

Fostering Health NC · A Guide for Guardians ad Litem



Building and Strengthening Medical Homes for Infants, Children, Adolescents and Young Adults in Foster Care

www.ncped's.org/foster-care-medical-home

What is Fostering Health NC? There are approximately 9,000 children in foster care in North Carolina. These children have special health care needs. Often because of the circumstances that led them to be placed into foster care, their physical, developmental, mental/social-emotional and oral health care has been inconsistent and sometimes impacted by crisis or injury. Fostering Health NC, a project of the North Carolina Pediatric Society, is focused on building and strengthening medical homes for infants, children, adolescents and young adults in foster care through integrated communications and coordination of care through a unique partnership among local Departments of Social Services, CCNC Networks, the pediatric care team, the child and the child's family.

A. Benefits of Medical Homes

Medical homes provide a single point of entry to a system of care that facilitates access to medical and nonmedical services. A medical home allows primary care providers (i.e. pediatricians or family physicians), parents, child welfare professionals, and other stakeholders to identify and address all of a child's physical and mental health needs promptly and as a team. All children benefit from medical homes through the establishment of a consistent, ongoing relationship with a primary health care provider and team who know the child well. This consistency is particularly helpful for children in foster care. A medical home preserves the relationship children have with their doctors and ensures medical records don't get lost, even when they return home or change placements.

B. Ensuring Medical Home Assignment

Social workers should coordinate with care managers (CCNC Network care managers and local health department CC4C care managers) and provider offices to ensure all of the children on their caseloads are enrolled with CCNC and assigned to a medical home. Social workers should then make positive contact with the medical home to make certain the practice knows that a child assigned to them is in foster care.

C. Frequency of Foster Care Visits

Children in foster care need to be seen early and often to identify health issues before they become crises.

Standards published by the American Academy of Pediatrics (AAP) and Child Welfare League of America (CWLA) are available in the Fostering Health NC Online Library and the AAP website. [See <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Health-Care-Standards.aspx>].

Summary of the AAP Standards:

- **0-6 months of age:** Should be seen every month
- **6-24 months of age:** Should be seen every 3 months
- **2-21 years and times of significant change:**
(e.g. change in placement, reunification)
Should be seen every 6 months

D. Types of Foster Care Visits

According to the AAP Standards of Care, the **Initial Visit** should occur within 72 hours of placement into foster care (NC Division of Social Services standard for completing this visit is within seven days). The **Initial Visit** should be an assessment of acute care needs and an opportunity to obtain releases of information from additional providers in preparation for the comprehensive visit. A second visit, called the **30-day Comprehensive Visit**, should occur within 30 days of placement into foster care, unless medically necessary to see the child sooner.

Follow-up Well-Visits should start within 60 to 90 days of placement, and additional health evaluations (mental health, developmental, educational and dental) should occur based on the child's age.

E. Screening for Social-Emotional and Mental Health Concerns

Children in foster care should receive screening for general health risks and strengths. Additionally, as a group, children in foster care are at high risk for social-emotional delay due to trauma. Screening is important; based on early brain development research, children exposed to toxic stressors experience increased risk for delays in social-emotional development. If ignored, such delays can lead to long term problems with health and behavior.

F. Social-Emotional and Mental Health Evaluation

Children who have a positive social-emotional screening or a known mental health condition should have a comprehensive mental health evaluation by a mental health professional in the practice or by referral to a provider in the community. For infants with a positive screen, there is a critical need to perform a comprehensive evaluation for social-emotional concerns and other developmental concerns with the parent and the infant and not just the infant. If you have a concern about a child's social-emotional or mental health, do not delay in bringing it to the attention of the DSS social worker.

G. Oral Health

Almost 35% of children and adolescents enter foster care with oral health issues. It is important to link these children with dental homes to have a comprehensive oral health evaluation within 30 days of placement into foster care to address their acute and preventive dental and oral health needs.

H. Transitions

Children in foster care experience many kinds of transitions and often all at once. Examples include living in a new home with their foster parents, joining a new foster family, visiting or reuniting with biological parents, starting at a new school or child care, making new friends, and sometimes having a new medical home. Children in foster care need time to adjust. Having a routine and structure can be very helpful for children of any age. Transitional objects (e.g., a favorite blanket, stuffed animal or other personal item) can also help make transitions easier.

The Indiana University's School of Medicine has published a handout for parents.

[See <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/IU-Transitions.pdf>]

The AAP offers tools specific to adolescents in foster care to help them working through transition. [See <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/AgingOut%20FINAL.pdf>]

A wide variety of tools are available for health care providers on how to address transition issues.

[See <http://www.gottransition.org/>]

I. Guardian ad Litem Statutory Role

The guardian ad litem (GAL) protects and promotes the best interest of abused and neglected children in juvenile court. The GAL is paired with an attorney advocate to protect the child's legal rights. Pursuant to N.C. Gen. Stat. § 7B-601, the GAL investigates to determine the facts of the case, the juvenile's needs, and available resources in the family and community to meet those needs; facilitates settlement of disputed issues; provides evidence to the court, usually in the form of a court report; conducts follow up investigations; and reports to the court when the child's needs are not met.

Symptoms and Behaviors That May Be Observed in Children in Foster Care

These symptoms may indicate that a child is not coping well and having problems related to social-emotional development and mental health.

Sleep problems

Feeding and Eating issues

Toileting issues (i.e., constipation, encopresis, enuresis, regression of toileting skills)

Self-regulation issues (inability to console or soothe or calm self, impulsive actions)

Frequent severe temper tantrums

Self-abuse (such as biting or hitting self)

Aggressive with other children

Defiance/arguing

Frequently in trouble at school and with peers for fighting and disrupting

Hypervigilance, anxiety, or exaggerated response

Excessive crying or worrying

Flat affect, withdrawn, not smiling, resists cuddling in infants (problems with attachment)

Dissociation (detachment, numbing, compliance, fantasy)

Difficulty acquiring developmental milestones in infants

Difficulty with school skill acquisition and keeping up in school

Trouble keeping school work and home life organized

Losing details can lead to confabulation, viewed by others as lying

Inappropriate sexual behaviors or gestures

See the Additional Resources section for more information, especially the AAP's *Helping Foster and Adoptive Families Cope with Trauma: A Guide for Pediatricians*.

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J. Appointment Process

When a county Department of Social Services files a petition in juvenile court that alleges a child is abused or neglected, a GAL is appointed to represent the child's best interest in the court proceeding. An appointment order, "Order to Appoint or Release Guardian ad Litem and Attorney Advocate" (AOC-J-207), designates the GAL and attorney advocate and is signed by the judge. A certified copy of the order is provided to the GAL to assist in the investigation of the case.

K. Records Requests

In fulfilling statutory duties related to an investigation, the GAL makes requests for confidential records relevant to the case and representing the child's best interest. In making a request, the GAL provides a copy of the appointment order which specifies the authority to obtain confidential information. Many federal laws, including the Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA), have specific exceptions that apply to guardians ad litem requesting protected information due to the appointment order and applicable law. If there is not a specific exception, the attorney advocate may issue a subpoena or request a specific court order regarding particular records.

L. Confidentiality

By statute, the GAL has the ability to obtain information or reports, whether or not confidential, that the GAL believes are relevant to the case. No privilege, except attorney-client, may be invoked to prevent the GAL and court from obtaining information. However, the GAL must respect the confidentiality of information or reports and is not permitted to disclose any information or reports except by court order or as otherwise provided by law.

J. Additional Resources

Foster Care

AAP Healthy Foster Care America: www.aap.org/fostercare

Mental Health

AAP Mental Health Initiatives: www.aap.org/mentalhealth

Trauma

AAP's *Helping Foster and Adoptive Families Cope With Trauma: A Guide for Pediatricians*:

<http://www.aap.org/traumaguide>

National Child Traumatic Stress Network: www.nctsn.org

Child Trauma Academy www.childtrauma.org

AAP Medical Home for Children and Adolescents Exposed to Violence: <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Medical-Home-for-Children-and-Adolescents-Exposed-to-Violence/Pages/Medical-Home-for-Children-and-Adolescents-Exposed-to-Violence.aspx>

Early Brain Development

AAP: Early Brain and Child Development:

[http://www.aap.org/en-us/advocacy-and-policy/aap-health-](http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/EBCD/Documents/EBCD_Well_Child_Grid.pdf)

[initiations/EBCD/Documents/EBCD Well Child Grid.pdf](http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/EBCD/Documents/EBCD_Well_Child_Grid.pdf)

Center on the Developing Child at Harvard University:

www.developingchild.harvard.edu

Zero To Three: <http://www.zerotothree.org/about-us/areas-of-expertise/free-parent-brochures-and-guides/>

FHNC Guide for Guardians ad Litem was developed by the Fostering Health NC State Advisory Team, with contributions from Marian F Earls, MD, MTS, FAAP, Director of Pediatric Programs for Community Care of North Carolina (CCNC).