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INTRODUCTION AND SUMMARY

Thank you, Chairman McDermott and members of the sub-committee for holding this important hearing today. As one of 12 million adults in this country who grew up in foster care, the government served as my parents. This committee and your colleagues in congress have stood in the places where our mothers and fathers belong for generations of foster youth, including the more than 500,000 children who live in care right now.

I am the Deputy Director of Foster Care Alumni of America. We are a national non-profit association that brings together those of us who share that foster care experience in order to be the permanent extended-family community for each other, something that many of us growing up never had. We also work with others—foster parents, social workers, policy makers, community members—to influence foster care practice and policy. Our goal is to erase the differences, the stigmas, the disparate outcomes that are faced by our brothers and sisters from care compared to the general public.

In addition to having grown up in foster care, I am a master's level social worker and have spent the last 19 years working in the child welfare system. I have worked in group home facilities, as a child protection worker, as a clinical social worker for young people in treatment foster care and their families. I now live in Minnesota and work around the country to improve the lives of those who come after me in foster care.

I am also proud to have been the licensed foster mother for three young people—Chris, Sean, and Tomikia. They came to me in their teen age years and are now 23, 24 and 26 years old.

The thing I know the most about in this world is foster care, having experienced it from so many different sides. On the topic of the use of prescription psychotropic medications with youth in foster care—and nearly any other topic related to child welfare—I have to start by acknowledging that there is simply no one right

answer. But I do want to make sure that you hear from many different perspectives about what we, as the community of alumni, ask you to consider on this topic. Remember, you have taken on the very real role of parents for people in and from foster care and your careful deliberations—both as law makers and as mothers and fathers—is what we need.

In my childhood, I spent 12 years in approximately 30 placements. I lived in placement in MN, ND, SD, ID, UT, MT, WY, and NE. I experienced foster homes, group homes, shelter facilities, detention and correctional institutions, kinship care, and psychiatric/residential treatment. Through those unstable years, I probably had a couple hundred people who were responsible for me—yet no family. I emancipated with no permanent connections and very few resources. My time in care resulted in a long list of diagnoses, including Post Traumatic Stress Disorder, Oppositional Defiant Disorder, Depression, and a sleep disorder. Because of the instability in my living situation, it seemed that the only option the professionals in my life were able to take for treating all of the diagnosed conditions was prescribing medication. Over the years I was on more medications than I can count--usually without my knowing what the meds were for, how I should expect to feel, side effects to watch out for, or any plan for follow up.

It was not until I was a senior in high school and in my last foster home that I even knew that I could question the medications or challenge the diagnoses. In that home, the foster parents dutifully gave me my handful of pills each night for the first week or two and finally asked what they were for. I said I didn't really know, other than that they were supposed to help me sleep. My foster father asked me why I don't sleep well without them and I told him that I get so anxious at night when I hear noises that I can't get any rest. These foster parents did something incredible. They skipped the medication one night, made cocoa, and sat around playing cards with me late into the evening. As we got into the deepest part of the night, we sat together and listened to all of the noises in the house. I could feel the familiar anxiety--but my foster dad patiently helped me figure out what all those noises were. It was the dog getting a drink of water upstairs. It was the furnace turning on. It was the water softener regenerating. My foster parents reassured me of my safety. They listened to my stories about how unsafe I had been in the home I came from. They acknowledged that I was actually very smart to be so vigilant and protective of myself that I didn't fall into such deep sleep that I could be hurt at my home. They helped me make sense of my reaction--which on paper looked like a disorder, but in the reality of my life had been the very best thing I could do for myself. They helped me to learn and believe that I didn't have the same reality anymore and I could let go of some of that vigilance.

Because of the insight and creativity of those foster parents, I was able to see my world in a brand new way. I was able to ask that my medications be decreased and eventually discontinued, and they supported me in getting the kind of

treatment that would make a sustainable difference in my life--learning new ways to cope, recognizing what is good and right in myself so that I could do more of it, identifying ways to keep myself safe without having to hide or fight. By the time I went off to college, I was no longer on any medications and I actually had the skills and knowledge I needed to take the place of the medications.

As you'll see in my testimony, we know from alumni that it is a common occurrence for youth in care to have an experience like this--receiving diagnoses and medications in response to their disordered lives. We know that sometimes that medication serves as a lifeline--it makes it possible for the young person to get through a particular crisis. They then have the opportunity to come out on the other side of the crisis to develop healthy strategies for coping. We also know that medications often are given as a substitute for what young people really need--stability, love, power, hope, and someone who sees them and hears them.

What is known about the mental health of people in and from foster care is that many of us have psychiatric needs due to the trauma of abuse and neglect. It is also true that youth in care face the additional trauma of removal from their homes and all of the people and places that are familiar and placement in the system. When youth experience placement instability, these traumas are compounded. The best treatment for this trauma is stability, patience, compassion, and safety.

We also know that young people in foster care are often coming from families of origin that are facing significant mental health issues. Whether as a result of trauma, a matter of genetic predisposition or a collision of those factors, many youth in care do have valid mental health disorders and do require treatment, sometimes including medication. Research conducted by Casey Family Programs¹ has shown that mental health outcomes for adult alumni of foster care are disproportionately poor compared to the general population. Among the findings:

- The rates of post-traumatic stress disorder (PTSD) among foster care alumni are about twice as high as PTSD rates in war veterans and nearly 5 times the rates of the general public.
- Alumni experience panic disorder at rates more than three times that of the general population.
- People in and from foster care have particularly high rates of ADHD, chemical dependency, conduct disorder and depression and other mood disorders.

There are no easy answers, but there are some recommendations we'd like to share as a community of alumni.

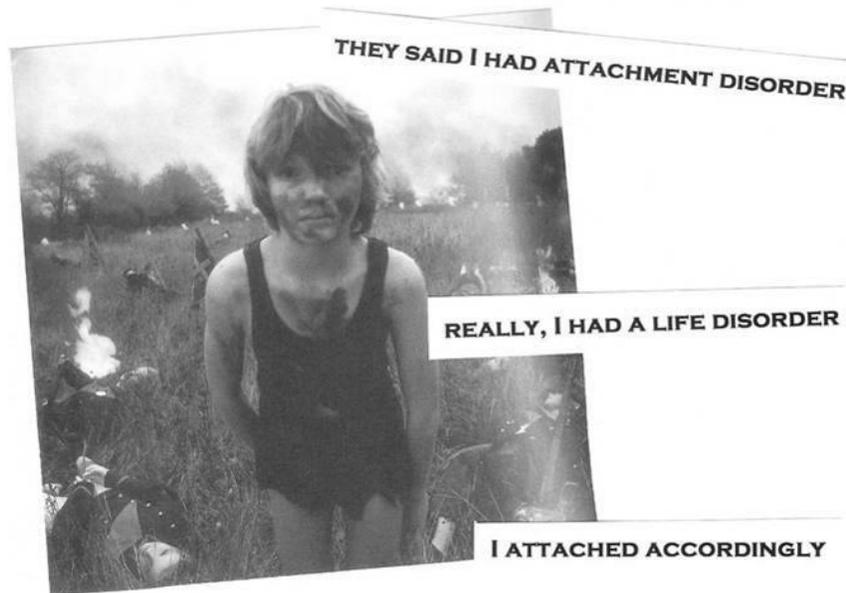
¹ Pecora, P. J., Williams, J., Kessler, R. C., Downs, A. C., O'Brien, K., Hiripi, E., & Morello, S. (2003). *Assessing the effects of foster care: Early results from the Casey National Alumni Study*. Seattle, WA: Casey Family Programs. Available at <http://www.casey.org>. Revised January 20, 2004.

Recommendations from alumni of foster care about the use of psychotropic medications:

- 1. Consistency is the key to adequate and appropriate mental health care. We need stable placements, we need a ‘medical home’, and we need professionals who know us and our circumstances—and who care about us enough to be effective advocates.**
- 2. Medication should not be the first option considered and should *never* be the only mode of support we receive. Pills cannot change the experiences we’ve faced or the life situations we’ve been put into.**
- 3. We need access to well-trained and supported professionals who can provide culturally competent services. The culture of foster care includes both challenges and victories that need to be recognized and supported by the people responsible for our care.**
- 4. We need ongoing access to health care even after we’ve been adopted, reunified, or emancipated. Our needs don’t change just because the court order or case plan does.**
- 5. We need to know about our own lives, and need to be the primary voice in planning and decision-making. We need access to our records, information about our diagnoses and medications, and the power to seek or refuse treatment based on an educated and supported knowledge about our own lives.**

What alumni of foster care want you to know:

Foster Care Alumni of America is proud to be a member of the national Task Force on Foster Care through the American Academy of Pediatrics. As part of our work with the AAP, we've been conducting a survey of our members about their experiences and recommendations regarding health and mental health care access and services. In addition, we have a national community art project where people in and from foster care have submitted postcard art about what they've learned, what they want to share in connection to their foster care experiences. Here are some of the insights we've gathered.

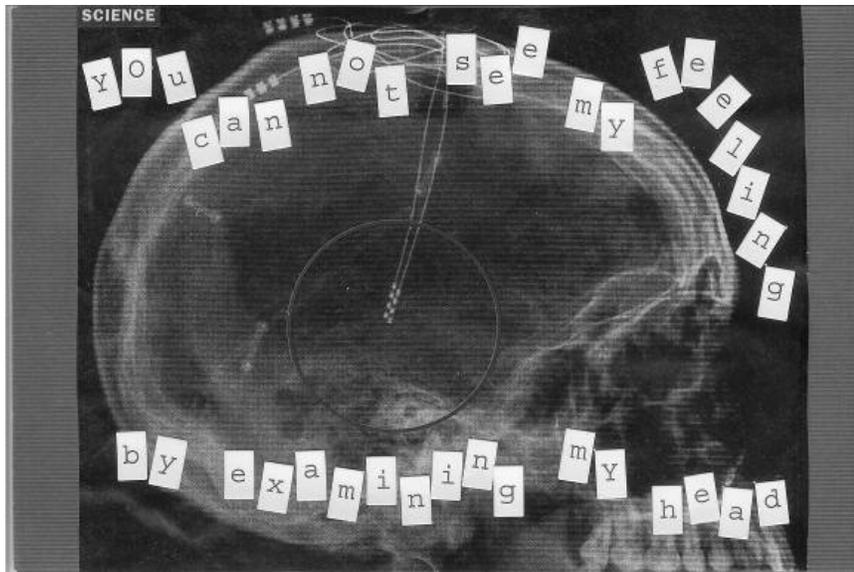


"I was over-diagnosed and over-medicated. I was depressed and emotional when I first entered care and I did not respond to antidepressants. So they thought I had something more serious, but what I had was a life problem."

--Alumna of care, mid-20s, Ohio

"Don't assume that foster children are "damaged" and need to be "fixed". Do your homework and learn as much as you can about the culture of foster care. Often individuals who are privileged in our society overlook even the simplest of things that foster children must deal with every day (e.g., who loves me? where do I belong?). Society continues to send messages to foster children about the value of family (e.g., home is where the heart is - family is the key to happiness) however, those who live outside of secure committed families feel marginalized and disempowered."

--Alumnus of foster care



“Scary things in my case file made people assume that there were scary things inside my head. I really was struggling, but I needed time with people, attention, someone who loved me, somebody to talk with who wasn't there for a paycheck.”
--Alumna of care, late 30s, Virginia

“I was put on medication as soon as I entered the system. Did they understand I was grieving, scared, confused about my life? No, they figured let's give her a pill. All I ever wanted was for someone to listen.”
--Alumna of care, California

“Once I left the system I became homeless and without money to afford medication I was left to my own devices: self-medicating with drugs. Luckily, the law "helped" me to learn my lesson. As an adult, my own children are in foster care. I don't think this would have happened if I'd gotten what I needed as a child and I'm working so hard to make it different”
--Alumnus of care

“Pills can't take away what happened to me.”
--Alumna of care

“The system enabled me to become chemically dependant to my meds. I sought out ways to feel numb once the system was gone, once my medical was cut off --
-- alcohol and drugs.”
--Alumnus of care

“The best care I got was people accepting me where I was at...not trying to change me as though I was broken/damaged, but being allowing me the room to express my experiences without judgment from the doctor or counselor. The most helpful experience was one in which the counselor or doctor did not assume they knew me based on a file.”
--Alumnus of care

CASE HISTORY

Assessment of the Child:

My childhood is documented in a file filled with painful details. My foster parents and social workers defined me in their reports:

"Inappropriate." "Defiant." "Defensive."

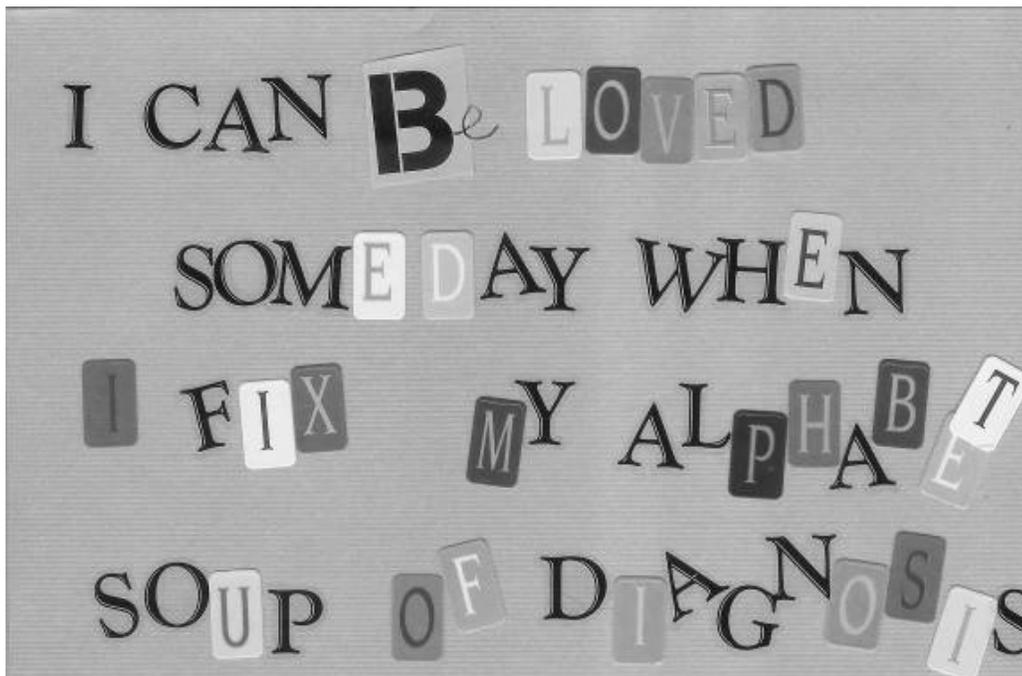
"Manipulative." "Demanding." "Belligerent."

Transition to Adulthood:

After leaving foster care, it took a while to finally believe in myself and understand who I am. *Passionate. Honest. Caring. Intelligent. Articulate. Resolute.*

"My case file made me look very oppositional--I had a long criminal history as well as chemical abuse issues. What seemed to escape the notice of the system was the fact that any criminal or using behaviors were all connected to my biological family--either activities done WITH them or as a method of coping with them. I think because of that, I wasn't taken seriously. I wasn't respected or heard."

--Alumnus of care



“I had 8 diagnoses. I wish they would have had compassion and realized group homes were tough...and so was my childhood...and just given it time....or provided me with an adjustment disorder diagnosis.”

--Alumnus of care

On behalf of all of us in and from foster care, thank you for standing in the place where our parents belong. Thank you for considering the expertise we have to offer as people who have learned about foster care from the inside. Know that our organization, Foster Care Alumni of America, is available any time policy related to foster care is being considered. We have members from all 50 states, with our youngest members being 18 and our eldest in their 80s. It matters to us that the youth who come after us in foster care have the best that the system has to offer—stability, love, safety, and peace—and we want to help you make that happen.