VIEWS ON FOSTER CARE AND ADOPTION IN NORTH CAROLINA

fostering perspectives

NOVEMBER 2013 • VOL. 18, NO. 1 WWW.FOSTERINGPERSPECTIVES.ORG

Sponsored by the NC Division of Social Services and the Family and Children's Resource Program

Foster and adoptive parents and the focus on child trauma

Today there's a real sense of urgency about trauma in the field of child welfare. There is a strong feeling that we must do a better job identifying children who have had traumatic experiences and making sure they get the support they need.

We've woken up to the fact that when it comes to child trauma, we must do better.

Fueling this urgency is mounting evidence that if it is left untreated, trauma can have a profound, negative impact on children's behavior, learning, health, and well-being not just in the short term, but for the rest of their lives. Findings from the Adverse Childhood Experiences study, some of which are summarized at right, illustrate how serious the consequences of trauma can be.

This issue of *Fostering Perspectives* is part of a nationwide effort to ensure foster, adoptive, and kinship parents know what they can do to help children heal and flourish after trauma. In these pages we:

- Explore what it means to be a "trauma-informed" parent
- Share strategies, suggestions, and tips for parents
- Tell you how you can learn more about this topic, which is so directly connected to the safety, permanence, and well-being of children.

We hope this issue is helpful to you and to the children we all care so much about.

The ACE Study Helps Reveal Trauma's Impact

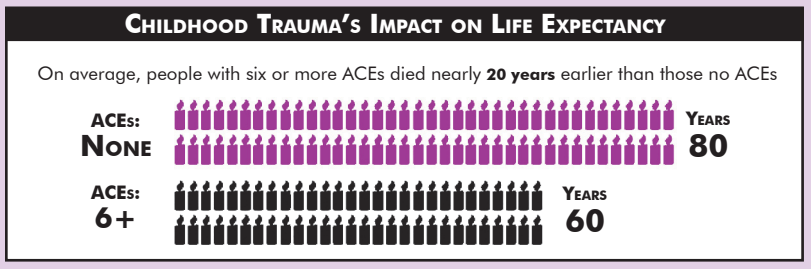
Adapted from CDC, 2013

The Adverse Childhood Experiences (ACEs) study looked at broad types of negative childhood experience: abuse, neglect, and family dysfunction.

Over 17,000 people who had health insurance completed a survey about their childhood experiences and current habits and behaviors. Researchers compared the number of ACEs (between 0 and 10) each person reported to their medical health record.

The study revealed strong links between adverse childhood experiences and risky behavior, psychological problems, serious illness, and life expectancy. In fact, on average people with six or more adverse childhood experiences died nearly 20 years earlier than those with no ACEs.

Trauma also has a big financial impact: the Centers for Disease Control and Prevention estimates lifetime costs associated with child maltreatment at $124 billion.



Trauma-informed parenting: What you should know

Annette and her daughter, June, were walking into the store. Suddenly June froze. Her body was rigid with fear. She refused to take another step and in a shaky voice asked to leave. On the way home she cried quietly, unable to explain.

After that day, Annette made an effort to learn about traumatic stress responses and child trauma, and to talk with other parents about their experiences. This gave her insight into what June was experiencing as they were walking into the store.

Today, Annette approaches parenting through a trauma-informed lens. She understands the nature of June's behavior and feels more competent about how to respond.

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So what should you know about trauma? To answer this question this article draws on information found in *Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents* (2010) by the National Child Traumatic Stress Network (NCTSN).

Trauma

First, it helps to know the difference between stressful and traumatic experiences. Virtually all children who enter foster care have had difficult and painful experiences. While all these experiences are stressful, some have been *traumatic*, meaning they threatened the life or physical integrity of the child or of someone really important to the child (such as a parent or sibling). When they are occurring, traumatic events usually cause intense physical and emotional reactions, including:

- A fight, flight, or freeze response;
- An overpowering sense of terror, helplessness, and horror;
- Automatic physical responses such as rapid heart rate, trembling, dizziness, or loss of bladder or bowel control.

How Children Respond to Trauma

Every child reacts to trauma differently. What is very distressing for one child may be less so for another. Responses to traumatic events

continued next page

Myths Parents Should Avoid

- My love should be enough to erase the effects of everything bad that happened before.
- My child should be grateful and love me as much as I love him/her.
- My child shouldn't feel love or feel loyal to an abusive parent.
- It's better to just move on, forget, and not talk about past painful experiences.

Source: NCTSN, 2010

Trauma-informed parenting

continued from page 1

depend on factors such as:

- The child's age and developmental stage
- The child's perception of the danger faced
- Whether the child was a victim or a witness
- The relationship the child has to the perpetrator or victim
- Whether the child has had other traumatic experiences
- Challenges the child faces after the trauma
- Whether adults are around to offer help and protection

According to the NCTSN, traumatic stress reactions fall into three categories:

Hyperarousal: Child is jumpy, nervous, easily startled.

Reexperiencing: Images, sensations, or memories of the traumatic event come uncontrollably into the child's mind.

Avoidance and withdrawal: The child feels numb, frozen, shut down, or cut off from normal life and other people. The child may withdraw from friends and formerly pleasurable activities. Some children, usually those who have been abused, feel detached from their bodies, and may lose track of time and space. To protect themselves these children may dissociate during any stressful or emotional event.

In reaction to traumatic stress children may exhibit a variety of troubling, confusing, or upsetting behaviors and emotions. They may have:

- A hard time concentrating or learning new information
- Nightmares or trouble falling or staying asleep
- Difficulty managing their feelings and emotions; they may be sullen one minute and cheerful the next, or suddenly become angry or aggressive
- A persistent feeling that they are not safe
- Problems forming trusting relationships
- A hard time handling even simple changes
- Extreme responses to stress

Children Are Resilient

Resilience is the capacity to recover from trauma. Generally speaking, children are more able to "bounce back" from trauma when they feel safe, capable, and lovable.

Many factors can promote resilience and help children see the world as manageable, understandable, and meaningful. These include:

- Healthy relationships with competent, caring, supportive adults
- Connections with positive role models or mentors
- Having their strengths and abilities acknowledged and cultivated
- A sense of control over their lives
- Being part of a community (e.g., family, scout troop, church, etc.)

No matter how old they are or what they've suffered, with nurture and support children who have been through trauma can regain trust, confidence, and hope.

Helping Children Heal through Trauma-Informed Parenting

Following are steps the NCTSN urges resource parents (foster, therapeutic foster, adoptive, and kinship) to take to help children build resilience and overcome the effects of traumatic stress:

1. **Understand trauma's impact on the children in your care**. With this as a foundation, work with other members of the team to identify ways to address challenging behaviors and help children develop new, positive coping skills. Child and family team meetings are one place you can connect with others to get support and find solutions.
2. **Help children feel safe**. Reassure them by creating a structured, predictable environment. Talk about what you've done at home and what the school is doing to keep them safe.
3. **Help children understand and manage overwhelming emotions**. By providing calm, consistent, loving care, you set an example and teach children to define, express, and manage their emotions.
4. **Help children understand and manage difficult behaviors**. Help them see the links between their thoughts, feelings, and actions, and to take control of their behavior. For more on trauma and child behaviors, see the article on page 6.
5. **Respect and support children's positive, stable relationships**. Children who have been maltreated often have insecure attachments to other people. Help them hold on to what is good about existing attachments, reshape them, and make new meaning from them. Engaging in shared parenting (cultivating positive, supportive relationships with birth parents) will help you do this. In addition, help children build new, healthier relationships with yourself and others.
6. **Help children develop a strengths-based understanding of their life story**. Help children overcome negative or distorted beliefs about their histories by being a safe listener for them. Work with them to build bridges across the disruptions in their lives. Life book work (preserving a child's memories, mementos, photos, drawings, and journals in a binder, album, or book) can help with this.
7. **Advocate**. It takes a team of people and agencies to help children recover from trauma. You are a key part of this team. Help ensure efforts are coordinated and help others to view your children through a trauma lens.
8. **Promote and support trauma-focused assessment and treatment**. The effects of trauma may be misunderstood or even misdiagnosed by clinicians who aren't trauma experts. Advocate for appropriate treatment. If your child is receiving mental health treatment, be involved. Understand the goals of the treatment and the purpose and possible side effects of any medications they may be taking.
9. **Take care of yourself**. To be effective, you must take care of yourself.

You can help children "bounce back" from traumatic events by helping them feel safe, capable, and lovable.

Conclusion

By creating a structured, predictable environment, listening to the child's story at the child's pace, and working with professionals trained in trauma and its treatment, resource parents can make all the difference.

Learn More about Trauma

National Child Traumatic Stress Network

The NCTSN seeks to raise the standard of care and increase access to services for traumatized children and their families. Their site has courses, tip sheets, and other resources. *Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents* is a highlight. http://www.nctsn.org

Child Welfare Information Gateway

A service of the Children's Bureau, Admin. for Children and Families, US DHHS. Provides access to print and electronic publications, websites, and online databases covering a wide range of topics. www.childwelfare.gov

Center for Excellence in Children's Mental Health (U. of Minnesota)

Focused on trauma and child welfare systems in a several issues of its newsletter *eReview*:

- What is trauma and why is it important? (March 2010)
- The impact of trauma on infants (Jan. 2012)

Online at http://www1.extension.umn.edu/family/cyfc/our-programs/ereview/

Zero to Three

Resources about the impact of trauma on young children and how caregivers can help them cope and recover. http://www.zerotothree.org/maltreatment/trauma/trauma.html

Trauma-Informed Parenting

How to ensure your child receives effective mental health treatment

by Donna Potter, LCSW

If you are a resource parent (foster, therapeutic foster, adoptive, or kinship), at some point you are likely to care for a child who is receiving mental health treatment. When this happens, you will want to know the answer to one important question: how can I make sure mental health treatment helps my child get better?

Greater Mental Health Needs

Before we answer that question, let's consider what we know about the mental health needs of children in foster care.

While not all children in care require mental health treatment, many do. It makes sense: these children have almost always experienced serious stressors, and their primary attachment figures aren't around to provide support and buffer these stressors.

Research confirms that kids in foster care have greater mental health needs than children in the general population. For example, about **80%** of children in foster care have attachment problems so serious they lead to behavioral disorders, anxiety, depression, and dissociation, compared to 14% of children in the general population.

The Northwest Foster Care Alumni Study found that young adults who had been in foster care had rates of PTSD higher than those of war veterans. The National Center for Child Traumatic Stress's analysis of 2,000 children in the child welfare system found more than 4 in 5 had a psychiatric diagnosis.

Clearly, ensuring children in care receive mental health assessments and treatment is a logical way to promote their well-being.

Recognizing Effective Treatment

Not all mental health treatments are equally effective, however. Fortunately, there are a couple of key ingredients that make up effective treatment. They are:

Assessment. Effective treatment starts with a thorough, trauma-informed assessment. This assessment should specifically analyze any symptoms or problem behaviors and determine which psychiatric diagnoses the child is experiencing—if any.

A really good assessment will include standardized measures administered to several people: to the child (if the child is at least 8 years old), to the caregivers, and to secondary caregivers, such as teachers. Why gather information from different sources?

1. Often children behave differently in different environments.
2. Children tend to report their internal symptoms, like sadness, worry, etc. better than their caregivers because often their caregivers are unaware of these issues.
3. Children tend to minimize their behavior problems, whereas their caregivers are better able to report on those.

An assessment should also include a review of previous records and consider how health issues, social skills, academics, and involvement with social services and the birth family might be impacting the child's functioning.

To be trauma-informed, an assessment must also screen the various potentially scary events a child may have experienced. This should be done with the child, the caregivers, the DSS social worker and, ideally, the biological family and the GAL.

Diagnosis. Information from the assessment may lead a clinician to give the child one or more psychiatric diagnoses,

A Caution: Sometimes clinicians diagnose children with psychiatric disorders without insuring that the child meets ***all*** the criteria for that diagnosis. For example, a child may have exhibited a behavior on one occasion, but the diagnosis actually requires that the child demonstrate a pattern of the behavior.

To guard against misdiagnosis, it is very reasonable for caregivers or social workers to ask for a print-out of the diagnosis right from the *Diagnostic and Statistical Manual, version 5*. Don't rely on descriptions of diagnoses from other sources (including the internet)—they can be misleading or wrong.

Treatment. If a diagnosis is made, the mental health clinician should follow the American Academy of Child and Adolescent Psychiatry Practice Parameters (www.aacap.org) for the effective treatment of that diagnosis. This should involve an evidence-based treatment. (For more on this, see below.)

Throughout the course of treatment the clinician should be measuring the child's symptoms. If symptoms are not decreasing, interventions should be adjusted.

Other Key Ingredients. Two other ingredients are also crucial for effective treatment: Caregiver involvement and therapeutic rapport (a good fit between clinician and child).

Finally, to be trauma-informed, interventions must actively take into account the losses and scary experiences kids have had and see their behaviors as ways they have learned to cope with those things.

Your Role on the Team

- **Work closely with your supervising agency to ensure children get effective treatment.**
- **Attend child and family team meetings, especially when children's mental health needs and treatment are being discussed.**
- **Document and communicate. Track and log any changes you see in your child's behavior, wellness, or functioning. Share this information with other team members.**

Caregiver Involvement Matters!

When children get treatment or therapy that never or only minimally involves caregivers, they can sometimes be in treatment for years without ever feeling or functioning any better.

As a caregiver, the more you are involved in your child's treatment, the better able you will be to report to the therapist about symptoms and behaviors you are seeing, work to help your child feel more emotionally safe in your home, and help them master the skills that will get rid of their symptoms.

If your child has behavioral problems, you are a big piece of the solution! Without your active involvement, those behaviors are unlikely to get better.

Treatment Should Be Trauma-Informed

Whatever intervention your child receives, the more trauma-informed it is, the better! That means the clinician should be working with you to figure out how the child's scary experiences have affected their beliefs about themselves, caregivers, and the world. Trauma-informed care recognizes that beliefs are what drive a child's behaviors.

When we are more aware of the ways in which a child might not feel emotionally safe in a particular situation, we can begin to change the child's behaviors by changing our own responses. This, in turn, will start to change the child's beliefs about the world, which will help them leave behind beliefs—and behaviors—that aren't helping them.

Donna Potter is Training Project Coordinator of the North Carolina Child Treatment Program and a Clinical Instructor at Duke University School of Medicine.

Is Your Child's Treatment Evidence-Based?

"Evidence-based" is a tricky phrase. Just because someone calls something "evidence-based" does not necessarily mean that it is. So how can a caregiver tell if their child's treatment is evidence-based?

Actually, it is fairly easy. Ask the therapist for the name of the intervention, then look it up on one of these two websites: http://www.nrepp.samhsa.gov or http://www.cebc4cw.org.

If you don't see the intervention listed, ask the clinician why. The clinician may provide you with a website designed by the developer of the intervention. While that can tell you what to expect, it is better to look to outside, unbiased organizations for an assessment of the intervention's usefulness.

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.

- 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.

Psychotropic (pronounced "sike-oh-trope-ick") medications affect a person's mind, emotions, moods, and behaviors. Examples include psychostimulants 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 that 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 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 meds can sometimes work 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 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.

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. 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

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
- www.nami.org/Template.cfm?Section=Ask_the_Pharmacist&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=61&ContentID=28925
- www.nami.org/Template.cfm?Section=By_Illness

Kids' Pages

Words and Pictures by and for Children in Foster Care

Vol. 18, No. 1 • November 2013

Writing Contest

Young people's thoughts about medication

In the last issue we asked children in foster care to respond to the prompt: "Some children in foster care take medicines to help them manage difficult behaviors or feelings. How might this help kids? How might it cause problems for them?" Here's what they told us.

Ty'Shawn, age 17

1st

If people that have certain feelings or behaviors do not take their medication, they may not be able to function properly throughout their day. For example, without their medication those who battle depression may go through the day feeling sad or frustrated. Those with ADHD may not be able to focus or productively cooperate with others. These examples show the importance and benefits of medicine.

Some meds actually seem to cause more harm than good.

However, there are also some cons to taking medication. Many children are teased because they are considered weird or strange or "different." This could really hurt a child and make them dislike others or start to believe what others believe about them.

Another disadvantage is that some medicines actually seem to cause more harm than good. Some have side effects that can be very extreme—seeming not to be worth the risk. For example, some medicine may make children "zoned-out." The medication may be so strong that the children seem not to have a personality or innovation. This is commonly referred to as the "zombie" state.

Like many other things we consume, there are positive and negative aspects to medications. It is our job to determine what is necessary and what is not worth the risk.

Ty'Shawn received $100 for winning first prize in the writing contest.

Christian, age 16

2nd

Some children do not like to take medicine. It is because they may feel like it's too much and that they can do better without the medicine. That's when some children refuse. And you know what? I was one of those children.

Some children do not like to take medicine. And I was one of those children.

I ended up at mental health. Because without the medicine, I was crazy. I couldn't think properly. I was like a hyperactive, very high-sugared, overrated, messed up person. I put my lips on the window when the nurse was looking at the files and reading. I was given a shot at the mental health hospital because I wouldn't calm down. I wouldn't sit on the bed. I wouldn't answer the woman who was trying to question why I ended up at mental health.

I ended up there because I had suicidal thoughts. Because when I didn't take my medicine I thought of that somehow.

I am never, ever going to refuse to take my medicine. I just have to take it or something will go wrong. Something will lead me somewhere. Who knows where?

My mom who adopted me and keeps me safe doesn't want me to go in that path again.

Christian received $50 for winning second prize in the writing contest.

Amber, age 17

3rd

I'm one of those that take medicine to help with their behavior. I think that the good thing about the medicine is that if the medicine helps the child, that child can go out into the world and live a very great and productive life. But if the medicine doesn't help that child, he/she could end up in trouble all the time and the foster parent would get tired of the child and won't [keep] them, and the child will have to jump from foster house to foster house. And that's not good. I think it's a good thing for kids to be on the right medicine—it helps the child and the foster parent.

I think it's a good thing for kids to be on the right medicine.

Amber received $25 for winning third prize in the writing contest.

Pros and Cons of Medication

The children below received $15 for having their work published in Fostering Perspectives.

Some kids and teenagers in foster care take meds for things like: behaviors, feelings, emotions, bad thoughts, and acting out. None of these are good. If your behaviors are not good you get in trouble. You sometimes can't control what you are feeling. One moment you will be excited, the next it's a whole different story—you are a whole different person. When you take meds it can change you. You can also feel different, like not yourself.

That's how I felt when I started on all my meds. It can affect you in so many ways. Meds may not work for you; they may make it worse than before. But they may not affect you. They may help you feel better. — Hannah, age 13

I'm a rising 3rd grader diagnosed with ADHD. I am also in foster care. I think some children in foster care take medicines to help them manage difficult behaviors or feelings. The medicines help calm them down and keep them concentrated in school. The medicines help children not to get distracted so they can stay focused and reach their highest goals.
—Dakota, age 8

I've been diagnosed with ADHD since third grade. Since taking my medicines from the doctor, I can stay more focused. I think some medicines can help kids function better. In school it can help kids with work and other important things, and also not to get hyper.

Some medicines can make you sick. Also, mixing medicines with other medicines can make you really sick. Some medicines can be bad for some kids—like making them sleepy, losing their appetite, and making them lose weight.

All medicines have their advantages and disadvantages. The medicine that I take helps me stay focused so I can concentrate in school. —Anayah, age 12

Parenting children who have experienced trauma

by Laura Phipps, MSW

Thanks to trauma, some children see the world as an unsafe place. That's why, for those of us who support children and families impacted by trauma, one idea is paramount: help kids feel safe!

Unfortunately, this isn't simple. True, it's not hard to move a child from a dangerous setting to one that is objectively safer. But physical safety is only half of the issue. We also need to help children feel *psychologically* safe.

Psychological safety is feeling safe, and it is based on each individual's experiences and understanding of what has happened to them in the past and what will happen in the future. Achieving psychological safety for children can be challenging because what's safe to one person may not feel safe to someone else. Unsafe feelings can be triggered by many different kinds of things: sights, sounds, smells, people, time of day, etc.

What's more, these feelings can be triggered without conscious awareness of it. This can be very confusing to caregivers because trauma histories can lead children to exhibit behaviors and emotions that don't make sense to us, and may be the exact opposite of what we think they should be doing.

Consider the child who comes in from playing outside and is very wet and dirty. You run a nice big bubble bath with toys and a fluffy white towel and call the child. She runs away screaming. Many of us would find that bath soothing and comforting, but for some children bath time reminds them of past trauma, so they react in a way we don't expect.

We feel psychologically safe when we feel safe, capable, and lovable. Parents must act in a way that sends a clear message in each area.

So, how can we help kids feel safe when it may not even be clear what "safe" means for them?

It is helpful to think about psychological safety as having three parts: we feel psychologically safe when we feel safe, capable, and lovable (NCTSN, 2010). Parents must act in a way that sends a clear message in each area.

1. You Are Safe

- Reassure children things have changed and that everyone is working to keep them safe.
- Be aware of trauma reminders; remove them when possible.
- Maintain children's contact with loved ones, friends, and siblings to reassure them the people who matter to them are still in their lives.
- Use compassion and understanding when addressing challenging behaviors.

2. You Are Capable

- Taking into account their developmental level, give children control over as many aspects of their lives as possible.
- Help them learn skills to manage overwhelming emotions.
- Make it clear you're sure they'll succeed in managing their emotions and behaviors.
- Build on children's existing skills and strengths.

3. You Are Lovable

- Show unconditional positive regard for the child as frequently as possible.
- Separate what children do from who they are—make it clear that they can make bad choices but still be a good person.
- Be excited to see them when they come home from school or have been separated from you.
- Express interest in what they think, feel, and are interested in; talk to them and ask their opinions about things.

Managing Challenging Behaviors While Promoting Psychological Safety

Trauma reminders can trigger intense reactions and are often at the root of many behavior challenges. It can be difficult to figure out how to balance (1) the need to address problem behaviors and hold kids accountable for their actions with (2) helping children feel psychologically safe. *continued next page*

Examples of Behavior Management Strategies

Prevent

- Eat dinner half an hour earlier to avoid meltdowns caused by hunger.
- Talk with the school about providing extra support for the child on mornings after parent-child visits.
- Give the child choices when seeking compliance ("you can do this or that").
- Practice a difficult transition right before you do it.
- Plan times to give one-on-one attention and tell the child when that will be and how long they have to wait.

Teach

- Teach a new skill to replace the problem behavior. So, if a child regularly starts fights with a sibling in the car, help her plan an activity such as listening to an audiobook to manage her boredom.
- New skills must meet the same need as the problem behavior. If the audiobook doesn't keep the child from getting bored, it won't eliminate the fighting. Effective teaching includes repeated modeling, practice, and feedback on use of the skill. To be used in a stressful situation, a skill needs to be "over taught." Example: you want the child to use a safe space instead of running away when overwhelmed. Model the skill by taking five minutes by yourself in your room when you're frustrated or angry, explaining to the child when you do so. Help the child create his own safe space with some favorite objects. Practice going there with him during different times of day and moods. With practice, the safe space will feel like a tool controlled by the child, not a punishment controlled by you. Feedback might include thanking and hugging the child for going to the safe space, or reminding him that the space is available when he forgets to use it.
- Don't try to teach skills during a crisis or highly emotional moment. Wait for a time when you and the child are calm.

Respond

Support the Positive Behavior

- Contracts: Best for structured feedback to support a new behavior. Example: when a child uses his safe space a certain number of times instead of running away, he receives a privilege.
- Frequent, specific praise: Focus on praising the new, desired behavior.
- Privileges and responsibility: As a new behavior is being mastered, add special privileges and responsibilities to show you know the child can handle them.

Reduce the Problem Behavior

- Logical consequences: These flow directly from the problem behavior. If a child has a meltdown about turning off video games, he loses use of the games for a period of time. Consequences need to be discussed in advance so everyone understands what will happen if the problem behavior continues.
- Loss of privileges: Privileges can be removed if the problem behavior returns.
- Disengage from conflict: Though difficult, do your best to stay calm and focused on what you want the child to do when the problem behavior occurs.

continued from previous page

Yet how can you show unconditional positive regard when behaviors are causing stress and frustration? How can you communicate confidence in their ability to master challenges while challenges are still occurring?

The answer is in how we understand and respond to children's behavior.

Understanding Problem Behavior

All behavior meets needs. When children experience trauma their most pressing need is survival. Many behaviors we would label as "bad" or "difficult" were necessary at one point for the child to survive.

We need to reframe our thinking about this behavior. Rather than seeing it as negative and hostile, we need to see it as a previously necessary survival skill that isn't working for their current environment. If hiding in the closet helped a child stay out of the way of an angry and abusive parent, that is a survival skill. But if the same child is hiding in the bathroom at school to feel safe, that same survival skill is getting in the way of them being successful in a different situation.

One helpful strategy is to remind yourself that ***it isn't about you***. It may feel like the behavior is aimed at you, but we have to remember that the child is behaving the way they are based on a situation from their past. This can be very difficult when a child is doing or saying things that are hurtful or dangerous, but it will help you respond in a way that will be more likely to work. It can help to keep a Q-Tip in your pocket as a reminder to "Quit Taking it Personally."

Responding to Problem Behavior

No matter how well we understand challenging behavior, it can still be incredibly difficult to change. It helps if you recognize that all behavior operates in a pattern; behavior is a reaction to certain triggers and is influenced by the reactions of others and the environment. If we break this pattern down, it becomes much easier to build a comprehensive plan that will help the child learn new, more appropriate behaviors over time.

There are three general strategies for responding to children's problem behaviors.

1. Prevent: Be a behavior detective. Look for clues about when behaviors happen and what is going on in the environment around the child. Once you see a pattern, make changes that prevent the problem from occurring in the first place. Eliminating trauma triggers is the most important prevention strategy for maintaining psychological safety.

2. Teach: Just as the child learned a series of behaviors that kept them safe, they can also learn new behaviors that meet the same need and are a better fit for their new environment. The goal is to identify the need behind the behavior and then teach a new skill that allows children to get this need met in a different way.

Caution: we must never remove a coping strategy without replacing it with another equally or more effective strategy. We want to maintain the sense of safety that these behaviors have provided in the past. This takes practice and support, but if the need is being met you should see improvement over time.

3. Respond: To support children in using new skills we need to respond differently to the old behavior and spend the majority of our time and energy responding positively to the new behavior. When the problem behavior occurs we need to respond in ways that demonstrate why this behavior is not a good choice. Logical consequences that focus on helping children understand the impact of their behavior are the best way to help teach this. Logical consequences need to be respectful, relevant, and realistic. Consequences that don't meet these criteria are less likely to work.

Positive responses to the new behavior can be given in a wide variety of ways, including verbal and nonverbal praise, positive contracts, earning privileges or special activities, or tangible reinforcement. What is most important is the frequency of positive responses, not the method. (Ideally there will be at least four positive comments for every correction—though there are those who think this ratio should be much higher.) Especially when a child is trying to learn a new skill, positive feedback needs to be frequent and specific. This will help support the child in feeling capable and increase psychological safety.

Most importantly, we need to remember that we want children to feel lovable, even when they are demonstrating difficult behavior. Choose your words carefully. Avoid statements that imply blame or express anger or impatience. Focus on the behavior, not the child. Validate children's feelings. Communicate a desire to help them figure out what is going on and learn how to be successful.

And remember: no one is perfect. We all make mistakes and say and do things we wish we hadn't. When this happens, the best thing you can do is model how to handle mistakes. Apologize for anything you feel was hurtful, and talk about your own feelings. Showing children that we all make mistakes and can try again is one of the most powerful ways to support them in doing it too.

Laura Phipps is a clinical instructor with the Family and Children's Resource Program, part of the UNC-CH School of Social Work.

Taking Care of Yourself Is Part of Trauma-informed Parenting!

Taking care of themselves is a must for foster, adoptive, and kin caregivers. If you don't, life becomes a spinning top, constantly twirling, and eventually you won't have what it takes to help the young people who depend on you.

Because you work with children who have histories of trauma, self-care also means protecting yourself from secondary traumatic stress.

Secondary Traumatic Stress

When foster, adoptive, and kin caregivers hear about the traumatic experiences of children or birth parents, they can experience extreme distress or even secondary traumatic stress (also called "vicarious trauma" or "compassion fatigue"). If you're exposed to others' trauma stories, you may have similar stress reactions.

How to Protect Yourself

Be aware of how your work with children and families can affect you. Try to recognize when you are feeling frustrated or overwhelmed, and identify ways to take care of yourself. These can include relaxation techniques, prayer or meditation, getting plenty of sleep, exercise and a healthy diet, keeping a routine schedule, making time for fun activities, and of course maintaining a robust support network of friends and family.

Talk to other resource parents, a therapist, or people who have gone through similar experiences to help you keep things in perspective, understand your own reactions, and avoid words or actions that could make the situation worse.

Why Make Time for Self-Care?

- Makes you more effective at accomplishing your goals.
- Gives you strength to manage difficult situations as they arise.
- Ensures you have the emotional resources and focus you need to help children, making you a more effective and fulfilled parent.

Challenges for Kinship Parents

Working with a traumatized birth parent can be more complicated for kinship parents, who often don't have training before becoming foster parents and may have a shared family history of trauma or feelings of shame, anger, responsibility, or guilt related to the parents' or child's trauma. Kinship parents may also have a strained relationship with the birth parent related to the parent's involvement with the child welfare system.

Kinship parents may be more personally impacted by both birth parents' and children's actions and reactions, and so may have a greater need to protect themselves from secondary traumatic stress.

Adapted from NCTSN, 2011

Foster care alumna and SaySo member shares her story

Lauren Zingraff

La'Sharron Davidson, who shares her story below, has been SaySo's Program Assistant since February 2013. She's also been an active member of SaySo since 2009.

In spite of having to leave high school due to challenges related to being in foster care, La'Sharron persevered and graduated from high school with a 3.87 grade point average.

She has taken classes at Vance-Granville Community College, where she hopes to receive her Associate's Degree in Arts. Her academic goal is to receive her Bachelors in Social Work from UNC-Greensboro.

La'Sharron's favorite food is Italian Chicken Alfredo Pasta. Her favorite color is yellow, although she is also partial to pink. She enjoys shopping and is a very talented hair stylist. (I know this from personal experience!).

La'Sharron was a workshop presenter at the 2013 National Independent Living Conference in Orlando, Florida.

La'Sharron has been upholding SaySo's motto of "speaking out today while making changes for tomorrow" since she entered foster care.

She has been upholding SaySo's motto of "Speaking out today while making changes for tomorrow" throughout her time in foster care and now as an alumna.

Below is La'Sharron's reflection on her journey through foster care.

For more information on SaySo, please visit our website (www.saysoinc.org). You can also find us on Facebook at "SaySo Speaks Out" and follow us on Twitter/SAYSOINC

Lauren Zingraff is the Executive Director of the youth advocacy group SaySo.

Because I SaySo by La'Sharron Davidson

For me foster care wasn't just a placement: it was a place to let go of your anger, venting it on others you don't know. It was a place for losing trust and maybe even gaining trust! Foster care was a life lesson for me. When you are in foster care you never know what will happen next!

Two Years, Two Placements

When I entered care I was 16 years old. I aged out at 18. In the two years I was in care I had two placements. My first lasted a year. My relationship with this family was so-so. Although we had our ups and downs, this family taught me how to manage life, especially when it comes to listening to and abiding by the rules. They also helped me become more independent and mature.

My second placement was at a group home. Now, when people hear "group home" they usually think it is the worst thing in the world. For me it was fun MOST OF THE TIME, though there were hardships. Living there taught me to be calm about any situations that cause conflict, and to ignore things that are irrelevant.

My placements taught me things I can use in the long term.

Overcoming Challenges

One of the biggest challenges about being in foster care was that I wanted more freedom, especially a chance to be with friends and see my siblings. I've always have been the type of person that loves to be around friends and family; it makes me the happiest person in the world. In foster care I didn't have too much input about seeing friends and family. There were a lot of restrictions.

There were also issues related to money and personal care. Personal care/hygiene is very important to me, but it costs money. Also, I have always loved to shop and buy certain things to fit in with my friends. However, in foster care I never had any allowance unless I worked.

This is where I started to dislike the system. I didn't want to speak to anyone—not even my friends—and I just couldn't have my way. This is when the trust started to fall out of place.

After a time, however, I figured out how to cooperate with others and let my feelings be free. Through a program called SaySo (Strong Able Youth Speaking Out) I talked with others that were in the same situation that I was. SaySo helped me get away from stress and have fun with my peers. Trust me, after being at SaySo events I never wanted to go home—it was that fun.

Eventually I looked for a job and finally found one. My first was at a fast food restaurant (Burger King) working part time. After a while I became full-time.

Aging Out

Then I thought to myself, "I am getting ready age out of foster care." I didn't want to sign the CARS agreement (Contractual Agreement for Continuing Residential Support) with DSS, because I didn't want to stay in foster care. I realized I had to save money to get my own place and a car. My foster parent never gave me information on how to be independent, such as making doctor appointments, budgeting, etc. I had to learn a lot of things on my own.

Supports to Help Me Succeed

I finally came across an organization called O4SA (Opportunity For Supervised Apartments). This organization was built for youth that had been in care, to help them become independent and mature. When I aged out of foster care I went to this place and talked with the landlord and the workers for O4SA. Basically you had to have income coming in every month, no criminal background, and a good apartment history. This program was also taught you how to budget. And best of all, they helped you PAY RENT!

I became close with the workers for the organization because they helped me along the way for about two years. But I never went to school—I hated school.

Then I lost my job and had a bad attitude about a lot of things because of my situation. Then two ladies, Ann Tropiano and Kristen Van Ormer, became my mentors and changed my life. They pushed me to strive for the BEST in life. I never thought I would be in the position I'm in now. But thanks to their faith in me I am the Program Assistant for SaySo.

Advice for Foster Parents

The most important thing foster parents should know is that the youth in the foster care system didn't put themselves there—we didn't ask to be there. All we want from you is sympathy, love, and a MENTOR. Mentoring is the biggest factor. You never know what a youth has been through. Don't judge a book by its cover.

Just like anyone else, we want to be loved!

NCFAPA
NC Foster and Adoptive Parent Association
Visit the Association's website at www.ncfapa.org

A message from the Association

Our Mission: to promote quality foster and adoptive services through collaborative advocacy, education, resources, reunification efforts, and networking.

In August 2013 Maurita Miller, President of the NC Foster and Adoptive Parent Association, resigned her position due to personal reasons. We are sorry to see her go! The Association would like to take this opportunity to thank Maurita for her service and to wish her all the best in everything her future holds.

A Proud History

Our association was established 38 years ago to support foster families. In 2005 the association added "adoptive" to its name, reflecting the reality that a great many foster parents become forever families for children in foster care.

Over the past four decades, the Association has done a lot for foster and adoptive parents and kin caregivers in North Carolina. Our achievements include:

- A popular annual training conference that for many years provided an opportunity for foster, adoptive, and kinship parents to gather for much needed training, networking, celebration, and mutual support;
- Technical assistance and support for foster and adoptive parents and local associations; and
- Advocacy efforts for children in North Carolina's foster care system. Our efforts in this area contributed to legislative increases in the foster care board rate (in 2003 and again in 2008). And we continue to advocate the "Raise the Age" campaign, an effort to change current state laws that automatically waive children age 16 and older to adult court when they break the law.

A Difficult Few Years

The past few years have been tough on nonprofit organizations everywhere, and the NCFAPA has not been immune. Many agencies and associations have had to shutter their windows and close their doors.

Though we've struggled, the NCFAPA will not be closing its doors. We will continue because foster and adoptive parents in our state need support and advocacy more than ever.

A Transition Period

However, we are going through a major transition. Longtime past President Stacey Darbee has stepped forward to lead and oversee this transition period. Goals for the near future include:

- Setting up an information website to keep parents apprised of local, state, and national news related to foster care and adoption;
- Email and social media communication with parents; and
- Surveying and assessing what parents need and how NCFAPA can reposition itself to help meet those needs.

Unfortunately for the foreseeable future we will not be able to do training or personally support individual needs.

We truly believe that after this reevaluation the NCFAPA will reemerge stronger, ready to be the leader and the voice of all foster and adoptive parents in North Carolina once again.

Responding to Trauma Triggers by Mark Maxwell

In the last issue of *Fostering Perspectives* I introduced you to my son Tyler. (As a reminder, this is not his real name; to protect privacy I also change some key details.) We adopted "Tyler" when he was 12; he's now 18.

Tyler's gifts to our family included an IEP (Individualized Educational Plans), PTSD (post-traumatic stress disorder), ADHD (attention deficit hyperactivity disorder), ODD (oppositional-defiant disorder), and RAD (reactive attachment disorder). I call these diagnoses and the behaviors they generate "gifts" because they've helped us comprehend the impact of child maltreatment and how important it is for foster and adoptive parents to understand about trauma and trauma triggers.

According to the National Center on Domestic Violence, Trauma and Mental Health, **trauma triggers** are reminders of past traumatizing events. They can be anything, even something apparently harmless.

For someone who's been terrorized by a partner or family member, simply encountering a person in authority can be a trigger. For a domestic violence survivor whose abuser made and enforced "rules" in the house, the very word "rules" might trigger a trauma reaction.

As parents it is important for us to identify, prevent, and respond appropriately to our children's trauma triggers. Failure to do this, according to the National Center for Family Homelessness, can negatively impact children's physical, emotional, academic, and cognitive development.

For Tyler, exposure to trauma triggers inspired drug-seeking behaviors. After he encountered a trigger he would create situations in our house that led to chaos and family blow-ups. This in turn sparked his drug-seeking behavior. In Tyler's mind, the family conflict justified his seeking out or stealing the resources he needed to get high. Sometimes he would even "cheek" his Adderall to sell to peers to get the money he needed to buy marijuana. (*Cheeking: When one pretends to swallow medication, but actually hides the pills in the part of the mouth between the gum and cheek.*)

As parents we can't shield children from all trauma triggers. But we can work to create safe environments free from media violence, chaos, and placement disruptions.

We can't shield children from all trauma triggers. But we can work to create safe environments free from media violence, chaos, and placement disruptions.

To do this, we must first understand what our children's specific trauma triggers are. In Tyler's case, we became detectives. We learned to pay attention, especially at times Tyler did not know we were present or watching him. When he attended an afterschool program, we partnered with the staff and asked them to look for patterns of behaviors, good and bad. We worked with his teachers, guidance counselors, and scouting leaders in an effort to learn how to parent our son.

For our children's sake, we parents must be flexible. For example, experience helped us see that we had to change our responses to Tyler's trigger-inspired behavior. We worked to remove ourselves from the daily circus that Tyler attempts to lead as ringmaster. This does not mean that we do not have real body/mind reactions, but we recognize that impulsive, irrational decisions by us can create greater harm to our entire family. We work to protect each other and our other children. Safety is priority one.

Parents should never hesitate to seek help from qualified mental health professionals, because children can face a number of other challenges (e.g., fetal alcohol syndrome) that may not be immediately obvious.

Parenting a child with a history of trauma isn't easy. My advice to parents is to continue to advocate, educate, take breaks, and build your support network.

Despite the challenges, it is worth it. After all, Tyler is our son. He's ours for life. We are his forever family.

Mark Maxwell is Vice President of Region 2 for NCFAPA. He has four children, three adopted from foster care with his life partner. Mark is a PhD candidate at Walden University.

Working with birth parents who have trauma histories

From the National Child Traumatic Stress Network, 2011

Just as children in foster care have lived through trauma, many of their parents have histories of childhood or adult trauma: physical abuse, sexual abuse, domestic violence, serious accidents, and community violence—along with the experience of having their children placed in foster care. These experiences, if left unaddressed, can continue to impact individuals well into adulthood. Parents' past or present trauma can make it difficult for them to work effectively with case workers and resource parents toward reunification with their children.

Even if you don't know a parent's personal history of trauma, recognizing that trauma may have played a role in their lives will help you more effectively support and work with the entire family.

How Trauma May Affect Birth Parents

As a result of past traumatic experiences, birth parents may:

- Have difficulty keeping themselves and their children safe and healthy. Some are overprotective, while others may not recognize real dangers that can threaten their children.
- Resort to coping in unhealthy ways, such as using drugs or alcohol.
- React more strongly and/or negatively to things—or have a harder time understanding and/or controlling their emotions, behavior and/or words.
- Be more susceptible to further trauma, such as domestic violence.
- Have an invading sense of loss of control, particularly during and/or directly following their child's removal from home. Often parents will re-experience this during case planning processes, visitation, court hearings, or when they or their child receive services.
- Find it difficult to trust others, especially people in positions of power—caseworkers, judges, and even resource parents.
- Be more vulnerable to trauma reminders—or triggers—when a sound, smell, or feeling brings back the experience of the trauma all over again. Reminders may cause parents to overreact to situations that others would not find difficult. Situations that trigger parents can include: children's behavior during visits, case conferences and court hearings, and/or interactions with resource parents or other authority figures.
- Become numb or shut down—even when interacting with their child—or misread your words or intentions. These difficulties can indicate the presence of trauma reminders.
- Mistrust or be jealous of you as the resource parent. They may second guess your role as caregiver or question your discipline or caretaking choices.

Working with Birth Parents

A good relationship between birth parents and resource parents promotes child safety, permanence, and well-being. While not easy to do, positive interactions between you and the birth parents can create a sense of safety, security, and support for the children in your care. Particularly in stressful situations, understanding how a history of trauma can impact birth parents can increase your likelihood of success.

Neither birth parents nor resource parents can accomplish their work effectively without the help of the other. Both caregivers bring a unique set of experiences, skills, and knowledge to the process of caring for the child. The following approaches can help you more effectively work with birth parents who have experienced trauma:

- Don't take difficult reactions personally. Understand that parents' anger, fear, resentment, or avoidance may be a reaction to their traumatic experiences—rather than to the child or to you.
- Remember that parents who have experienced trauma are not "bad." Blaming or judging them will likely make the situation worse rather than motivating them to change.

- Show birth parents that you genuinely care by complimenting their efforts to keep their child safe. Support them in their role as parents by asking for suggestions on how to care for their child. When differences of opinion in parenting beliefs and practices arise, understand that they may be reacting to feelings of fear, inadequacy, or losing control. Focus on the child to keep disagreements from becoming personal.
- Model direct and honest communication. Share your observations (instead of opinions) when presenting information that may be hard to handle. Similarly, be aware of and openly acknowledge your own mistakes.
- Establish clear boundaries and expectations with birth parents and caseworkers. Be consistent and, when you make a commitment, follow it through. Work hard to come to agreement, rather than staying stuck on being "right" or trying to "win."
- Remember that visits, court hearings, and case conferences are difficult for birth parents and children. Work with them to set a routine for these encounters: decide together how to handle meetings, say goodbye, schedule phone contacts, and so forth. Tell birth parents and caseworkers about any event that might affect the quality of the meeting (e.g., the child had a tough day at school, didn't sleep well, etc.).
- Stay calm, even-toned and neutral during stressful situations—you'll be less likely to generate arguments. If not a kinship provider, always ask the birth parent how they would like to be addressed—this conveys respect.
- Remember that things will not always go smoothly, even if you are trying as hard as you can. Work towards mutual trust, while keeping in mind that it may take some time.

Videos explore shared parenting, trauma and behavior

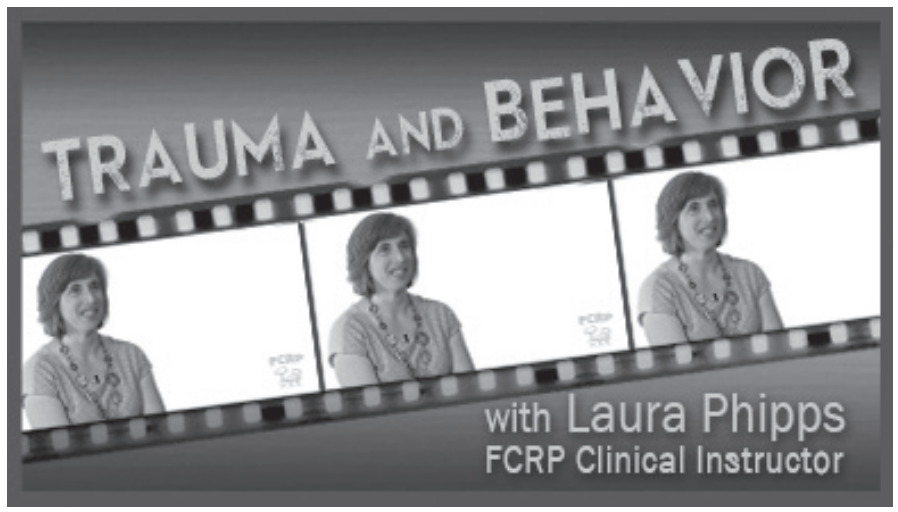
There's an exciting, free, and helpful new resource for child-placing agencies and foster/adoptive parents—a series of short, down-to-earth interviews on topics related to children and families involved with the child welfare system. Parts of the series of particular interest to foster parents, relative caregivers, and child welfare professionals include:

Free, helpful resources for learning more about shared parenting and managing children's behaviors.

Trauma and Child Behavior. UNC-CH faculty member Laura Phipps, a behavior coach and an expert in behavior management, describes the effect of trauma on the brain, explores why traditional parenting approaches often don't solve the behavior problems of children with a history of trauma, and offers suggestions and encouragement for parents and caregivers.

- Part 1: How Trauma Affects the Brain
- Part 2: Why a "Cookbook Approach" Doesn't Work
- Part 3: The Importance of Relationship
- Part 4: Advice for Struggling Caregivers

There is also a study/discussion guide to help groups and individuals get the most out of these 4 videos.



Shared Parenting. Donna Foster, a trainer and former foster parent, defines shared parenting, suggests ways to overcome common barriers, and offers shared parenting advice for foster parents.

- Part 1: What is Shared Parenting?
- Part 2: Overcoming Common Barriers
- Part 3: Advice for Foster Parents

This interview series is produced by the Family and Children's Resource Program, part of the Jordan Institute for Families at the UNC-Chapel Hill School of Social Work. It can be found at: http://fcrp.unc.edu/videos.asp.

By the Numbers: Foster Homes in North Carolina

On August 30, 2013 there were 8,882 children in the custody of North Carolina county departments of social services. About 40% of these children were placed with relatives.

To care for the remaining 5,500 or so children, North Carolina relies on:

- **100 county departments of social services**. All these agencies supervise traditional family foster homes; five (Catawba, Johnston, Moore, Randolph, Wilson) also supervise therapeutic foster homes.
- **105 private child-placing agencies** licensed by the NC Division of Social Services. These agencies provide a variety of services; most contract with county DSS agencies to supervise traditional family foster homes, therapeutic foster homes, or both.
- **80 residential child care facilities** (group homes) licensed by the NC Division of Social Services. These placements are more often used for adolescents and children with serious mental or physical health difficulties.

Foster Homes

Parents in traditional **family foster homes** are trained to care for abused and neglected children while their parents work with DSS to resolve their family issues. Parents in **therapeutic foster homes** receive special training to provide care for children with serious emotional and behavioral problems. On August 30, 2013 North Carolina had 6,584 licensed foster homes. Of these:

- **3,657** were family foster homes. DSS agencies supervised 2,458 (67%) of these; private agencies supervised 1,199 (33%).
- **2,927** were therapeutic foster homes. Private agencies supervised 99% of these.

Because foster homes are such an essential part of our efforts—foster care could not exist without them—and because they can have such a direct effect upon the well-being of children, it helps to have some sense of how the system uses foster homes and how long foster homes remain active.

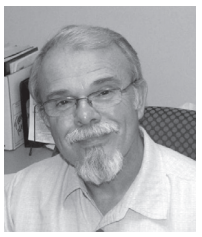
Use. Gibbs (2005) examined administrative data on use of foster homes in Oregon, Oklahoma, and New Mexico. Although she cautions that her findings are not necessarily generalizable to other states, she found that in these states just 20% of foster parents provided 60% to 72% of all foster care days. This is in line with the conclusion reached by Stukes Chipungu and Bent-Goodley (2004), who found that on a national level 33% of licensed homes have no children placed in their homes at any given time.

As of August 30, 2013 there were 6,584 licensed foster homes in North Carolina.

Length of Service. In the three states she studied, Gibbs found that between 47% and 62% of foster parents quit fostering within one year of the first placement in their home, and that at least 20% of all foster homes left the system each year.

We do not have data about the length of service for foster homes in North Carolina. However, we do know that a large number of new foster homes are licensed each year. For example, in SFY 2012-13 North Carolina licensed 1,265 new foster homes (NCDSS, 2013).

This means that about a fifth of North Carolina's current foster homes were licensed within the past fiscal year.



CFTs support trauma-informed work with foster and adoptive parents

by Billy Poindexter

Foster and adoptive parents and kin caregivers are often the ones with the most first-hand information about how children in foster care are doing and what they need. Other members of the team—social workers, therapists, birth families, physicians, school personnel—need to know this information so they can help the children and support their caregivers. If only there were a way to get information to everyone at the same time!

Luckily, there's something that can do just that. It's called the child and family team (CFT) meeting process.

How does the CFT process help resource parents as they work with traumatized children?

CFTs bring everyone to the table for information

The CFT process is about bringing the support system for a child and or family together for the sharing of information. Seldom do providers have the opportunity to see what services others provide, the parameters of those services, and how each can better deliver those services. Sometimes information comes to the CFT meeting in the form of personal representation or a written report, but everyone hears it at the same time. The meeting provides the format for everyone to identify, clarify, and coordinate with each other.

CFTs are flexible . . .

- **In purpose**. CFTs should always have a clear, defined purpose that flows around the child. A purpose can be broad—for example, "exploring options for treatment and family support," "clarifying roles, schedules, expectations, and family needs," or "providing clarification and answering questions regarding a diagnosis." The CFT process is even flexible enough for a parent to have a meeting to "express family frustration with the system and identify options for support."
- **In frequency**. A CFT can be called at any time. Although North Carolina policy requires them to be held at certain intervals, CFTs can be held as needed.
- **In who calls them**. Child and family team meetings are tools for families as well as social workers and community providers. As a foster or adoptive parent, ask for and expect to receive this process from your foster care agency.

CFTs are safe

An effective CFT meeting process is guided by preparation which identifies a mutually understood purpose, agreed-upon ground rules, and a neutral third party facilitator. This provides an environment for the group to do their best thinking while acknowledging the emotional roller coaster a family may be experiencing. This is a valuable aspect of this process—it is not judgmental or simply directive, but provides a safe place and a controlled process that allows the many voices in the family's situation to be heard.

They're interactive

In CFTs, all parties present should be able to interact together around a defined purpose. Families aren't expected to automatically know how to deal with trauma; it is understood that in this and other areas they will need understanding and support from their system. A well facilitated CFT promotes the asking of questions, clarification of information, and mutually agreed upon steps for achieving goals.

And CFTs are respectful

- **Of vulnerability**. It can be uncomfortable to admit you don't know how to parent a traumatized child. The CFT environment accepts this and seeks to promote understanding.
- **Of parenting's emotional impact**. Some behaviors may not appear until well after a child is placed in foster care. When this happens, the impact on the family can be powerful. The CFT meeting process is a place where honest emotions are expected and respected as real and deserving of support.
- **Of the challenges families face**. Foster parenting involves integrating a traumatized child into the biological family system. This can lead to mixed emotions. The CFT process provides a place for healthy discussion of these challenges and productive input from the support system.

A coordinated system, flexibility, safety, interaction, and respect—are these not what we want for children? The CFT process is a way to bring these benefits to our foster/adoptive parents as well.

Billy Poindexter is a CFT facilitator with Catawba County DSS and a trainer for the Center for Family & Community Engagement at NC State University.

To Learn More about CFTs . . .

Read *Fostering Perspectives*, vol. 16, no. 2 at www.fosteringperspectives.org

Supporting Children During CFTs

Although they bring lots of benefits, CFTs can also stir up a lot of feelings. As a foster or adoptive parent, you are in a position to help young people prepare emotionally for these meetings.

Begin by asking children how they feel about the upcoming CFT. As you discuss their feelings, make sure they understand the purpose of the meeting, who has been invited, and their own role.

Help children understand that they have a right to be present at a CFT that concerns them. If they want to be there, they have the right to be heard. If they don't want to participate or there is some reason why full participation is not possible, help them find a way to ensure their voice, thoughts, and ideas are shared at the meeting.

How Do Youth in Foster Care Feel Before a CFT?

Afraid, homesick, and hopeful are the emotions I feel at my team meeting. —Dalton, age 11

I hate CFT meetings. I hate the "all eyes on me" feeling. I also hate the embarrassed feeling you have when you have to explain why you're in trouble. —Nikki, age 16

I sometimes get scared when I am about to go into my meetings, because I do not know what the team is going to say or if they are going to move me. Sometimes I am happy to meet because I have important things to talk about. Sometimes I am so excited to see the people who are in my meeting that I just can't sit still. —Tiffany, age 14

Why do I get nervous when I hear that I have a [meeting]? I cannot express how I am really feeling, but I do have many emotions. My hands are shaky and I feel sick to my stomach. I don't know what's going to happen next. I feel like my future is being tossed around like a ball. I have questions that need to be expressed out loud. I have to face my fears. —Melanie, age 14

Reprinted from Fostering Perspectives, vol. 16, no. 2

NC passes new laws affecting foster parents

by Deana K. Fleming, Associate Counsel, NC Guardian ad Litem Program

Sometimes changes are made to state and federal laws that have a direct impact on foster and adoptive parents. This article describes laws passed in 2013 by the legislature in North Carolina that may be of particular interest to you.

Changes Related to Adoption by Foster Parents

When it enacted House Bill 350 (Session Law 2013-129) during the 2013 Legislative Session, the North Carolina General Assembly amended several provisions of the Juvenile Code governing abuse, neglect, dependency, and termination of parental rights cases, including G.S. 7B-1112.1, which governs the selection of adoptive parents by a county department of social services (DSS). Recognizing that foster parents are often interested in adopting children in foster care who become eligible for adoption, the legislature enacted certain procedural safeguards related to due process for foster parents.

Foster parents must now be given notice and have a right to be heard in court if they want to adopt but are not selected.

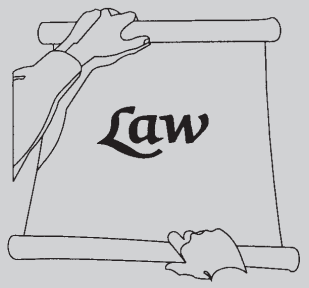
In the new legislation, the process of selecting adoptive parents remains the responsibility and within the discretion of DSS or the agency that has legal custody of a child. However, the new law states that:

- **DSS must consider interested foster parents**. When it selects adoptive parents for a child in foster care child, the DSS agency must consider current placement providers, if those placement providers want to adopt the child.
- **DSS must notify foster parents of adoption decisions**. When the adoption selection committee at DSS reaches a decision, the agency has ten (10) days to notify foster parents that adoptive parents have been selected.
- **If they are not selected, foster parents have a right to be heard in court**. If the foster parents want to adopt but are not selected by DSS, they can file a motion to be heard in juvenile court. They have ten (10) days from the date they were notified of the adoption committee's decision to file this motion. The DSS will provide a copy of a motion for review to the foster parents; the foster parents must then complete and file the motion with the juvenile court for a hearing. If they file this motion, the child may not be moved to the proposed adoptive home until after the court hearing.

While this amendment gives the foster parent notice and an opportunity to be heard in court, it does not make the foster parent a party to the juvenile case. When the juvenile court judge hears the motion filed by a foster parent, the judge will consider the recommendations of DSS, the guardian ad litem, and other facts related to the selection of adoptive parents. The judge then determines whether the proposed adoptive placement is in the child's best interest. If the judge determines the proposed adoptive placement is not in the child's best interest, the adoption petition is not filed and the adoption selection committee must reconvene to make a new selection. If foster parents who wish to adopt are again not selected, the procedure starts over. However, legislative intent indicates DSS agencies should give serious consideration to foster parents who wish to adopt, unless the adoption is not in the child's best interest.

This legislation went into effect October 1, 2013 and applies to cases filed or pending after that date.

Link to the legislation: http://www.ncleg.net/Sessions/2013/Bills/House/PDF/H350v4.pdf (Scroll down to page 18, section 36)



Foster Care Children's Bill of Rights

Thanks in part to lobbying by SaySo (Strong Able Youth Speaking Out), the legislature amended G.S. 131D-10.1 to provide for a Foster Care Children's Bill of Rights as set forth below:

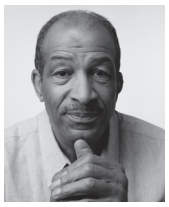
1. A safe foster home free of violence, abuse, neglect, and danger.
2. First priority regarding placement in a home with siblings.
3. The ability to communicate with the assigned social worker or case worker overseeing the child's case and have calls made to the social worker or case worker returned within a reasonable period of time.
4. Allowing the child to remain enrolled in the school the child attended before being placed in foster care, if at all possible.
5. Having a social worker, when a child is removed from the home, to immediately begin conducting an investigation to identify and locate all grandparents, adult siblings, and other adult relatives of the child to provide those persons with specific information and explanation of various options to participate in placement of a child.
6. Participation in school extracurricular activities, community events, and religious practices.
7. Communication with the biological parents if the child placed in foster care receives any immunizations and whether any additional immunizations are needed if the child will be transitioning back into a home with his or her biological parents.
8. Establishing and having access to a bank or savings account in accordance with State laws and federal regulations.
9. Obtaining identification and permanent documents, including a birth certificate, social security card, and health records by the age of 16, to the extent allowed by federal and State law.
10. The use of appropriate communication measures to maintain contact with siblings if the child placed in foster care is separated from his or her siblings.
11. Meaningful participation in a transition plan for those phasing out of foster care, including participation in family team, treatment team, court, and school meetings.

It is important to note that a violation of this section does not create a legal cause of action by a foster child against the State, the Division of Social Services, or the foster care provider. However, this Bill of Rights will be implemented in policy.

This Act became effective July 23, 2013.

Link to legislation: http://www.ncleg.net/Sessions/2013/Bills/House/PDF/H510v5.pdf

Note: The rights of children in foster care in North Carolina are also outlined in section 10A NCAC 70E .1101 of our state's administrative code, which can be found online at http://reports.oah.state.nc.us/ncac/title 10a - health and human services/chapter 70 - children's services/subchapter e/10a ncac 70e .1101.pdf



A reader asks . . .

Am I right to hesitate to ask for respite, even though I really need it?

I need respite care, but fear that asking for it will impact my foster care license. Am I right to worry about this?

Respite is essential for the survival of all parents and caregivers, including foster parents!

Foster families face an array of demands. The children who enter their homes may be disabled or medically fragile, and many exhibit emotional or behavioral challenges as a result of trauma. Each child brings his or her own needs, demands, and experiences into the foster home. All these factors can be very taxing!

The break that respite provides can allow foster parents to renew their energy for parenting, which results in better care and treatment of children. If respite is provided regularly it can help prevent foster parent burnout and exhaustion. This in turn prevents placement disruptions and multiple moves, which research studies and experience have shown to be very bad for children.

Despite these benefits, some foster families share your concerns about respite. Some fear that agencies will interpret a request for respite as a signal that the foster parent is already overwhelmed or unfit to care for the children in their homes. Others fear that asking for help will threaten their foster care license. Another common concern among foster parents is that the children will not receive adequate care from the respite provider.

However, it is important to be open and honest with your agency about your needs, which directly impacts the care of the children in your home. Being open about your needs also ensures the longevity of your role in the foster care system. Workers want to support foster parents, and they know they need respite. Some agencies have licensed foster parents dedicated to providing short-term respite. These providers receive the same training and possess the same skills as other foster parents.

Preparation is the key component for successful respite. As a first step, talk with your social worker and make arrangements before you need a break. Once a respite family has been identified you will want to take the time to prepare both the child and the respite family for the respite period. Part of this preparation should include a pre-placement visit between the child and the respite family before the actual respite period begins.

Once you have asked for and prepared for respite, don't forget to enjoy it! Do what you can to put worry out of your mind and to see this time to "recharge your batteries" as a critical part of your job as a foster parent.

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 right.

fostering perspectives (Nov. 2013)

Sponsors. NC Division of Social Services, the NC Foster and Adoptive Parent Association, 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: jdmcmaho@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.

Printing Information. The NC Department of Health and Human Services does not discriminate on the basis of race, color, national origin, sex, religion, age, or disability in employment or the provision of services. 10,500 copies printed and mailed at a cost of $3,391.08, or $0.32 per copy.

Frequency and Distribution. Issues appear every May and November. Printed copies are sent directly to all NC county DSS agencies and to all foster parents and child-placing agencies licensed through the NC Division of Social Services. If you think you should be receiving a printed copy but are not, please contact us at the address above.

Online. www.fosteringperspectives.org

Subscribe Online. To be notified about online issues, e-mail jdmcmaho@unc.edu with "FP subscribe" in the subject line.

References. See the online version of this issue for references cited in this issue.

Project Broadcast: Bringing Trauma-Informed Practice to NC's Child Welfare System

Project Broadcast is a five year grant awarded to the NC Department of Health and Human Services, Division of Social Services. It strives to improve the well-being of children and families through the development of a trauma-informed child welfare system. Funded through the Department of Health and Human Services, Administration for Children and Families, Children's Bureau (Grant # 90CO1058) through September 2016, this project will invest over $625,000 each year toward implementing trauma-informed practices.

The project selected nine demonstration counties (Buncombe, Craven, Cumberland, Hoke, Pender, Pitt, Scotland, Union, and Wilson) to begin this very important work. The plan is to learn from these counties how best to implement trauma-informed practices and then incorporate these practices statewide.

To assist them in creating a trauma-informed child welfare system, Project Broadcast has outlined five primary strategies:

1. Develop a trauma-informed workforce. This includes foster, adoptive, kinship and therapeutic parents, child welfare staff, and the broader child serving organizations such as schools, law enforcement, domestic violence, courts, etc. By using training developed by the National Child Traumatic Stress Network (NCTSN), our workforce will be able to apply trauma-informed practices to improve the lives of the children they serve.

2. Increase the number of clinicians able to provide trauma-informed, evidence-based treatment. Clinicians will be trained via the North Carolina Child Treatment Program (NC-CTP) in the following treatment interventions:

- Attachment and Bio-Behavioral Catch-up (ABC)
- Parent-Child Interaction Therapy (PCIT)
- Trauma-Focused Cognitive Behavioral Therapy (TFCBT)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

3. Increase the public's access to clinicians. Do you know who in your county provides good quality mental health treatment? We will expand the NC-CTP 'rostering' process to include the above treatment models. You will be able to visit www.ncchildtreatmentprogram.org and find a therapist in your area.

4. Increase the ability of child-serving agencies to share data. There are many agencies working toward helping children, but they do not always talk to each other. Our project strives to improve our ability to access the necessary data we need to effectively work with children.

5. Ensure our state and local policies are trauma-informed. These policies include things such as screening children for trauma, and developing a system that can monitor and treat the emotional trauma associated with the child's maltreatment and removal from home.

The NC Division of Social Services has partnered with the Center for Child and Family Health, a National Child Traumatic Stress Network site, as well as the University of North Carolina at Chapel Hill to assist them on this project. For more information, contact Jeanne.Preisler@dhhs.nc.gov; 336/209-5844.

Help us find families for these children

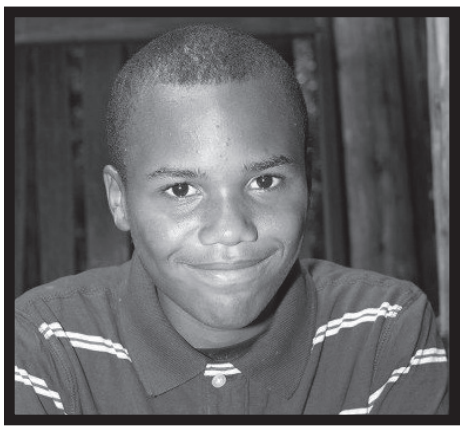
For more information on these children or adoption in general, call the NC Kids Adoption and Foster Care Network at 1-877-NCKIDS-1 <www.adoptnckids.org>

Breanna, age 11

Breanna is a charming and beautiful young lady. She can easily win someone's love with her demeanor. She loves junk food and can be a very picky eater. Breanna enjoys art, computer games, and loves playing with the Little PetShop animals. Breanna is a typical 11 year old; she enjoys being outside and likes running track. However, she is knowledgeable about certain things well beyond her years and desires a lot of attention. Therefore she needs to be the only child in the home.

Breanna is doing fairly well academically in school but has the ability to do better. She is somewhat distractible and this takes away from her classroom learning. Breanna has had trouble in the past with reading; it would be beneficial for her adoptive parents to work on this and read with her at home.

Breanna participates in weekly therapy. This will be something that needs to continue so she can thrive in an adoptive home. Breanna will be successful with a two-parent family that has structure and consistent parenting techniques in regards to rules and boundaries. The perfect family for Breanna will be confident in their parenting skills and work as a team to help her succeed.



Edrick, age 16

Edrick is helpful, sweet, shy, and lovable. He is respectful of adults and prefers one-on-one attention. He is also a good athlete. Edrick is family-oriented and curious about life.

Edrick is on the wrestling team at school. His coach says he is a real asset to the team and that the entire team loves him. He also likes to play computer and video games. He enjoys going to church and the library. He likes to dress nice, especially nice shoes.

Edrick is in the 10th grade and benefits from extra support in school. He completes his homework after school and enjoys reading prior to bedtime. Edrick is in good health and is an active teenage boy. He receives services to improve his social skills and personal boundaries.

Edrick needs a mature, patient couple that can keep him safe and provide a lot of one-on-one attention. The adoption team is willing to consider all types of families, but would prefer a two-parent home. Single parents will also be considered. Edrick needs a positive male influence in his life. He very much wants to be part of a stable family. Edrick needs an experienced family that knows how to advocate for and support children that have been abused or neglected. He will need to be the youngest child in his forever family.

Emily, age 13

Emily is helpful, playful, musical, and loves animals. She responds well to routine, structure, affection, and praise.

Some of Emily's favorite activities include singing and listening to music (particularly country music), drawing, dancing and bike riding. She also enjoys climbing trees and swinging, playing "Shoots and Ladders," and going out to eat. She likes to watch The Disney Channel and Nick Jr. Some of her favorite TV shows are *Blue's Clues*, *What Not to Wear*, and *Craft Wars*. Her favorite foods are spaghetti, pizza, and burgers.

In school Emily loves language arts and social studies. When she grows up, she'd like to have a big farm with horses and lots of animals. She'd like to be a veterinarian or an eye doctor. Emily wants younger siblings, especially a sister, in her forever family. Her ideal family will love animals as much as she does.

Michelle, age 10

Michelle is playful, silly, and lovable. She has a bounce-back spirit, a keen sense of humor, and a unique, warm laugh that's pleasant to the ear. She is careful and cautious around people she doesn't know well, but opens up and shows affection once trust is established. She responds well to positive reinforcement and having a stable caretaker.

Michelle loves video and board games, drawing and reading, and the Disney Channel. Singing and dancing are also favorite activities, as are going to the library and eating fried chicken, pizza, and McDonalds.

Michelle wants an African American forever family. This family will need a strong female parental presence. Her family should provide consistent structure and boundaries while making Michelle to feel accepted and loved. They should be open to maintaining a relationship with her foster mom.

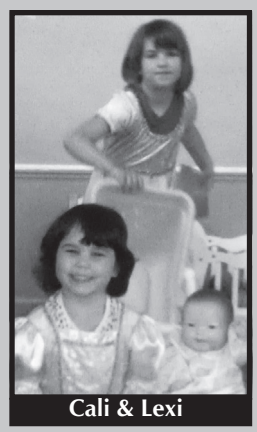
Update

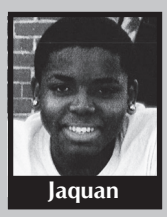
Five children of the twelve featured in the May 2012 issue have been matched with adoptive families! However, the children shown here are still waiting for forever families. To learn about them, go to www.adoptnckids.org.


Christian


Drexton


Pamela


Cali & Lexi


Jaquan


Kiana

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:

Sometimes youth in foster care get into trouble with the law. What should foster parents, social workers, GALs, and others do to support them when this happens?

Deadline: February 6, 2014

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, social security number (used to process awards only, confidentiality will be protected) 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 a cash 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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Get in-service training credit for reading this newsletter!

Enjoy reading *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 v18n1

1. What is trauma?
2. Why is it important for foster parents and other substitute caregivers to understand trauma and its effects?
3. What are the benefits of being actively involved in your child's mental health treatment?
4. How can you determine a mental health treatment is evidence-based?
5. Name four things you can do to ensure children taking psychotropic medications get the care and oversight they need.
6. Why does Laura Phipps advise you to carry a Q-Tip?
7. What is La'Sharron Davidson's advice for foster parents?
8. Behavior management strategies can be divided into three categories: Prevent, Teach, and Respond. Give two examples of strategies for each category.
9. Which right in North Carolina's new "Foster Care Children's Bill of Rights" do you think will be easiest to guarantee? Which will be the hardest?
10. How might past trauma affect birth parents and what are the implications for how you interact with them?

NC Launches Online Orientation for Prospective Foster Parents

http://ncswlearn.org/foster

North Carolina has launched a new resource to support foster parent recruitment and training: an online orientation that sends a consistent, inspiring message to families considering providing therapeutic or family foster care. It is:

- **Easy to Find**. Simply go to http://ncswlearn.org/foster.
- **Fast!** Takes just 15 minutes. No registration—just click the link and begin.
- **Super Helpful**. Explains foster care, describes the children in need of foster families, and tells you how to take the next step to becoming a licensed foster parent in North Carolina.

Know someone considering becoming a foster parent in our state? This orientation is a great way to start their foster care journey!