

fostering perspectives

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Promoting physical health for young people in care

Resource parents have a big influence on the children in their care—especially when it comes to their health. After all, every day offers opportunities to model and teach children about nutrition, exercise, and caring for their bodies. On top of that, resource parents take children to appointments and provide hands-on care to help them manage colds and more serious medical conditions.

To support this essential work, this issue provides information on a variety of subjects related to the health of young people in foster care. In it you'll find ideas for managing food-related behaviors in children who have experienced trauma, as well as tips related to diabetes care, oral health, the HPV vaccine, and more. We hope you find it helpful.

Quick Tips for Foster Parents and Kin Caregivers

At Placement

- For kids ages 0 - 3, ask if there's been a referral to early intervention services.
- If DSS doesn't share health summary forms 5206 (Initial Visit), 5208 (30-Day Comprehensive Visit), and 5209 (Well Visit), follow up—they contain key information!
- Inform the child's doctor (whose name will be on the child's Medicaid card) the child is in your care.

Communication

- Tell the agency of any significant development in a child's health, or if you need help with the child's physical care.
- Maintain open communication with the agency. It may be able to offer support (e.g., respite) to help ease the stress of caring for the child.

QUICK TIP



Type 1 diabetes in foster care by Katie Souris

Type 1 diabetes (T1D) is an autoimmune condition in which the body eventually produces no insulin. This serious condition is fatal if left untreated. There is effective treatment, but no cure.

A diagnosis of Type 1 diabetes is life changing for a person of any age, but for children and their families it can be particularly hard. Managing diabetes every day is essential for a person's survival and well-being. Taking a day off from finger pricks and insulin injections isn't an option, and prioritizing healthy eating and physical activity is important for blood sugar control.

Annahi's Perspective

In the box at right Annahi, a young woman in foster care, shows amazing strength and self-awareness as she describes her diabetes journey from diagnosis, through denial, and ultimately, to positivity.

In her story, you'll see that Annahi blamed herself for not managing her diabetes as a young child. This isn't really fair. Children can't reasonably be expected to be in charge of managing their diabetes. Managing T1D can be complicated and requires education, dedication, and a network of support. These elements must be maintained and promoted by caregivers as the child grows into maturity and self-management.

Lori Church Whitmire, a Certified Diabetes Educator, offers a helpful way of thinking for caregivers: "Until the child is ready to take care of their own basic needs," she says, "he or she should not be assuming the responsibility for diabetes care." *See TYPE 1, p. 2*

When I stumbled, I discovered my strength

by Annahi, age 14

My name is Jennifer, but I like to be called Annahi. I am 14 years old and I am diabetic and happy and proud to be. My life has been a struggle, but it has been the best it can be.

I don't regret the choices I made because that's what made me stronger and what made me the person I am today. Yes, I've had ups and downs like any other teen, but at the end I know how to smile and move on.

My favorite colors are turquoise, lime green, and peach. I am a teenager gone wild, and a kind and friendly person. I like to make new friends and socialize, but I also like to spend time with my family.

Being diabetic doesn't mean I can't enjoy the world or go out and have fun. Yes, I stay strong and fight it and deal with it every day. I'm thankful for my struggles because without them I wouldn't have stumbled across my strength.

What follows is an excerpt from a paper I wrote called "One Battle, a Million Struggles."

It Hasn't Been Easy

I was diagnosed with diabetes eight years ago [at age 6]. It has not been easy.

I just couldn't deal with it anymore, so I started to eat anything I wanted.



Sometimes my blood sugar was good. Other days it would skyrocket, which means it was extremely high, like in a dangerous zone. Then I just couldn't deal with it anymore, so I started to eat anything I wanted.

I wasn't supposed to do that, but I did. I couldn't eat candy or any type of sweets, but I would anyway. Then it got to where I was getting tired of living the diabetic life, tired of taking medication every single day, so I would skip my doses. Other times I would just forget to take them.

This made me feel so, so sick.

The Emergency Room

I ended up in the hospital—in the emergency room—with DKA (diabetic ketoacidosis). [Diabetic ketoacidosis is a serious condition

see ANNAHI, p. 2

Type 1 from previous page

“There are things they can learn to do along the way and should learn to do along the way,” Whitmire says. “For example, I have seen children as young as three and four already learning how to test their own blood sugar. But sometimes, the child does not have the dexterity to perform the task. And even though the child may be able to perform the task, they may not understand the impact of the results. That is where the parent [caregiver] needs to step in and guide and teach.”

Caregivers Are Crucial!

Like other young children, those with T1D deserve the chance to play, explore, and learn with the guidance of loving caregivers. True, their lives will be complicated by the condition and all the energy, consideration, and adaptation it takes. Yet with support they can live happy, healthy lives.

Annahi recognizes how her current caregiver, Mary, prioritizes her well-being. Caregivers of children with Type 1 diabetes have the difficult task of being an empathetic support person while also ensuring the child completes what can be uncomfortable management tasks. What’s more, children’s management methods and routines differ, with some using injections while others wear an insulin pump. Children and caregivers must work together as new challenges arise.

Challenges and Opportunities

Caring for a child with Type 1 can be daunting because a regular schedule and frequent check-ins are so essential for these children. Yet, the experience of relating over the shared goal of blood sugar management can improve communication between caregiver and child.

Living with T1D can also help children learn to set and achieve goals and prioritize wellness from an early age. In fact, children growing up with diabetes may develop a greater appreciation for health and become more mature and independent as a result.

Helpful Resources

Caregivers of children with Type 1 diabetes can benefit from finding a support network for their children and themselves. Here are some resources you may find useful if you are caring for a child with this condition:

- TypeOneNation, a vibrant social network for people with T1D, their families, and friends. <http://typeonenation.org/>
- American Diabetes Association. <http://www.diabetes.org/living-with-diabetes/parents-and-kids/>
- TuDiabetes.org. <http://www.tudiabetes.org/>

Katie Souris is completing her MPH in health behavior at UNC-Chapel Hill. She’s been living with T1D for 11 years and writes about her experiences at <https://thesweetadventurer.wordpress.com/>

Annahi continued from page 1

that can lead to diabetic coma or even death.) It was horrible, but since I’d made the wrong choice I had to deal with it.

[The people in the hospital] helped me feel better so I would soon be able to go home, but not for long. I would be back and forth, going to the emergency room about every other month.

I never really thought what could happen because of all of this.

Two in the Hospital

My mom was expecting a baby. Close to her due date I ended up in the hospital again. While I was there my mom was admitted to labor and delivery. A few days later I was ready to go home but my mom wasn’t.

This was when the doctors decided to report our medical issues to DSS (the department of social services).

DSS Gets Involved

That evening a well-dressed lady walked in with a big thick folder in her hand. We talked awhile, then she asked me if I knew anyone I would be willing to stay with while my mom was in the hospital.

The only person that came to my head was a lady who went to my church. I gave her Ms. Julia’s information. The next day I got out of the hospital and went to Ms. Julia’s house.

I felt pretty good being there—she was a really nice lady and pretty cool.

Later a social worker arrived saying I would be put into foster care. I didn’t really know what she meant. I just knew I would be staying with Ms. Julia longer.

Why Am I in Foster Care?

One day I decided to ask the social worker why they had put me into foster care. She told me that it was because I was having too many difficulties at home controlling my diabetes. Then I asked her when I could go home.

She said, “I don’t want to upset you, but I honestly don’t know. It might be a long time before you can go back.”

My face dropped and she kept talking.

I told her, “STOP, that’s enough! I don’t want to know any more!”

From her shadow I saw her pulling her hair back, then take her hand and slowly reach out for mine. Meanwhile I was trying to hold my tears from falling. I pulled my hand away from hers as if I’m telling her, “Don’t touch me!”

She gently put her hand on my chin, trying to lift up my head. I lifted it up and looked away from her.

In a soft voice she said, “Don’t think I’m the bad guy here or that I took you away from your family because I don’t want you to be with them. If I took you away, it was because I want to help you and your family do what is right for you. We

want you to be healthy and to grow up and be someone in life.”

In my head all she was saying was entering one ear and exiting through the other. I was ready for her to go.

Be Strong

When she left, Ms. Julia came in the room. She looked at me as if she was going to drop some tears, too. I immediately looked away and started to cry.

She started out by saying, “I’m sorry, I know how you feel.”

“Ugh, it’s OK,” I replied.

But then I said, “It’s all my fault.”

She said, “Jenni, no! Don’t say that. You just didn’t think of the consequences of your actions.”

“Look,” she said, “I know it’s hard and you sure didn’t expect all this to happen, but all I can really say is you need to try to be strong for your mom and your sisters.”

I said, “OK, I’m going to try.”

Months Pass

Months passed by and I started to get used to this whole different life. My mom started to take classes at the community college so she had to find a babysitter for my sister. She asked Ms. Julia and she agreed.

So I got to see my baby sister when she was there, but not as often as I wanted it to be. But other than my yearning for my family, so far things were really good.

I wasn’t having so much trouble with my diabetes.

Tragedy

One day Annahi returns home from school to learn that her baby sister died in her sleep while in Ms. Julia’s care. After the funeral Annahi is placed with Mary, a different foster parent. Eventually Annahi reunifies with her family, but once again her diabetes goes out of control. DSS places her back with Mary.

Doing Great

[At Mary’s house] I was happy and at the same time sad—another whole different life again! But deep down I knew it was for the best. It would be hard, but my life would be better.

So far I am doing great. Yes, Mary can be hard on me, but I’ve learned it’s always for a good reason. She’s really a caring and loving person to me.

I know she doesn’t know this because I hardly say this or anything, but I love her! She’s my hero, the one who came into my life when I least expected it. The one that God put in my way for a reason.

Thank You, God, for my life and all You’ve done in it. I know we are all different and my story has a purpose that can impact the lives of others forever.

Yes, Mary can be hard on me, but I’ve learned it’s always for a good reason. She’s really a caring and loving person to me.



Conquering food-related fears and behaviors by Bob DeMarco

Oprah Winfrey once had actor Sidney Poitier on her show as a guest. She asked him about his difficult early life and how it affected him today. In response, Poitier opened his suit jacket and pulled out a Snickers bar.

“This is always with me,” he told Oprah. “When I was a child there were times where we were starving. We had no food. Even after I grew up, made a living, and could put food on my table, and in abundance, I still lived with the fear that I would not have enough food. I live with that fear even today. So, this candy bar is always in my pocket!”

A Common Issue

Food is often an issue in families with children who have experienced early trauma or neglect. The causes vary, but the results are often the same: overeating, undereating, hoarding food, stealing food. The way children deal with their often intense feelings about food—especially when combined with other challenging behaviors—can drive resource parents to the brink.

In our home we’ve dealt with “The Cave Man” who can’t shovel food in fast enough, “The Bird” who refuses to eat at all, “The Bottomless Pit” who never seems to fill, “The Night Owl” who won’t eat dinner but is starving at 2 a.m., “The Scavenger” who takes from everyone else, and “The Collector,” who likes to store leftovers from the evening meal under the bed.

Our kids had indeed come from a neglectful situation and at times went for days without someone offering them food. This might explain why raw spaghetti and dry cake mix are comfort foods for them, or why my son feels an intense need to provide for his younger sister, or why he asks about lunch while eating enough breakfast for three grown men.

Food Can Be a Minefield

Food-driven behaviors present real challenges for parents and add to the length and breadth of the emotional minefield we navigate as we try to help our kids heal. Many of the mines I’ve stepped on are because I didn’t use the proper parenting techniques I’ve learned. One would think that after five years parenting children with trauma backgrounds, I would know authoritative parenting doesn’t work and that I will not win a battle for control with my kids.

One would think. And yet I have been heard to say:

“You will not leave the table until you eat that chicken”... BOOM (mine explodes).

“You will not hide food in your room”... BOOM (mine explodes).

We can easily avoid some mines by looking

at our kids through a trauma lens. Others are trickier and require greater caution.

I actually said this to my tween daughter: “Honey, don’t eat more. I know you don’t want to put on more weight.”

To be honest, with that one I didn’t even know I had goofed up. I was truly trying to encourage her. It wasn’t until my 18-year-old daughter pulled me aside and told me what the message sounded like on the receiving end. With one careless remark I took a shot at my daughter’s already crumbling self-image...KAAAAABOOOOM!

Thank God these kids are so resilient and that I get so many chances to teach my kids how to apologize and to forgive.

What We’ve Learned

As with most things, there are no easy answers when it comes to food challenges. But here are a few things we’ve learned:

Ironically, many of the medications prescribed to kids like ours to help manage their mood and behaviors affect their appetite. We’ve seen significant swings in eating patterns when meds have changed. Watch out for side effects.

We’ve learned that our kids sometimes confuse emotional and physical feelings. Anxiety, for example, can be mistaken for hunger. On the way to therapy both kids would claim to be “starving” but after some probing we helped them see the “hunger” sensation was coming not from their freshly-filled bellies, but from concerns about what the therapist might bring up.

Understanding these and other things has led my wife and I to the realization that battling with our kids over food is not a good fight. Instead we’ve chosen to come alongside our kids to join them in the fight against their food-related fears. Now, this doesn’t mean we allow a free-for-all. Rather, it is changing our frustration- and control-driven perspective to one driven by empathy and creativity.

What Works for Us

The Basket. We’ve ended the midnight marauding of the Night Owl and the hoarding of the Collector with one simple accommodation. In addition to teaching the kids there are appropriate and inappropriate times to eat, we’ve put a well-stocked basket of healthy, packaged foods in each child’s room. They may eat from this basket any time they like. We’ve told them, “When it’s getting low, just let us know and we’ll fill it back up.”

This approach does several things. First, it quells their fear there won’t be enough food. Second, it stops the negative behavior, allowing me to get a good night’s sleep. Third, it gives them some control. They help select the contents of the basket and can eat anything

from the basket whenever they want. Finally, it is one small proof to our kids that we are “in their corner” and can be trusted to provide for them... (mine defused).

Breakfast. We take a similar strategy with breakfast. My son can eat as much as he wants, but we put some limits around it. First, he cannot help himself—we must serve or supervise the serving of the cereal or English muffin. Second, we require that healthy foods be in the picture. We choose breakfast cereals with low sugar and high fiber as the “base” and allow the children to mix in a small amount of sugary cereal if they choose. If that’s not enough, a second bowl of just the “healthy base cereal” can be had. The next course must include fruit, and we usually finish with protein (often peanut butter on toast).

My son no longer needs the food basket in his room, but he tends to get up earlier than the rest of us. The solution? On Friday nights we provide a granola bar he can eat in the morning to help tide him over, so the rest of us can sleep in a bit.

At School. We’ve worked similar strategies into our kids’ IEPs at school. For example, our son’s IEP calls for him to stay well hydrated and have a snack every two hours, which allows him to focus on his schoolwork. We send the healthy snacks to school as they are needed.

Let Your Struggles Be a Strength

Food related issues run deep, are hard to overcome, can manifest in different ways, and if not dealt with well, can be a real source of strife.

The truth is, we all have demons that haunt us and drive our behaviors. Whether it’s anxiety about food, low self-esteem, lack of confidence, or something else, I encourage you to use your personal experiences (I’m talking about your struggles) as a means of connecting with your child. Use them as a way to understand how hard it can be to overcome deep-seated fears and beliefs.

I’ve found I’m most successful as a parent when I’m able to maintain the perspective that it is me and my kids against the demons that haunt them, and I find that I’m best able to have that perspective when I identify with them. As many of you know, parenting kids who have been traumatized can often be an exhausting and thankless job. There is power in reminding ourselves why we foster and adopt in the first place.

When it comes to challenges around food, a healthy dose of understanding coupled with small, simple accommodations can help our kids cope with their fears and do the healing and growing they need to do.

Bob DeMarco is an adoptive parent in North Carolina.

Tips for acting boldly to change diet and exercise for kids

As parents and caregivers, you are critical to establishing the necessary and lifelong habits of healthy eating and exercise in children.

Act boldly as a

- **Role model** — Make sure to eat healthy, wholesome foods and get plenty of exercise yourself. Be consistent; this should be a permanent part of your lifestyle. Set a good example.
- **Gatekeeper** — You have the power to monitor and control what your kids eat, what exercise they get, and how much time they spend watching TV, surfing the web, or playing videogames. You're in charge.
- **Taste-setter** — You can influence your kids' appreciation for the flavors of healthy food very early on, which can last them into adulthood. Start them off right.
- **Advocate** — Use your voice to push for positive changes in child care, schools and your communities that facilitate healthy eating and exercise. They have the right to be healthy.

Change their diet

- Use healthy, wholesome foods (i.e., fruits, vegetables, whole grains, lean proteins, and low-fat dairy) that are nutrient-dense when cooking family meals or preparing snacks. Limit consumption of empty calories in the form of sugary, processed, and fast foods.
- Use Go, Slow, Whoa as a guide.
 - **Go foods** — low in fat, sugar and calories and nutrient-dense, e.g., fruits and vegetables. Great to eat anytime.
 - **Slow foods** — higher in fat, added sugar and calories, e.g., white bread, pancakes, fruit canned in syrup. Should be eaten less often.
 - **Whoa foods** — very high in fat, added sugar and calories while low in nutrients, e.g., candy, soda, French fries. Eat once in a while in small portions.
- Make sure that calorie intake and portion sizes are matched to your child's age and activity level.
- Find ways to make over family favorites by using healthier ingredients (e.g., more veggies, less fat) or healthier methods of cooking (e.g., grilling or baking instead of frying).
- Connect kids to their food by continually introducing them to new types of healthy food and allowing them to participate in food shopping and preparation so that they can understand what goes into their meals and maintain healthy cooking habits as they grow up.
- Protect the time you eat with your kids — children who dine at regular family meal-

times get better nutrition, perform better in school and bond better with their families.

- Change their media diet — limit TV time to one to two hours of quality programming per day, monitor internet use and make sure they avoid snacking during TV time.

Change their exercise routine

- Make time to play or be active with your kids — set aside 60 minutes everyday to play catch; go for a walk, jog, bike ride or swim; or play tag.
- Make sure your kids get enough activity to balance the calories that they take in.
- Give them gifts that encourage activity — e.g., sporting equipment, active games or enroll them in community sports teams.
- Walk as much as possible — e.g., walk with your kids to school, after dinner, instead of watching TV.
- Move around at home with your kids — e.g., yard work, gardening or work around the house.

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Kids in Foster Care Deserve Special Consideration

For foster parents and kin caregivers, every day is a chance to teach children about nutrition and exercise. Yet we must be mindful of how we do this. For example, it's a good idea to always:

- Ask the child's medical provider before altering a child's diet or exercise, since you may not know all there is to know about their health.
- Maintain a trauma lens. For example, say a child is overweight and depressed by the losses she's experienced. Instead of asking her to exercise more or eat less, talk to her about the importance of matching activity and calorie intake—and be a good role model for her.
- Focus on positive health and wellness messages ("spinach is great!"). Negative messages can have unintended consequences. For example, saying "fast food is bad for you" may feel to a child like criticism of their parents, if fast food is a staple in their family.

The bottom line? You should definitely teach children how to get and stay healthy. However, in doing so, it's important to consider the child's entire situation and all the challenges they face. Use the tips on this page, but with awareness and sensitivity.

Why are you critical to establishing healthy behaviors in your kids?

You are role models

- Children are instinctively primed to imitate their parents and caregivers. They are incredibly sensitive to the messages that are sent about eating and exercise. You exert the most influence on your children's behavior and can model healthy attitudes and habits toward food and physical activity that persist as they grow up.

You are gatekeepers

- Parents and caregivers control the types of food children have access to in the home and can maximize access to healthy, wholesome foods (fruits, vegetables, lean proteins, whole grains and low-fat dairy).
- You can also monitor children's diet, exercise, and limit media consumption (TV/video watching, web surfing and videogames).

You are taste-setters

- Parents and caregivers significantly influence the likes and dislikes that children attach to certain foods. These influences can last a lifetime. Each of us can probably remember a favorite home cooked meal from our childhood. There is even research that suggests that this begins in infancy; children who are breastfed may be exposed to different flavors in their mother's breast milk than the sugars and fats in infant formula. Breastfeeding may provide protection from the development of obesity.
- Eating with your children at regular family mealtimes can help establish positive nutrition habits and healthy weights for children.

You are advocates

- Parents and caregivers can push local leaders to introduce affordable transportation (e.g., bus or shuttle lines) to supermarkets or grocery stores if there are none in their communities.
- You can call for the construction of parks or playgrounds and restriction of fast food places in your neighborhood.
- You can push school administrators to introduce after-school programs that incorporate physical activity or nutrition education, healthier school lunches, and policies that eliminate the use of vending machines on school grounds.
- You along with members of your community can volunteer to coach afterschool sports.

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NC initiative seeks to improve health of kids in care

Fostering Health NC is a statewide initiative focused on improving health outcomes for children and youth served by the foster care program. This effort, led by the NC Pediatric Society, is working to ensure every young person in foster care has a medical home and that their healthcare aligns with standards recommended by the American Academy of Pediatrics (AAP).

What is a medical home?

A medical home is a doctor's office—typically a pediatric or family medicine practice—that serves as a central place where all of a child's medical records can be maintained and periodically reviewed. The idea is to have as many health care decisions as possible made by one office to ensure children get coordinated care.

There are many benefits to this approach. By taking children to the same doctor for check-ups, vaccinations, and sick visits, you help the doctor build a complete picture of the child's health, which can help detect changes that need attention. Repeat visits strengthen the relationship you and your child have with the doctor, leading to greater trust and comfort.

How often should visits occur?

Children should be seen by a doctor early and often upon entering foster care. The purpose of these visits is to assess their physical, dental, emotional, and behavioral health needs.

The American Academy of Pediatrics standards recommend children have an **Initial Visit** within 72 hours of entering care to quickly assess their condition, make referrals, and fill needed prescriptions. (*Note: NC policy is that the initial visit should occur within 7 days of children entering care.*)

The Academy's standards also call for a **Comprehensive Visit** within 30 days of the child's entry into care. This visit should include a full physical health evaluation as well as:

- A mental health evaluation
- A developmental health evaluation (for children under age 6)
- An educational evaluation (for children over age 5)
- A dental evaluation

After these early visits, children in foster care need **Well Visits** (also known as check-ups) twice as often as other children. Here's a summary of the AAP-recommended check-up schedule:

- **0-6 months of age:** every month
- **6-24 months of age:** every 3 months

- **2-21 years and at times of significant change:** every 6 months

Why is the medical home model important for children and youth in foster care?

Social workers and health care providers often have a hard time finding health records for children in care. This can lead to poorly coordinated care.

Frequent check-ups also help children cope better with trauma. On top of the maltreatment they may have suffered, research shows that children experience significant stress when they are removed from their homes or switch foster homes. By closely monitoring the child's health and assessing the relationship between the foster parent and child, a doctor can identify early signs of problems and provide prescriptions, referrals to other services, and take action to prevent crises.

What does this mean for foster parents?

In the near future, North Carolina foster parents will likely be asked to attend more doctor visits than in the past. In addition, you may be asked to take children to specialty visits, such as mental health providers.

Though time-consuming, these visits will do much to protect and promote children's well-being. What's more, fre-

The medical home model is an effective way to protect and promote the health of children in foster care.

quent doctor visits have been shown to reduce health crises requiring hospitalization.

How can you help?

There are a number of ways to support good care coordination for the children you foster. For those already in your care, confirm with the case worker that the child is assigned to a medical home. For children who have recently

entered care, ensure they have completed the Initial Visit and Comprehensive Visit described above. Ask the child's medical home provider for a copy of the treatment plan and any notes for foster parents and school personnel.

Once the child has a medical home, work with providers there to meet the AAP-recommended check-up schedule. If you need to seek urgent care or emergency room care for the child, remember to have a copy of the records for that visit sent to the child's medical home.

Where can you learn more?

You may find more information in the NC Pediatric Society's "Parent Handout," which can be found in the Fostering Health NC Online Library: http://c.ymcdn.com/sites/www.ncped.org/resource/collection/8E0E2937-00FD-4E67-A96A-4C9E822263D7/Parent_&_Caring_Adult_Handout_2-29-16.pdf.

If you have further questions, please contact Fostering Health NC program staff at 919-839-1156.

Health Insurance Until Age 26 for Youth Aging Out of Foster Care and Former Foster Youth

The Affordable Care Act requires states to provide youth under 26 with continued health insurance coverage under Medicaid if they were in foster care at age 18. This ensures former foster youth can access the health care services they need—just like non-foster youth who can stay on their parents' insurance plans until 26.

Who is eligible?

You are eligible for full Medicaid coverage to age 26 in North Carolina if you:

- Are between the ages of 18 and 26; and
- Were in foster care at age 18 and enrolled in NC Medicaid; and
- Are a North Carolina resident; and
- Aren't receiving Medicaid from another state; and
- Aren't an inmate of a public institution.

What about youth in care now who are about to age out?

Youth should set up an appointment with their county's Medicaid Eligibility worker to begin the paperwork. Your LINKS Coordinator can help set this appointment up if necessary. The paperwork can be completed in advance and ready to process on your 18th birthday.

What about former foster youth under age 26 without health insurance?

If you know a young person who was in foster care on their 18th birthday, is not yet 26, and who does not have health insurance, encourage them to contact their local county department of social services. You can find a directory of NC county DSS agencies here: <http://www.ncdhhs.gov/divisions/dss/local-county-social-services-offices>

Sources: NCDMA, 2014; Children Now, 2014



Talking to teens in foster care about sexual health by Beth Vazquez

If you're a foster parent, you may feel unsure whether it's your role to talk with teens in your care about sexual health issues, like contraception or preventing sexually transmitted infections (STIs). You may even be thinking (hoping!) this is someone else's job.

But the truth is, teens can't hear this information too often. Even if it feels a bit awkward at times, showing teens that you're willing to have the conversation will help them feel you're someone they can turn to if they have questions or need guidance.

Concerning Statistics

While teen pregnancy rates are trending downward nationally, there's still work to do. The most current data available tell us that in North Carolina 32 out of every 1,000 girls age 15-19 become pregnant, ranking us 22nd in the U.S. with regard to teen pregnancy.

There's even more cause for concern if you look at foster care. Teen girls in foster care are two and a half times more likely than girls not in care to become pregnant by age 19. In one study, half of young men aging out of foster care reported they had gotten someone pregnant by age 21. Compared to their peers, teens who have had adverse childhood experiences—like those served by the foster care program—are more likely to engage in risky behaviors (sexual and otherwise).

Cultivating Open Communication

When it comes to sexual health and making informed decisions, perhaps the most valuable resource to a teen is a trusted adult who is willing to listen and provide information and guidance without judgment. Positive and open communication with a caring adult supports healthy decision-making and builds self-esteem in young people. Here are a few tips for foster parents on open communication with teens around sexual health.

1. Start by building trust. Ask your teen what they think and reinforce that you care. If a child asks a question you don't know how to answer, let them know you'll get more information and get back to them. Be sure to follow through.

2. Spend quality time. Really get to know the young people in your care—their likes and dislikes, friends, worries, and hopes and dreams for the future. Watch TV with them and use what's happening in their favorite shows to spark conversations about issues they're facing in their own lives.

3. Have age-appropriate conversations about bodies and sex with the children in your care. Do this early and often. This can't be a "one and done" conversation. Be prepared to share accurate information (there are lots of great resources online—a few are listed in this article). Keep your con-

versations honest, open, and non-judgmental. "Talk With Your Kids" (see link below) provides guidance on what conversations to have at what age.

4. Share what you believe and be willing to ask teens what they think and why.

Don't shy away from questions that invite you to share your own values—questions such as, "At what age should people start dating?" Or, "Why should I wait to have a baby?" Remember that some youth in foster care may view having a baby as a way to find family stability and unconditional love. In response, help them think through what they would need to support a baby at this stage in their lives. Be mindful not to shame them.

5. Talk with boys, too! These conversations aren't just for girls. Children of all genders and sexual orientations need support and information around sexual health topics such as dating, sex, healthy relationships, pregnancy, and sexually transmitted infections.

6. Seek out and use helpful resources. Here are just a few examples:

- Advocates for Youth (<http://bit.ly/J6oLGd>)
- Children Now (<http://bit.ly/1tihbQC>)
- National Campaign to Prevent Teen and Unplanned Pregnancy (<http://bit.ly/1yU4ZXH>)
- Talk With Your Kids (<http://bit.ly/2caCkqp>)

For more resources for teens, go to <http://bit.ly/2cYgAk4>

It Takes a Village

If for some reason those open conversations between you and your teen aren't going anywhere, help them think of a trusted adult (or a few!) they can go to with questions or concerns about sexual health. This person may be a foster parent, social worker, therapist, mentor, guardian ad litem, parent, or other relative. While it might feel awkward for

Teens Can Consent for Medical Services Related to Sexual Health

While it's usually a good idea to talk things through with a trusted adult, some teens might not feel safe getting a parent or guardian's permission to get on birth control or get tested for a sexually transmitted infection. Technically, they don't have to. North Carolina law (see N.C.G.S. § 90-21.5) gives minors, even those in foster care, the right to obtain the following medical services without a parent or guardian's permission:

- Birth control
- Testing and treatment for sexually transmitted infections (STIs), including HIV (see N.C.G.S. § 130A-135)
- Pregnancy testing and prenatal care
- Treatment for substance abuse or mental illness

a teen to ask certain questions, having the courage to speak up means taking a stand for their health, and that's pretty awesome!

BrdsNBz "Warm" Line

The BrdsNBz text message warm line is a resource for North Carolina teens ages 13 to 19. To use BrdsNBz, teens simply text ncteen to 66746 and opt-in. Users only need to opt-in once, and the service is free (though regular message rates apply). Teens can text their question to 66746 and receive an answer within 24 hours. Teens most often use the text line to ask questions about sex, relationships, bodies, and safety. While trained sex educators provide medically accurate answers to questions asked on the text line, they cannot diagnose medical issues and they do not provide information on sexual technique. BrdsNBz has a strict confidentiality policy and will only break confidentiality if a user indicates danger of imminent harm.

Beth Vazquez is a Capacity-Building Specialist with SHIFT NC's Every Teen Counts project.

Every Teen Counts

In 2015, SHIFT NC (Sexual Health Initiatives For Teens) was awarded a five-year grant from the Office of Adolescent Health (OAH) to fund Every Teen Counts (<http://bit.ly/2cR6nBp>), an initiative that builds the capacity of partners serving youth in the foster care and juvenile justice systems to implement evidence-based sexuality education programs. In January 2016, social workers from Granville, Vance, and Halifax counties received training and technical assistance to implement *Making Proud Choices! An Adaptation for Youth in Out-of-Home Care*. Six facilitators from SaySo (Strong Able Youth Speaking Out) were also trained and will begin implementing healthy sexuality programs with youth in out-of-home care this year. A second cohort of partners from foster care and juvenile justice will begin the capacity-building process in fall 2016.

Teens participating in these programs learn about preventing unplanned pregnancy, protecting against sexually transmitted infections (including HIV), and creating healthy relationships. They learn about their rights as minors in North Carolina to consent to sexual health care services, including access to contraception and testing/treatment for STIs, and how and where to access teen-friendly health care services.

If you are a LINKS Coordinator or other DSS social worker interested in learning more about Every Teen Counts, please contact Kia Thacker at kthacker@shiftnc.org or Beth Vazquez at bvazquez@shiftnc.org.



Protect children's long-term health with the HPV vaccine

As parents, we do everything we can to protect our children's health now and for the future. Today, there is a strong weapon to prevent several types of cancer in our kids: the HPV vaccine.

HPV and cancer

HPV is short for Human Papillomavirus, a common virus. In the United States each year, there are about 17,500 women and 9,300 men affected by HPV-related cancers. Many of these cancers **could be prevented with vaccination**. In both women and men, HPV can cause anal cancer and mouth/throat (oropharyngeal) cancer. It can also cause cancers of the cervix, vulva, and vagina in women; and cancer of the penis in men.

For women, screening is available to detect most cases of cervical cancer with a Pap smear. Unfortunately, there is no routine screening for other HPV-related cancers for women or men, and these cancers can cause pain, suffering, or even death. **That's why a vaccine that prevents most of these types of cancers is so important.**

More about HPV

HPV is a virus passed from one person to another during skin-to-skin sexual contact, including vaginal, oral, and anal sex. HPV is most common in people in their late teens and early 20s. Almost all sexually active people will get HPV at some time in their lives, though most will never even know it.

Most of the time, the body naturally fights off HPV, before HPV causes any health problems. But in some cases, the body does not fight off HPV, and HPV can cause health problems, like cancer and genital warts. Genital warts are not a life-threatening disease, but they can cause emotional stress, and their treatment can be very uncomfortable. About 1 in 100 sexually active adults in the United States have genital warts at any given time.

HPV vaccination is recommended for preteen girls and boys at age 11 or 12 years All preteens need HPV vaccination so they can be protected from

HPV infections that cause cancer. The CDC (2013) describes the HPV vaccination as routine.

The vaccine is given as a 3-dose series over the course of seven to eight months. The best way to remember to get your child all of the shots they need is to make appointments for the remaining shots before you leave the doctor's office or clinic.

Teens and young adults who didn't start or finish the HPV vaccine series also need HPV vaccination. Young women can get HPV vaccine until they are 27 years old and young men can get HPV vaccine until they are 22 years old. Young men who have sex with other men or who have weakened immune systems can also get HPV vaccine until they are 27 years old.

Vaccinating early is best

HPV vaccines offer the best protection to girls and boys who receive all three vaccine doses and have time to develop an immune response **before** they begin sexual activity with another person. This is not to say that your preteen is ready to have sex. In fact, it's just the opposite—it's important to get your child protected before you or your child have to think about this issue. The immune response to this vaccine is better in preteens, and this could mean better protection for your child.

Is the HPV vaccine safe?

Yes. HPV vaccination has been studied very carefully and continues to be monitored by CDC and the Food and Drug Administration (FDA). No serious safety concerns have been linked to HPV vaccination. **These studies continue to show that HPV vaccines are safe.**

The most common side effects reported after HPV vaccination are mild. They include pain and redness in the area of the arm where the shot was given, fever, dizziness, and nausea. Some preteens and teens may faint after getting a shot or any other medical procedure. Sitting or lying down for about 15 minutes after getting shots can help pre-



Photo illustration

Jacquelyn's Story

"I was healthy—and got cervical cancer."

When I was in my late 20's and early 30's, in the years before my daughter was born, I had some abnormal Pap smears and had to have further testing. I was told I had the kind of HPV that can cause cancer and mild dysplasia.

For three more years, I had normal tests. But when I got my first Pap test after my son was born, they told me I needed a biopsy. The results came back as cancer, and my doctor sent me to an oncologist. Fortunately, the cancer was at an early stage. My lymph nodes were clear, and I didn't need radiation. But I did need to have a total hysterectomy.

My husband and I have been together for 15 years, and we were planning to have more children. We are so grateful for our two wonderful children, but we were hoping for more — which is not going to happen now.

The bottom line is they caught the cancer early, but the complications continue to impact my life and my family. For the next few years, I have to get pelvic exams and Pap smears every few months, the doctors measure tumor markers, and I have to have regular x-rays and ultrasounds, just in case. I have so many medical appointments that are taking time away from my family, my friends, and my job.

Worse, every time the phone rings, and I know it's my oncologist calling, I hold my breath until I get the results. I'm hopeful I can live a full and healthy life, but cancer is always in the back of my mind.

In a short period of time, I went from being healthy and planning more children to all of a sudden having a radical hysterectomy and trying to make sure I don't have cancer again. It's kind of overwhelming. And I am one of the lucky ones!

Ultimately I need to make sure I'm healthy and there for my children. I want to be around to see their children grow up. I will do everything to keep my son and daughter from going through this. I will get them both the HPV vaccine as soon as they turn 11. I tell everyone—my friends, my family—to get their children the HPV vaccine series to protect them from this kind of cancer.

vent injuries that could happen if your child were to fall while fainting.

Serious side effects from HPV vaccination are rare. Children with severe allergies to yeast or latex shouldn't get certain HPV vaccines. Be sure to tell the doctor or nurse if your child has any severe allergies.

What about boys?

HPV vaccine is for boys, too! This vaccine can help prevent boys from getting infected with the types of HPV that can cause cancers of the mouth/throat, penis, and anus. The vaccine can also help prevent genital warts. HPV vaccination of males is also likely

to benefit females by reducing the spread of HPV viruses.

To learn more

- For more about HPV and the HPV vaccine visit <http://www.cdc.gov/hpv>
- For more about vaccines for preteens and teens visit <http://www.cdc.gov/vaccines/teens> or call 800-232-4636.

Adapted from the Centers for Disease Prevention and Control 2015 publication on HPV from its series "Diseases and the Vaccines that Prevent Them" (<http://www.cdc.gov/vaccines/parents/diseases/teen/hpv-indepth-color.pdf>)



Writing Contest

What does “healthy” mean to me?

In the last issue of we asked young people in foster care, “What does being healthy mean to you?” Here’s what they had to say.

Anthony, age 11



There are four types of being healthy: physical, mental, emotional, and social.

Social health in my house means having a good friend group to talk to when you have a problem. For example, you can join clubs, have neighborhood friends, and school friends. I am part of a church club called AWANA, and I was in a school club in 4th and 5th grades.

Being emotionally and mentally healthy means to not feel down or depressed about yourself. You should be happy and feel good. I talk to my friends or my family (mom or sister) and they help me when I have a problem.

Last but not least is being physically healthy, which means eating good food and exercising. [This] doesn’t mean you have to join a football league. You could swim, run, bike, or even just play outside.

The last thing my mom taught me is that it is OK to eat junk food once in a while. You can take breaks from sports or your clubs. And I love this one: it is OK to have a free day every so often. You can just wear your pj’s one Saturday and play video games or watch Netflix or TV. . . .

Try some of these things and stay healthy.

ANTHONY RECEIVED \$100 FOR TAKING TOP PRIZE IN THE WRITING CONTEST.

To me, social health means having a good friend group to talk to.

Carissa, age 14



Things that help me keep myself healthy are techniques like being able to self-soothe, “change your perspective, not your identity.”

. . . The two [techniques] that [have] helped me most are (1) live in the moment and (2) accept what you can’t control.

I didn’t give up because I was a foster kid, I kept my life going and got accepted into Challenger Early College High School. I’m going to college to become an obstetrician-gynecologist (OB-GYN) because I took advantage of my position in life and [am] making it into something great! *CARISSA RECEIVED \$50 FOR TAKING SECOND PRIZE IN THE WRITING CONTEST.*

Things that help me keep myself healthy are techniques, like being able to self-soothe.

Dionna, age 15



Being healthy is something everybody can choose

. . . . Being healthy on the inside is also important. When I say “inside” I don’t mean your organs, like your lungs and heart and stuff. I’m talking about being healthy mentally. When a person goes through a lot or has experienced some negative things in life it destroys the peace in their minds. When that person doesn’t get help, they get sick mentally. That’s why counselors and therapists are there—to help heal minds. It’s unhealthy for a person’s mind to be so destroyed that they would even try to commit suicide. . . . It’s not good to hold in pain and misery. . . . Take care of yourself inside and out.

DIONNA RECEIVED \$25 FOR TAKING THIRD PRIZE IN THE WRITING CONTEST.

Being healthy is something everybody can choose.

Youth Ideas about What “Healthy” Means

You shouldn’t be consuming any type of drugs. Drugs can make you lose brain cells, and you can’t get those back. Instead of smoking or drinking or drugs you should work out! Do something that motivates you. Go outside and play basketball, soccer, or baseball—anything that makes you happy and [challenges you] in a positive way. . . . There are people that care about all of us. . . . Pick healthy choices in life! — *Christine, age 16*

Being healthy to me means [having] good relationships with people. . . . A healthy relationship won’t make you sad or depressed. . . . Also, being healthy . . . [means] eating right and having the proper sleep time. Being healthy . . . is important [if you want] to live through this century and make this world change for the good! — *Dawn, age 18*

Being healthy means having good relationships.

Your mental health and physical health go “hand in hand.” Each will always be affected by the other. . . . In so many ways my thoughts on what being healthy means go back to being in foster care and things I have dealt with in my past. This may be a little off topic, but always try to stay positive. Trust me, I know sometimes it’s hard to do, but a wise lady once told me “nothing beats failure but a try.” — *Elizabeth, age 16*

One of the very common health issues that we face in America today is obesity. . . . If you’re obese you are more likely to have high blood pressure, diabetes, and high cholesterol. . . . To stay healthy and prevent obesity eat small portions, eat reduced- or fat-free snacks, and never forget your fresh fruits and vegetables. . . . Just because someone is skinny doesn’t mean that they are healthy, either. There are some skinny people who suffer from bulimia nervosa, [which is caused by] guilt or the feeling or the need to control weight. — *Gabriella, age 15*

Being healthy to me . . . means you eat right, you exercise, and you have normal readings. But it’s also being mentally healthy, being able to physically challenge yourself. Health does revolve around your body and also your mind—because without a healthy mind you can’t have a healthy body. Health starts with a healthy attitude, and without that healthy mindset you aren’t going to receive the health you want. You have to be determined and motivated! — *Haley, age 15*

Without a healthy mind you can’t have a healthy body.

Being healthy means having a positive attitude toward everything. . . . Work through every situation. For example, if something has happened at school or at home and it kind of put you down, make sure you have somebody to call or talk to, because it’s not healthy to keep worrying about the situation and keeping it inside—especially if you have no control [over the situation]. To have a great life . . . believe you can make something of yourself and block out all negativity. — *Jasmine, age 13*

Healthy means eating healthy foods like broccoli, spinach, apples, sour grapes, and corn. Every veggie and fruit is very good for you. Drinking water is best for your body. I love water. I love water so much I can drink it for years. Exercise is healthy, too. I ride my bike and jump on the trampoline. Going outside is very great for you. . . . I like going outside and smelling the fresh air. Nature helps the brain, body, and the heart. All are needed to feel well. — *Trinity, age 10*

THESE YOUNG PEOPLE RECEIVED \$20 FOR HAVING THEIR ESSAYS PUBLISHED.

Dental and oral health for young people in foster care

The health of your mouth, teeth, and gums is linked to your general health and well-being at every stage of life. “A healthy mouth enables not only nutrition of the physical body, but also enhances social interaction and promotes self-esteem and feelings of well-being” (Dental Health Foundation, 2016).

The opposite can also be true. Dental and oral health problems can be painful and may contribute to low self-esteem at any age. There’s evidence that in children they may also be linked to poor school performance (Seirawan, Faust, & Mulligan, 2012).

A Challenge for Kids in Foster Care

Up to the time they enter foster care, children and teens have often had only fragmentary and sporadic dental and oral health care. Many—more than one in three, according to one study—have acute and/or chronic dental and oral health problems (AAP, 2016a).

Often these problems are undiagnosed or under-treated. Common dental and oral health problems among children and teens in foster care include “bottle tooth decay” in very young children, multiple dental cavities in older children, and malocclusion (imperfect positioning of teeth when jaws are closed).

Entering foster care is no automatic fix. According to the American Academy of Pediatrics (2016a), dental and oral health care are some of the most difficult health services to access for children and teens in foster care.

Tips & Resources for Parents

At Placement

If a child already has a dentist when they are placed in your home, continue using that dentist unless the child has had a bad experience with that dentist.

Young Children

Choosing a brush. Use a soft-bristled brush designed for an infant’s or child’s teeth.

Holding a toothbrush. If the child has trouble holding a toothbrush, try making the handle thicker by putting it inside a tennis ball. The handle can also be strapped to the child’s hand with a wide rubber band, a hair band, or Velcro. Or, buy a toothbrush with a thick handle.

Teaching the child to brush. Break the process into small steps the child can understand and practice. Ask a dentist, dental hygienist, or early childhood specialist for help, if needed. Another way is to place a hand over the child’s hand to guide the toothbrush as the child brushes.

Using toothpaste with fluoride. Use toothpaste with fluoride that the child likes and that feels good in his or her mouth. An adult should always place toothpaste on the toothbrush. Under age 3: Use a small smear (about the size of a grain of rice). Ages 3–6: Use a pea-size amount.

Positioning the child. Make the child comfortable while you brush their teeth.

Keeping the child engaged in brushing. Use a timer, a short song, or counting as a game to encourage brushing for 2 minutes.

Source: American Academy of Pediatrics, 2016b

Children and Teens

Brush twice a day with an ADA-accepted fluoride toothpaste. Clean between the teeth daily with floss or another interdental cleaner. Eat a balanced diet and limit snacks. Visit your dentist regularly.

Youth Aging Out of Foster Care

If possible, schedule a complete dental checkup and take care of any dental issues before a youth leaves care. The youth should identify a dentist they will continue to use and determine whether coverage is available or what the cost will be (NYS Office of Children and Family Services, 2009).

Sealants

Children should get sealants on their permanent molars as soon as the teeth come in — before decay attacks the teeth. The first permanent molars come in between age 5 and 7. The second permanent molars come in between age 11 and 14. Other teeth with pits and grooves also might need to be sealed. Teens prone to decay may also need sealants. Talk to a dentist about sealants for your child (NIH, 2015).

Resources for Learning More

- American Academy of Pediatrics Resource Library. <http://www2.aap.org/foster-care/resourcelibrary.html> and search by the topic “Dental Health”.

Practice and Policy in NC

The American Academy of Pediatrics (2016a) recommends every child and teen entering foster care have a dental evaluation within 30 days of placement. North Carolina child welfare policy and practice support this recommendation.

North Carolina policy dictates that within 7 days of entering foster care every child should have an **Initial Visit** with a medical provider (typically a physician) to quickly assess their condition, make referrals, and fill needed prescriptions. If appropriate, a referral to a dentist could occur at this time. Within 30 days of entering foster care every young person should have a **Comprehensive Visit** in which a medical provider gives them a more thorough assessment, including a dental evaluation and, if needed, a referral to a dentist (NC DSS, 2016).

What Can I Do?

As a foster or adoptive parent or kinship caregiver, you are in a good position to ensure the children in your care get timely assessments, receive the dental care they need, and learn habits to safeguard their oral, dental, and overall health for years to come. Below you’ll find information and suggestions to help you with this important mission.



What Dental Care Services Do Kids in Foster Care Need?

Comprehensive dental care for children in foster care includes follow-up care for all conditions identified in the initial dental assessment. Dental care services may include:

- Initial exam, preventive services, and sealants on permanent molar teeth upon entry into foster care
- Begin routine dental visits by age one
- Preventive care every 6 months
- Examination by dentist annually
- Sealants on newly erupted molars at preventive visits
- Ongoing restorative care to promptly address every problem identified, including: timely access to restorative care; fillings; root canals; replace missing and damaged teeth; periodontal care for gum disease; immediate access to dentist or oral surgeon for pain or dental trauma; immediate access to effective medication to relieve pain; orthodontics for severe handicapping dental conditions

Source: NYS Office of Children and Family Services, 2009

Dental Care Can Be a Trauma Trigger

For children who have been sexually, physically, or emotionally abused, getting dental care can be a trauma trigger. If children are anxious about dental care, find out what’s most concerning to them by asking questions such as “Are there particular parts of the dental treatment that are difficult for you?” or “Is there anything we can do to make you feel more comfortable?” Other tips to make dental treatment easier for those with trauma histories include:

- Choose a dentist based on their gender, if that will help reduce your anxiety.
- Ask to bring a friend or family member to the appointment with you or have another staff member present during exams. Tell the dentist you are anxious. You need not explain why.
- Agree with the dentist on a non-verbal signal to indicate increased anxiety and a message in case you want to stop treatment.
- Use relaxation aids such as headphones with soothing music.
- Ask that you be the one to handle the suction instrument whenever possible.
- If the smell of latex is a problem, ask the dentist to use vinyl gloves.

Sources: dentalfear.com, n.d.; Dougall & Fiske, 2008



Concussion awareness for parents

by Lynn Makor and Liz Newlin

A concussion can affect a child's ability to learn and stay focused. Regardless of the intensity of the head impact, a concussion is a type of

brain injury that changes the way the brain normally works. It is caused by a bump, blow, or jolt (with or without physical contact) to the head. Concussions can occur without loss of consciousness.

Concussion Symptoms

Signs of a concussion can show up right after an injury or may not appear or be noticed until hours or days after the injury.

Physical symptoms following a concussion may include:

- Headaches
- Double vision
- Light and noise sensitivity
- Dizziness
- Lack of coordination
- Physical fatigue

Learning difficulties following a concussion may include:

- Mental fatigue
- Attention slippage
- Memory lapses
- Slower ability to take in/respond to new information
- (Possibly) Language problems

Any of these symptoms may negatively affect a student's learning, behavior, emotional regulation, or social functioning when they return to school.

When to Get Medical Attention

If your child or teen has one or more of the symptoms below following an injury to their

head or neck, seek medical attention right away.

- Appears dazed or stunned
- Is confused about events
- Answers questions slowly
- Repeats questions
- Can't recall events prior to/after the hit, bump, or fall
- Nausea/vomiting
- Loses consciousness (even briefly)
- Shows behavioral or personality changes
- Forgets their class schedule or assignments; other memory lapses
- Unsteady on their feet

What Schools Must Do

The North Carolina State Board of Education has a policy requiring each public school to develop a plan to provide needed support for students who have been diagnosed with a concussion. Children and teens who return to school after a concussion may need to:

- Take rest breaks as needed
- Spend fewer hours at school
- Be given more time to take tests or complete assignments
- Reduce time reading or writing or in other academic tasks
- Reduce time on computers or other electronic devices

What You Can Do

Parents/caregivers can also take steps to help children return to school safely following a concussion, including the following:

- Seek/ensure treatment by a medical professional
- Find out who the "Concussion Contact" is at your child's school
- Talk with your child's teacher, school

nurse, coach, school psychologist, and/or counselor about your child's concussion and symptoms they are experiencing

- Provide the paperwork from your doctor, documenting the concussion and any suggested accommodations for school
- Provide ALL follow up documentation from the doctor to the appropriate school personnel
- Communicate with school staff members any concerns you have regarding your child's recovery/functioning

Because NC's "Return to Learn" concussion policy is new (effective July 1, 2016), you may also need to educate the child's social worker about the new school policy. If the child has a concussion and the child has a CCNC or CC4C care manager, make sure this person is aware of the concussion so they can further advocate for support as needed.

Conclusion

Learning, behavior, and emotions can be affected in many different ways and for differing lengths of time following a concussion. It is important for parents and caregivers to know the signs and symptoms and take the necessary steps if they suspect or have knowledge that their child has sustained a concussion. When parents engage in the steps outlined above, it will ensure their child's school is fully informed of the concussion and will assist in developing an individual plan of action in order to facilitate the child's safe return to school.

Lynn Makor, MA, CAGS, and Liz Newlin, RN BSN, NCSN, co-chair the Children and Youth Committee of the NC Brain Injury Advisory Council.

Fostering Wellness

In fall 2016 an exciting new project launched in the Triangle that promises to provide opportunities for young people transitioning out of foster care to improve their employment skills, to live healthier lives, and to become strong community-wide advocates for healthier living.

This unique project, Fostering Wellness, focuses on the local food system as the vehicle to create these new opportunities. The local food system is a booming sector in the Triangle and demand for competent, reliable employees is high. In addition, the food system has few barriers for entry and provides numerous ways for young people to participate in the growing, harvesting, processing, packaging, transporting, marketing, and disposing of food.

Throughout the year, Fostering Wellness hosts eight-week workforce readiness programs focused on a variety of different topics relevant to the food system. Topics include culinary arts, customer service

and administration, logistics, hospitality, and more. Through these programs, Fostering Wellness participants receive skills-based training in aspects of the food system, one-on-one career development coaching, opportunities to interact with local leaders and employers in the food system, and access to supportive services in housing, education, and other areas.

This program is open to young people between the ages of 18 and 25 living in Wake, Durham, or Orange counties who have transitioned out of foster care. For more information, please contact Stacy Bluth, Executive Director, at sbluth@fosteringwellnessnc.org.

Fostering Wellness is funded through a GSK Impact Grant and is administered through the collaboration of several nonprofit agencies including SaySo (Strong Able Youth Speaking Out), Community Partnerships, Inc., Dress for Success, Life Skills Foundation, Interfaith Food Shuttle, The Hope Center at Pullen, and United Way of the Greater Triangle.



Fostering Wellness program participants cooking alongside the PNC Arena Staff.



Medical consent for children in DSS custody

by Sara DePasquale, Assistant Professor of Public Law and Government at the School of Government at UNC-Chapel Hill

All children in the custody of a county child welfare agency (typically called a department of social services, or DSS) need medical care at some point. Yet when medical treatment is needed, questions often arise about who consents to the child's care. As we will see in this article, state law helps answer these questions, but there is no single, simple answer that applies to all children in foster care.

When Is a Child in DSS Custody?

A child is placed in DSS custody by a court order that is entered in an abuse, neglect, or dependency proceeding. Custody can be ordered to DSS at two different points: nonsecure and/or disposition. *Nonsecure custody* is a temporary custody order entered before the adjudicatory hearing. *Dispositional orders* are entered after a child has been adjudicated abused, neglected, or dependent. Dispositional orders include custody provisions, one of which may be custody to DSS.

What is Informed Consent?

Informed consent is voluntarily given to a health care provider by a patient or by a person authorized to consent for a patient. The consent is for a specific treatment the medical provider has explained in a way that would give a reasonable person a general understanding of the treatment, including its most frequent risks and hazards.

Who Consents?

On October 1, 2015, two new NC laws about medical decision-making for children in DSS custody went into effect (G.S. 7B-505.1 and G.S. 7B-903.1(e)). Based on these laws, who consents to a child's care depends on the type of care needed.

Routine and Emergency Care

When a child is in DSS custody, DSS has the authority to arrange for and consent to the child's:

- routine medical and dental care (note, mental health is not included here);
- emergency medical, surgical, or mental health care; and
- testing and evaluation in exigent circumstances.

The law doesn't define "**routine**" care, but some guidance is provided by the medical community. For example, a well-child visit, which involves height, weight, and blood pressure measurements; a check of vital functions; vision, hearing, dental, developmental, and lead screening; a physical examination; and up-to-date immunizations, is widely recognized as routine.

Merriam-Webster Dictionary defines rou-

time as "a regular course of procedure." Using that definition, a "sick visit" is probably routine since a routine practice for a parent of a sick child typically includes scheduling a visit with the child's medical provider and following the course of recommended treatment.

Emergency treatment is also not defined by the law, but Medicaid regulations define an "emergency medical condition" and "emergency services." (Most children in foster care are eligible for Medicaid.) Emergency services are given to an individual by a medical provider when needed to evaluate or stabilize an emergency medical condition, which is a condition that involves acute symptoms of sufficient severity that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- placing the person's health in serious jeopardy,
- serious impairment of bodily functions, or
- serious dysfunction of any bodily organ or part.

Exigent means requiring immediate attention. In exigent circumstances, DSS can consent to tests and evaluations but not to the treatment of any condition diagnosed from the tests or evaluations.

Non-Routine and Non-Emergency Care

When the Parent Consents

The general rule for a child in DSS custody who requires non-routine or non-emergency medical care is that the child's parent, guardian, or custodian ("parent") consents. Maintaining a parent's right to make decisions for his or her child recognizes the state policy of having child welfare workers partner with parents when making decisions regarding the child and that "parents of children in foster care placement retain many of their rights" (NC DSS Child Welfare Services Manual, Section 1201.V, 2015).

When DSS Consents

There are two exceptions to this general rule. One, a parent may complete a written authorization allowing DSS to consent to the child's treatment. Two, after a hearing, the court may enter an order that authorizes DSS to consent to the child's treatment when the court has

Can a North Carolina Foster Parent Give Consent for Medical Treatment of a Child in Foster Care?

No. A foster parent is not a person standing *in loco parentis* to a child. As a result, a foster parent cannot consent to treatment of a child in their care. Nor can a county department delegate its medical decision-making authority to a foster parent. A foster parent may only consent to a child's medical care when there is a court order that delegates that right to the foster parent.

found by clear and convincing evidence that the non-routine or non-emergency treatment or evaluation is in the child's best interests. Depending on the facts of the case, the court order may designate specific treatments (e.g., counseling) or all non-routine and non-emergency treatment for the child.

Non-Routine and Non-Emergency Care

The law does not define types of medical care, but it does identify a partial list of non-routine / non-emergency treatments:

- Prescriptions for psychotropic medications.
- Participation in clinical trials.
- Immunizations when it is known the parent has as *bona fide* religious objection to the standard schedule of immunizations.
- Surgical, medical, dental, psychiatric, psychological, or mental health tests, care, or treatment that require informed consent.

Other treatments not included in this list that are not routine or emergency care require a parent's consent unless the parent has authorized DSS to consent or a court order grants the department that authority.

What about a Child with a Chronic Condition?

It is unclear if treatment that is routine for a particular condition (e.g., diabetes) but is not routine for all children is "routine." If there is disagreement over whether the parent or DSS should consent, a court must decide the matter.

What if You're Unsure about Treatment Type?

If there is any question as to whether a treatment is routine, emergency, or exigent, ask the medical provider.

Can a Child in Foster Care Give Medical Consent?

Under North Carolina law, a licensed physician may accept a minor's consent for medical services for the prevention, diagnosis, and treatment of:

- a sexually transmitted or reportable communicable disease,
- pregnancy,
- abuse of alcohol or controlled substances, or
- emotional disturbance.

A minor's ability to consent to these specified medical services is not affected by an order that places the minor in DSS custody. The medical provider may accept the minor's consent without seeking the consent of the minor's parent or the county DSS.

Caring for a child who takes psychotropic medication

Children in foster care—especially those who have experienced trauma—often require mental health treatment. For many, that treatment involves prescriptions for psychotropic medications.

Psychotropic (pronounced “sike-oh-trope-ick”) medications affect a person’s mind, emotions, moods, and behaviors. Examples include psycho-

stimulants such as Adderall® and Ritalin®, antipsychotics such as Seroquel®, and antidepressants such as Paxil® and Zoloft®.

When it comes to managing children’s medications, foster parents and kin caregivers have an important role to play. After all, you’re the one who spends the most time with the child. You know whether that child is taking the medication appropriately and how that medication affects that child’s behavior.

So what can foster parents and caregivers do to make sure children taking psychotropic medications get the care and the oversight they need? Here are some suggestions:

1. See this as a team effort. Managing children’s care is a shared responsibility. Important partners in this task include your supervising agency, the birth family, and the DSS that has custody of the child. When it comes to managing medications, it is very important that the team work with someone with special expertise in this area—usually this will be the child’s mental health clinician or physician.

It can be intimidating to work with doctors and mental health clinicians, but you bring something essential to the table—information about the child and how they are doing. Without this, it’s hard to make good decisions or recommendations about treatment and medications.

2. Be sure you have the information you need. Communicate regularly with the child’s social worker, mental health provider, and physician to make sure you have a current list of all children’s prescriptions and dosages.

3. Watch for side effects. The majority of children will not experience any side effects from their medications; however, side effects are possible. Different psychotropic medication can cause different side effects so it’s important that you are familiar with the possible side effects.

If a child in your care is taking medications, be sure to ask the prescriber about

- Know why the child is taking a particular medication.
- Know side effects to watch for and what to do if they occur.
- Know what your agency expects of you.

possible side effects and what to do if they occur. If you see anything that concerns you, be sure to let the prescriber know.

4. Beware of over-medication or inappropriate medication. The same dose of medication can have different effects in two different people because not all people react to medications the same. Just because a dosage doesn’t cause drowsiness in one child, doesn’t mean it won’t

cause another child to be drowsy. This is similar to being aware of side effects. If the medication seems to be having a negative impact on the child for any reason, let the child’s social worker and prescriber know right away.

5. Document and communicate. Track and log any changes you see in your child’s behavior, wellness, or functioning, especially when a medication has just been introduced or an adjustment has been made. Share this information with other members of the team caring for the child.

6. Remember that medication often works best when used in combination with therapy. When it comes to treating anxiety, depression, or other mental health needs, medication alone is sometimes not as effective as medication in combination with therapy. If a child in your care is taking psychotropic medication, but is not receiving therapy, ask the child’s social worker and other members of the child’s team if therapy would be appropriate.

7. Listen to the child. Children and youth are a great source of information about their medications and how well they are working. Older youth can use a journal to note any changes in their experience on a medication, concerns they have, or responses to

Psychotropic Medications and Children in Child Welfare

- Between 13% and 52% of children involved with child welfare use psychotropic meds—rates of use notably higher than children in the general population.
- As they age, children in foster care are more likely to be prescribed psychotropics. The rate is 3.6% among 2-5 year-olds, 16.4% among 6-11 year olds, and 21.6% among 12-16 year olds. Also, as they age children are more likely to be prescribed multiple psychotropic drugs.
- In foster care, males are more likely to receive psychotropics (19.6%) than females (7.7%).
- Kids in the most restrictive placement settings are most likely to receive psychotropics. Nearly half of young people in group or residential homes take at least one psychotropic.

Source: USDHHS, 2012

treatment. Sharing these written notes with physicians and DSS staff during or between appointments can help providers gauge the effectiveness of a treatment and alerts them to unintended effects of the medication.

8. Know your limits. If you are a foster parent, therapeutic foster parent, or kin caregiver, understand that you do not have the power to give consent for treatment or to make decisions about treatment or medication for children in foster care. If a decision needs to be made about these things, involve other members of the child’s team, in particular the child’s social worker.

9. Ask for help if you need it. If you don’t feel comfortable with your responsibilities related to a child’s medication, reach out to your supervising agency—they will be glad to answer your questions, clarify your role and what is expected of you, and provide you with the training and support you need to look after the children in your care.

Medicines Prescribed to Some Children in Foster Care

Second Generation Antipsychotics

- Clozaril®—clozapine
- Risperdal®—risperidone
- Zyprexa®—olanzapine
- Abilify®—aripiprazole

SSRI Antidepressants

- Prozac®—fluoxetine
- Celexa®—citalopram
- Luvox®—fluvoxamine
- Lexapro®—escitalopram

Mood Stabilizers

- Depakote®—divalproex/valproic acid
- Tegretol®—carbamazepine
- Topamax®—topiramate

Psychostimulants

- Dexedrine®—dextroamphetamine
- Concerta®—methylphenidate
- Vyvanse®—lisdexamfetamine
- Daytrana®—methylphenidate transdermal

To Learn More

Consult the National Alliance on Mental Illness (NAMI) to learn more about specific medications:

- www.nami.org/template.cfm?section=About_Medications
- <http://www.nami.org/Learn-More/Mental-Health-Conditions>



Universal precautions

All foster parents in North Carolina should have a good understanding of universal precautions and blood-borne pathogens. After all, agencies are required to

provide foster parents with training in this subject before a child can be placed in their homes. What's more, this training must be updated (retaken) once a year, or as often as required by the American Red Cross, the American Heart Association, or an equivalent organization.

But if you want to keep yourself and those under your care safe, a quick refresher never hurt. In this spirit, we share with you the following, which is from a fact sheet from New Jersey's Foster and Adoptive Family Services (2014).

Universal Precautions

Universal precautions are actions that you take to place a barrier between yourself and potentially infected body fluids. Blood and other body fluids (e.g., semen, vaginal fluids, saliva, urine, feces, and vomit) can contain viruses and bacteria that can be passed on to another person through direct contact. Hepatitis B and C, as well as HIV, are diseases that can be transferred from one person to another through contact with infected blood and/or body fluids. Since there is no way to know without testing if a person has Hepatitis B and C, as well as HIV, it is recommended that you treat all body fluids as though they are infected. Here are suggestions for protecting yourself and others.

How do blood and body fluids spread from one person to another?

Blood and body fluids are passed from one person to another through:

- open areas on the skin
- splashing in the eye
- the mouth
- unprotected sexual activity (oral, anal, and vaginal)
- injury with contaminated needles or other sharp objects
- prenatally (mother to baby) and during child birth

How do you protect yourself from blood and body fluids?

The easiest way to protect yourself from blood and body fluids is to have the injured person treat his own wound. If he is unable to take care of himself, or he needs help, use latex gloves. If you do not have disposable gloves available, use a plastic bag (trash, shopping, or sandwich) over your hands to create a barrier. If you are at work,

your employer must provide appropriate personal protective equipment (gloves, goggles, disinfectant, etc.). Know where these items are located so that you will be prepared to protect yourself.

How do you safely handle a bleeding injury?

- The child or adult should hold an absorbent material to the wound; a clean disposable diaper offers a good absorbent material with the added protection of a plastic backing.
- You can also use paper towels, tissues, or newspaper.
- Have the injured person apply pressure until the bleeding stops.
- Assist with placing a bandage over the wound if needed.
- Dispose of bloody material in a plastic-lined trash can or sealed plastic bag.
- Everyone should wash their hands with soap and running water as soon as possible. (Disinfectant waterless hand cleaners or towelettes may be used if soap and running water are not available.)

How do you clean surfaces that have blood and body fluids on them?

- Wear disposable gloves.
- Wash the area with soap and water, and dry the area.
- Disinfect the surface with a solution of one part bleach to ten parts water, or you can use a hospital-strength disinfectant (e.g., Lysol, Cavicide, or Non-Acid Bathroom Cleaner [NABC]). Allow the area to remain wet for at least 3 minutes before drying. Consult the container label for differences in recommendations due to product strength.
- Use disposable cleaning materials if possible, such as paper towels instead of cloth.
- Dispose of cleaning materials and gloves in a sealed plastic bag.
- Wash hands with soap and running water. (Again, disinfectant waterless hand cleaners or towelettes may be used if soap and running water are not available.)

These suggestions are for information only and are not meant to be used for self-diagnosis or as a substitute for consultation with a health care provider. For more information, call your health care provider or your local health department.

What Is Considered an Emergency?

1. A child who is having difficulty breathing (like asthma or choking).
2. Child's color doesn't look right (blue tinged or very pale).
3. Any head injury. Observe the child for the first 12 hours after a bump on the head. During this time, if the child is dizzy, or fainted, or is too sleepy, or is difficult to wake up, or acts drunken or drowsy, or has a bad headache, or is vomiting – bring to the ER.
4. A deep cut that may need stitches after-hours when clinics and doctors' offices are closed. *In the meantime:* gently clean the wound with large amounts of lukewarm running water (use Betadine), and wrap or cover with a clean bandage or cloth. If bleeding is very heavy apply pressure – but not too hard!
5. Seizures (also called convulsions or fits). A prolonged seizure can be life threatening. *In the meantime:* remove all obstacles in the area around the child and provide cushioning under the head if he/she is banging it on a hard floor. DO NOT try to stop movements, BUT turn to side if vomiting or drooling heavily.
6. Any heavy bleeding that cannot be stopped within five minutes.
7. An accident or injury where you think a serious injury may have occurred (e.g., depending on the force, direction, or location of the injury).
8. A high fever and it is after-hours when your doctor's office or clinic is closed (or when your doctor/clinic instructs you to go to the ER).
9. Excessive diarrhea or vomiting. Infants and very young children dehydrate quickly, so this may be a serious emergency. The child may require intravenous fluids.
10. Any eye injury. Do not apply pressure or put anything into the eye.



Unsure? Call the child's medical home if you aren't sure a situation merits a visit to the ER or Urgent Care.

Note: If your child's eye is swollen and/or crusty from allergies or "pink eye" (conjunctivitis), it is not an emergency. Take to an office or clinic as soon as possible. Do not to share towels or clean both eyes with the same cloth. It may be contagious from one eye to the other – or to someone else.

Poison: If the child eats or drinks something that may be poisonous (e.g., medicine, cleaning products, or plants), call Poison Control (1-800-222-1222) and get advice on what to do.

Consent: Foster parents cannot consent to treatment. Call your caseworker as soon as you get to the ER. Give all paperwork and instructions you receive from the ER to your caseworker.

Adapted from NYS Office of Children and Family Services, 2009



A reader asks ...

Can you help me with these medical terms referring to children in foster care?

I hear various conditions described when referring to foster children and I'm not sure what some of them are. Can you define some of the more common terms and tell me how to get more information about these and other conditions I have questions about?

This is a great question and one that NC Kids gets quite frequently. Let's look at some of the more common conditions and find out what they mean. We'll also differentiate between a few of the more common conditions that are easily confused.

Enuresis is the voiding of urine ("peeing") into the bed or clothing after the age where the ability to hold one's urine would typically be expected (age 5).

Encopresis is having bowel movements in inappropriate places such as in clothing or on the floor after the age of 4. This can be involuntary or intentional.

Pica is a pattern of eating non-food materials (such as dirt or paper) lasting more than one month. Children with Pica may eat clay, dirt, hairballs, ice, paint, sand, etc.

Adjustment Disorder and Reactive Attachment Disorder

Adjustment Disorder is the development of behavioral or emotional symptoms in response to a stressor, such as abuse or neglect, or being removed from primary caretakers. Unlike Reactive Attachment Disorder, Adjustment Disorder is common—most children in foster care experience it at some point during their journey through the system. In fact, many children outside foster care develop adjustment disorders in response to stressors such as chronic illness and divorce.

Reactive Attachment Disorder is a rare condition in which children exhibit emotionally withdrawn and inhibited behaviors. Because the child's basic needs for comfort, affection, and nurturing haven't been met, the child's growing brain may be permanently altered. This creates difficulty establishing loving and caring attachments with others and hurts their ability to establish future relationships. For more on diagnosis and treatment of RAD, see this article from *Children's Services Practice Notes*: http://www.practicenotes.org/v19n3/CSPN_v19n3.pdf.

Dysthymia and Depression

Two terms people often confuse are Dysthymia and Depression. **Dysthymia** is a sad, dark, or low mood experienced almost every day for a period of at least two years. The symptoms are less severe than major depression and include feelings of hopelessness, insomnia, low energy, low

self-esteem, poor appetite or overeating, and poor concentration.

Depression involves similar symptoms that are more acute and intense than Dysthymia. Depression engulfs a person's day-to-day life and interferes with one's ability to work, study, eat, sleep, and have fun. The feelings of helplessness, hopelessness, and worthlessness are intense and unrelenting, with little, if any, relief. These feelings persist for two weeks or more.

For more information on these and other conditions experienced by children in foster care, we recommend contacting a pediatrician or child therapist specializing in children who have experienced trauma. If a family decides to use the Internet to obtain more information, we recommend using reputable websites such as <http://www.apa.org/> and <http://www.webmd.com/>.

Response by the NC Division of Social Services. If you have a question about foster care or adoption in North Carolina you'd like answered in "A Reader Asks," send it to us using the contact information in the box at top right.

For more on these and other conditions, contact a pediatrician or therapist specializing in children who have experienced trauma.

fostering perspectives (Nov. 2016)

Sponsors. NC Division of Social Services, SaySo, and the Family and Children's Resource Program, part of the UNC-Chapel Hill School of Social Work's Jordan Institute for Families.

Contact Us. *Fostering Perspectives*, c/o John McMahon, Family and Children's Resource Program, UNC-Chapel Hill School of Social, CB# 3550, Chapel Hill, NC 27599-3550. Email: jdcmcmaho@unc.edu.

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Mission. *Fostering Perspectives* exists to promote the professional development of North Carolina's child welfare professionals and foster, kinship, and adoptive parents and to provide a forum where the people involved in the child welfare system in our state can exchange ideas.

Disclaimer. The opinions and beliefs expressed herein are not necessarily those of the NC Division of Social Services or the UNC-Chapel Hill School of Social Work.

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SaySo

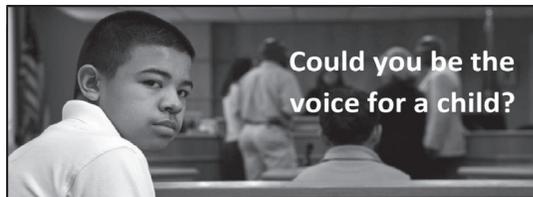
SaySo, Strong Able Youth Speaking Out, is a statewide, North Carolina-based association of youth aged 14 to 24 who are or have been in out-of-home care. This includes all types of substitute care, including foster care, group homes, and mental health placements.

MISSION

"To work to improve the substitute care system by educating the community, speaking out about needed changes, and providing support to youth who are or have been in substitute care."



SaySo, Inc.
Tel: 800/820-0001
(toll-free)
Email: sayso@ilrinc.com
Web: www.saysoinc.org



Could you be the voice for a child?

Did you know that 2,000 abused and neglected children in North Carolina will go to court alone? You can help. Become a Guardian ad Litem.

Stand up today to say, "I am for the child."

More than 2,000 abused and neglected children in NC go to court without someone to advocate just for them.

- Could you speak up for their best interests?
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If so, becoming a Guardian ad Litem advocate could be a great opportunity for you! To learn more, find us at any of the links below or call 1-800-982-4041.



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Help us find families for these children

For more information on these children or adoption in general, call the NC Kids Adoption and Foster Care Network at 1-877-NCKIDS-1 <www.adoptnckids.org>



Dajaun (age 10)

Dajaun is a friendly and talkative little boy who is very inquisitive. He likes all types of music and loves to dance. Dajaun also likes to play basketball, baseball, and soccer. He loves to make things with his hands, and he's especially fond of building with Legos. Dajaun is happiest when he's outside; he says he would like to live on a farm one day.

The ideal forever family for Dajaun is an experienced, two-parent family capable

of providing him with loving guidance, structure, consistency, and clear boundaries. His family should also have a comprehensive understanding of how child trauma, grief, and loss impact behavior and development. Dajaun would thrive in a family who listens to him and helps him express his emotions in a calm and productive way.



Phalen (age 9)

Phalen is an affectionate, loving, independent little boy with a charming smile and infectious personality. He is very social and loves interacting with others. Phalen enjoys playing on his iPad, watching Peppa Pig, and swimming. He's very smart and learns quickly. Electronic tablet devices are his favorite mode of learning.

The ideal family for Phalen should have a flexible schedule and be able to maintain ongoing appointments as well as participate in various types of therapy to assist

him in increasing his mobility and speech. Phalen would be most successful with caregivers who are calm, patient, and who have the ability to work with him on developing his skills. Phalen has a strong bond with his brothers. It will be important for his adoptive family to facilitate continued visitation between the siblings.



Kylie (age 10)

Kylie is friendly, kind, and outgoing. She gives her all to everything she does. Kylie loves to draw, sing, attend church, participate in softball, do arts and crafts, and play "school." One day she would like to be an art teacher or work at a day care. Kylie likes to help around the house with laundry, chores, and preparing meals. She is not a picky eater and especially loves vegetables fresh out of the garden. Kylie does best when she has firm limits and consistency in her daily routine, expectations,

and the care that she receives.

A family who has experience with attachment issues and the behavioral challenges associated with them would be best suited for Kylie. Kylie needs a family with no pets and where she will be the youngest or only child. Her forever family should be willing to work with her current foster parent and other significant supports to help her transition to her forever family and to provide continuity in her life. It is vital that Kylie's relationships with her older brother and her foster family be maintained.



Markell (age 5)

Meet Markell! This happy little boy is a joy to everyone who meets him. Known for his infectious laughter and contagious smile, Markell loves trains, musical toys, and cartoons. He also loves to attend church and to visit the park. Some of Markell's favorite foods include yogurt, mashed potatoes, and ice cream.

This resilient little boy deserves permanence in the right family. The ideal family for Markell will have experience working with children with disabilities and be committed to caring for him into adulthood. Markell's family will be committed to

effectively scheduling and managing various medical appointments and performing daily care tasks, as well. It is important that the forever family for Markell is able to lift him and maneuver his wheelchair. Markell also needs to maintain contact with his siblings through telephone calls and visits.



Terreil (age 13)

Terreil is a lovable young man who is described as kind, playful, and sensitive. He likes to play Xbox and really enjoys riding his bike. He also loves to play with the dogs at his current placement. (*In this photo he's getting a kiss from one of those dogs.*) His favorite hobby is cooking, and he's currently taking a cooking class at the YMCA to sharpen his cooking skills. Terreil thrives when given one-on-one attention from adults.

Terreil would like to be adopted by a two-parent home with a strong, positive male role model. He needs to know that he is safe and can trust a family who will set limits and provide him with structure. He likes to talk through his feelings in a calm manner and requires an adoptive home who can provide a calm environment for doing so. Terreil's family also needs to be open to maintaining contact with his two sisters. Terreil would be most successful as the youngest child in his adoptive family. Terreil deserves a family that will meet him where he is and help him reach his tremendous potential for success.



Vivian (age 16)

Vivian is a respectful and social young lady who is full of life and energy. She has striking red hair that pops in the sunlight. She is described as spontaneous, caring, pleasant, and "always smiling." Like many girls her age, Vivian is a big fan of the band One Direction, and she also loves the Twilight books and movies. She absolutely loves horses and horseback riding. When she grows up she would like to be a horse trainer and work at Disney World. She also likes cars and dreams of driving a Ford Mustang one day. In her free time, Vivian likes to read, play on her tablet, or play video games, especially *Legend of Zelda*.

Vivian is excited to be adopted. She would like a nice, caring, and supportive family that has pets, preferably horses. She would prefer a two-parent home with older children, though other family types will also be considered. Her forever family will need to commit to caring for Vivian into adulthood when it is clear that she can safely be independent. She needs a family to accept her for who she is and to consistently praise her strengths. She requires higher supervision to keep her safe and secure. This sweet girl will bring great joy to a special family.

Writing Contest

First Prize: \$100 • Second Prize: \$50 • Third Prize: \$25

If you are under 18 and are or have been in foster care, please send us a letter or short essay in response to the following question:



Describe a healthy relationship in your life today. How do you know it is healthy?

DEADLINE: February 2, 2017

E-mail submissions to jdmcmaho@unc.edu or mail them to: Fostering Perspectives, Family & Children's Resource Program, CB#3550, UNC-CH School of Social Work, Chapel Hill, NC 27599-3550. Include your name, age, address, and phone number. In addition to receiving the awards specified above, winners will have their work published in the next issue. Runners-up may also have their work published, for which they will also receive an award.

Seeking Artwork and Other Writing Submissions

Submissions can be on any theme. There is no deadline for non-contest submissions: submit your work at any time. If sent via U.S. Mail, artwork should be sent flat (unfolded) on white, unlined paper.

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Fostering Perspectives will soon go all online—copies will no longer be printed and mailed out to readers.

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Get in-service training credit for reading this newsletter!

Enjoy *Fostering Perspectives* and earn credit toward your relicensure. Just write down the answers to the questions below and present them to your licensing social worker. If your answers are satisfactory, you'll receive 30 minutes of training credit. If you have questions about this method of gaining in-service training credit, ask your worker.

In-Service Quiz, FP v21 n1

1. Based on Katie Souris' article, what are some of the challenges and potential rewards of parenting a child with Type 1 Diabetes?
2. Describe the "small, simple accommodations" Bob DeMarco and his wife made to help manage their children's struggles around food and why you think they were successful.
3. Name three things you do—or could do—to help children in your home build lifelong habits of healthy eating and exercise.
4. Why is it important for children and youth in foster care to have a medical home? What are the benefits?
5. What is HPV? Why is the HPV vaccine recommended for girls and boys at age 11 or 12?
6. What should a resource parent do to ensure a young person aging out of foster care has health insurance at least until age 26?
7. When can a foster parent give consent for medical treatment of a child in foster care?
8. Name three things foster parents and caregivers can do to ensure children taking psychotropic medications get the care and the oversight they need.
9. For what kinds of medical treatments can a child in foster care give consent without consulting foster parents or the agency?
10. If you haven't already, go to <http://eepurl.com/brPe9b> and sign up for the *Fostering Perspectives* email list.

Agencies Should Share Health Information with Foster Parents

According to North Carolina policy, DSS must share information about a child's medical needs, medication, any special conditions, and instructions for the child's care with the foster parent prior to or at the time of placement. The social worker is responsible for bringing any medications, glasses, hearing aids, etc. to the foster care placement with the child. Social workers should document when these items are given to foster care placement providers.



In addition, DSS must provide copies of the following health summary forms to foster care placement providers:

- **DSS-5206 (Initial Visit)**. Completed at a brief medical visit to occur within 7 days of the child's entry into care.
- **DSS-5208 (Comprehensive Visit)**. Completed at a thorough medical visit to occur within 30 days of the child's entry into care.
- **DSS-5209 (Well Visit)**. Completed at "check-up" medical visits that should occur every month for children ages 0-6 months of age, every 3 months for children ages 6-24 months, and every 6 months as well as at times of significant change for children ages 2-21 years.

If DSS doesn't share these health summary forms, follow up—they may contain important information needed to properly care for the child.

Blank copies of these forms can be found online at <https://www2.ncdhs.gov/info/olm/forms/dss/>.

Source: NC DSS, 2016a; 2016b