, different roles to play. We should let foster parents sign up for the role they are good at and make sure there is a team to get all of the child's needs met. A parent who is excellent at connecting with the child and can provide therapeutic and trauma-sensitive parenting should be freed up to do that.

Luckily, we were a team. We didn't divide our roles completely, but Maya would often attend to the emotional needs of T. and our daughter. Maya could figure out what we should all be doing when it was clear T. was coming home from a visit with her mother in a dysregulated state. At other times, Maya would put out the call for “all hands on deck” so that Binny could leave work early to strategize about how to handle the emotional fallout from the day.

As time went on, this divide-and-conquer approach became more pronounced because having all four of us together was triggering for both girls and escalated emotional tensions. Binny would take T. to play outdoors, pick her up from aftercare, and sit with her in the evenings and chat. But this separation divided our family, and we would meet after bedtime and talk for hours about what had happened and to strategize for the next day. We cannot imagine how a single parent could possibly manage either the logistics or the emotional fallout.

The system should require that foster parents participate in the mental health interventions provided to the children (as appropriate). As Roman notes, “[T]here is often ‘no clear expectation that [foster parents] will participate in any form of mental health interventions with children in their care.’”⁸⁴ It is impossible to provide truly effective trauma treatment without the presence and involvement of a person with some kind of attachment relationship to the child. Trauma is healed in the context of relationships. This, too, takes time and should be reflected in the compensation that foster parents receive.

We disagree with one of Roman's key components of her proposal for treating foster parenting as work. She proposes that in paying foster parents for their labor,

84 *Id.* at 200 (quoting Shannon Dorsey, Elizabeth M.Z. Farmer, Richard P. Barth, Kaylin Greene, John Reid & John Landsverk, *Current Status and Evidence Base of Training for Foster and Treatment Foster Parents*, 30 CHILD. & YOUTH SERVS. REV. 1403, 1404 (2008)).

the system can expand the demands of that labor contract to require that foster parents serve a mentoring and/or a facilitative role in relation to the child's biological family.⁸⁵ We believe that the discussion of professionalization should be separated so that these two proposals are not conflated. The skills required to navigate not only the caretaking role for the child, but also a mentoring role for biological families who have not consented to this relationship are far beyond what should be expected from foster parents and it is far beyond the ability of our current system to train and support parents in this role. In addition, we must remain aware of "the deeply-rooted stereotypes and assumptions about black family dysfunction [that] lead to stark inequalities in treatment of parents and children of color, given the subjective and discretionary nature of child welfare decision making."⁸⁶ The power imbalances inherent in the biological/foster parent relationship make a mentoring role for foster parents untenable. Instead, we should make sure that culturally-sensitive, trauma-informed parenting programs and tools are made available to both biological and foster families.

Conceptualizing all foster care as therapeutic foster care and conceptualizing foster parenting as work, taken together, can change how we view foster parents' role in the system. For example, a highly functioning system of therapeutic foster care with intense involvement by other actors in the system could mean that compensation for foster parents, even if conceived of as work, could be reduced. A less effective system of therapeutic foster care could mean that foster parents would be paid more. These proposals should be viewed not just as independent proposals, but interdependent proposals where both sides of the equation need to fit together.

The availability of supports for foster parents—including therapeutic foster care supports and paying foster parents for their labor—can also help biological parents when a foster child returns to her home. These supports are critical in addressing what is sometimes referred to as the "recidivism" rate, shorthand for the success of reunification efforts. The long-term success rate for reunification is depressingly low, by some accounts as low as thirty-five percent.⁸⁷ This low success rate should not be surprising. Children who enter the foster care system have more challenges than those who do not. When they return to their families, their parents are parenting a child who has experienced an attachment disruption and has experienced potentially more trauma than the child had when she left the home. More support for foster parents would help protect foster children from some of the negative consequences of foster parents parenting with inadequate resources.

It is our belief that exploited workers cannot provide truly trauma-sensitive care to others. Not paying for this care work degrades the quality of care. We have a moral obligation to advocate for non-exploitative conditions for foster caregivers, not only for the protection of foster caregivers, but because it is an essential condition of appropriate care for children that their caregivers be supported. An exploited

85 *Id.* at 185.

86 *Id.* at 187 n.28.

87 *Id.* at 188 n.37.

caregiver not only affects the foster child but the entire family system.

In 2016, after we were no longer foster parents, the D.C. City Council enacted legislation that clarified the rights and responsibilities of foster parents.⁸⁸ While the legislation represented an improvement to the status quo, it did not address the concerns that motivated our proposal for reform.

CONCLUSION

Let social workers be social workers; let parents be parents. In order for foster parents to have the emotional resources to provide the emotional connection and to respond to the emotional and regulatory effects of trauma, they have to not be completely consumed by the complex logistics inherent in the life of a child in the system.

The support that is available to children, parents, and foster parents in treatment foster care should be made available to all children and families in the foster care system. Children must have trauma-sensitive services so that their needs are met and placements are not disrupted. The work of foster parents is all-consuming and isolating. Foster parents need to receive trauma-sensitive training and support that rises to the level of treatment foster care so that our most vulnerable children can be provided with the best care that we know how to provide.

88 Foster Parents Statements of Rights and Responsibilities Amendment Act of 2016, 2015-603 D.C. Code Adv. Leg. Serv. 1 (Dec. 21, 2016) (enacted as D.C. Law 21-217) (“To amend the Prevention of Child Abuse and Neglect Act of 1977 to require the Mayor to issue rules to consolidate existing rights and responsibilities for foster parents, to require the Child and Family Services Agency to inform foster parents of their rights and responsibilities, to provide copies of the Statements of Rights and Responsibilities for Foster Parents to current foster parents, to incorporate the Statements of Rights and Responsibilities for Foster Parents into scheduled trainings for foster parents, to develop an implementation plan for the dissemination of the Statements of Rights and Responsibilities for Foster Parents, to develop a process for receiving and handling reports of violations and complaints, and to establish annual reporting requirements to the Council and the public on outcomes related to reports of violations and complaints.”); *see also Foster Parents Statements of Rights and Responsibilities Amendment Act of 2016: Public Hearing on Bill 21-603 Before the D.C. Council Comm. on Health and Human Servs.* (July 14, 2016) (statement of Damon King, Senior Policy Attorney, Children’s Law Center), <http://www.childrenslawcenter.org/testimony/testimony-foster-parents-statements-rights-and-responsibilities-amendment-act-2016>.