CASA
Court Appointed Special Advocates
FOR CHILDREN

THE NATIONAL COURT APPOINTED
SPECIAL ADVOCATE ASSOCIATION

CASA/GAL Pre-Service Volunteer Training Curriculum

Pre-Work Handouts

CHAPTER ONE

HEARST foundations

OJJDP

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Version 2, November 2017

CHAPTER 1:

Pre-Work Handouts

CONTENTS

Pre-Work Instructions

This section details the Pre-Work that you need to complete before the classroom session. Completing this work prior to the session will allow you to fully participate during the training session and build the knowledge and skills you need to be an effective and successful CASA/GAL volunteer.

Prior to attending the first session of the volunteer training, please complete the following assignments:

- Read the CASA/GAL volunteer job description provided by the facilitator.
- Read "Developing Competencies for CASA/GAL Volunteer Work" on pages 2 through 8. Mark the areas on the checklist that are your current strengths, as well as the areas you want to work on during the training.
- Read "Child Welfare History" on page 9, and write down any questions you have about the material.
- Read “Alphabet Soup," on page 17, which provides a list of acronyms used by your local CASA/GAL program and the local court system.
- Read the Bleux Case File on page 18. In your own words, write a case history in one or two paragraphs. What additional information would you like to know about the family in the case? Write down a few questions that you have.

Developing Competencies for CASA/GAL Volunteers

Volunteer Work Handout

Please review the following competency checklist. As you review each area, note whether it is a current strength or if it is an area that needs further development.

Volunteer Name: **Date:**

Competency Category	Knowledge, Skills and Attributes	Current Strength	Competency to Develop
CASA/GAL Role	Knows how to define the CASA/ GAL role		
	Understands the function of a CASA/GAL report to the court		
	Understands the competencies necessary to succeed as a CASA/ GAL volunteer		
	Knows how to act within the CASA/GAL volunteer role and can differentiate his/her role from that of others involved in the case		
	Knows how to find support and resources to assist his/her advocacy		
	Understands how to obtain relevant confidential information		
	Understands the importance of partnering with his/her supervisor to develop goals and to discuss issues and assess progress		
	Understands the importance of participating in ongoing professional development to strengthen advocacy skills		

Competency Category	Knowledge, Skills and Attributes	Current Strength	Competency to Develop
Communication	Knows how to effectively articulate a point of view while advocating for the needs of the child		
	Understands the importance of establishing trust and rapport with all parties		
	Understands the importance of speaking and writing clearly and concisely		
	Knows how to work collaboratively and manage conflict effectively		
	Recognizes the importance of treating others with dignity and respect		
	Knows how to be an active listener		
	Understands and respects the perspectives, values and input from others		
	Knows the importance of being forthright, thorough and detail oriented		
	Knows how to utilize basic communication and interviewing skills		
	Knows strategies for interviewing children		
	Understands the elements of a court report		

Competency Category	Knowledge, Skills and Attributes	Current Strength	Competency to Develop
Cultural Competence	Understands the extent to which cultural institutions and values may oppress, marginalize or alienate some individuals or groups and create or enhance privilege and power of others		
	Understands and demonstrates self-awareness to eliminate the influence of personal biases and values when working with diverse groups		
	Knows strategies and steps to take to increase cultural competency skills and demonstrate culturally competent child advocacy		
	Understands how to recognize and challenge own biases		
	Understands the root causes of disproportionate representation of children of color in the child welfare system and the disparate outcomes children of color experience		
	Knows how to be sensitive and responsive to different cultural differences		

Competency Category	Knowledge, Skills and Attributes	Current Strength	Competency to Develop
Sound Judgment	Knows how to set healthy boundaries and respects the boundaries of others		
	Knows how to adhere to all policies, ethical guidelines and procedures		
	Recognizes the importance of flexibility in handling case-related changes		
	Understands managing challenges by collaborating based on the best interest of the child		
	Knows how to maintain objectivity and avoid making assumptions		
	Understands the importance of anticipating and recognizing potential problems		
	Understands making appropriate fact based recommendations to the court		
	Understands basing decisions on thorough review of the information		
	Understands evaluating alternative decisions		
	Understands the confidentiality requirements of being a CASA/ GAL volunteer		
	Understands that your personal values and biases about mental illness, domestic violence and substance abuse can affect your objectivity		
	Knows how to evaluate what is in a child's best interest		

Competency Category	Knowledge, Skills and Attributes	Current Strength	Competency to Develop
Initiative	Knows how to be self-motivated and work independently		
	Understands the importance of being resourceful and identifying needs as well as services to meet the needs		
	Recognizes the importance of ensuring all parties are moving expeditiously toward permanency		
	Knows the importance of persistence in pursuit of information		
	Understands the need to advocate for access to quality, individualized services		
	Understands the need to respectfully challenge the status quo		
	Recognizes the importance of creating innovative strategies to resolve issues		
Foundations of Knowledge			
	Understands the importance of using a strength-based approach		
	Understands concurrent planning		
	Understands advocacy differs dependent on the age of the child		
	Understands the options for permanence for a child		
	Understands how to identify a child's basic needs		
	Understands the cycle of attachment		

Competency Category	Knowledge, Skills and Attributes	Current Strength	Competency to Develop
Foundations of Knowledge (cont'd)	Understands possible reactions to separation & loss		
	Understands age appropriate behavior and development for children of all ages		
	Understands how mental illness impacts families		
	Understands the factors that contribute to a child's resilience		
	Understands how poverty can impact families and children		
	Understands strategies to advocate for children and adolescents with mental health disorders		
	Understands the ways that substance abuse can affect children & families		
	Knows the importance of being aware of resources in the community that assist with substance abuse		
	Understands how domestic violence affects children & families		
	Understands the nature and scope of trauma and how it affects children		
	Understands the importance of resilience in overcoming trauma in children		
	Knows strategies to address educational challenges		
	Understands the issues faced by LGBTQ youth in the child welfare system		
	Understands the risk factors for child abuse and neglect		

Competency Category	Knowledge, Skills and Attributes	Current Strength	Competency to Develop
Foundations of Knowledge (cont'd)	Understands the factors that contribute to child resilience		
	Recognizes the importance of understanding a child's journey through the child welfare system		
	Understands MSL and its importance when advocating for a child's best interest		
	Understands the nature and scope of the roles of others (e.g., caseworkers, attorneys, therapists, etc.)		
	Knows the importance of the federal laws that impact his/her advocacy		
	Understands what constitutes abuse and neglect		
Self Care			
	Understands the importance of healthy coping strategies to prevent burn out		
	Understands the importance of being aware of personal limitations		
	Understands the importance of setting clear, healthy boundaries and can identify indicators of stress		
	Understands the importance of maintaining a healthy life style		
	Understands the importance of knowing when to ask for and accept help		
	Understands the importance of maintaining a sense of hope and optimism		

Child Welfare History

Mary Ellens' Story

Mary Ellen's case took place in 1874. Her spirit remains with us because her case is generally regarded as the beginning of public concern for the plight of abused and neglected children.

Mary Ellen was a child whose father was dead and whose mother could not care for her because she was destitute and had to work full time. The New York Commission of Charities and Correction placed Mary Ellen with Mary McCormack Connolly and her husband, who were to care for her and report each year on her progress.

Instead, Mrs. Connolly abused her. She beat Mary Ellen, locked her in a room, rarely allowed her outside and did not provide adequate food or clothing.

Upset by the child's screaming, a neighbor told a mission worker about Mary Ellen. The mission worker could find no one to intervene; the police had no grounds because no crime was being committed, and the agencies wouldn't get involved because they did not have legal custody.

The mission worker finally appealed to Henry Bergh, the founder and president of the ASPCA, the American Society for the Prevention of Cruelty to Animals. He took up her cause and was able to persuade a judge to hear her case.

Mary Ellen was carried into the courtroom wrapped in a horse blanket. This is what the newspaper reported that she told the judge:

My father and mother are dead. I don't know how old I am. I call Mrs. Connolly mama. I have never had but one pair of shoes, but I cannot recollect when that was . . . My bed at night has been only a piece of carpet stretched on the floor underneath a window. Mama has been in the habit of whipping and beating me almost every day. She used to whip me with a twisted whip—a raw hide. [Mama] struck me with the scissors and cut me . . . I have no recollection of ever having been kissed by anyone—have never been kissed by Mama. Whenever Mama went out I was locked up in the bedroom. I do not want to go back to live with Mama because she beats me so.

Child Welfare History, Cont'd.

Mary Ellen was removed from the people who had mistreated her. Her case stirred public attention, and complaints began to pour in to Henry Bergh. So many cases of child beating and cruelty to children came to light that citizens called a community meeting and formed an association "for the defense of outraged childhood." That association gave rise to the Society for the Prevention of Cruelty to Children, which was formally incorporated the year after Mary Ellen's situation came to light.

Child-focused policies are relatively new:

- 1899: First juvenile court (Chicago) placed dependent and delinquent children in homes for wayward youth or reform schools.
- 1910: X-ray technology was developed, eventually allowing doctors to detect subdural (under the skin) injuries and untreated fractures.
- 1938: First legal rights of children: Fair Labor Standards Act imposed restrictions on working hours and conditions.
- 1962: Dr. C. Henry Kempe created the diagnosis for battered child syndrome.
- 1965: Mandatory reporting laws were in place in all states.

Beginning in the 1970s, the United States Congress became aware (along with the rest of the nation) that the child welfare system was not adequately protecting children. From a historical perspective, it can be said that we are still relatively new to the concepts of protecting abused and neglected children and developing appropriate systems, methods and programs to cope with the problems these children face.

The chart on the following pages outlines information about federal child abuse and neglect laws. You do not need to memorize these laws; just become familiar with them.

Federal Child Abuse & Neglect Laws

1974: Child Abuse Prevention & Treatment Act (CAPTA), P.L. 93-247, amended 1996

Created the National Center on Child Abuse and Neglect and earmarked federal funds for states to establish special programs for child victims of abuse or neglect.

This law requires that states:

- Have child abuse and neglect reporting laws
- Investigate reports of abuse and neglect
- Educate the public about abuse and neglect
- Provide a guardian ad litem to every abused or neglected child whose case results in a judicial proceeding
- Maintain the confidentiality of child protective services records

For CASA/GAL volunteers:

- Learn whether you, as a CASA/GAL volunteer, are a mandated reporter
- Learn whether the guardian ad litem has to be an attorney in your state

1978: Indian Child Welfare Act (ICWA), Public Law 95-608

This law requires that states:

- Recognize that Indian children have special rights as members of sovereign nations within the United States
- Responded to congressional hearings in the 1970s that revealed a pattern of public and private removal of Indian children from their homes, undermining their families and threatening tribal survival and Native American cultures

For CASA/GAL volunteers:

- Ask whether every child has Native heritage
- Investigate tribal resources and services that can benefit the child
- Be aware that jurisdiction can be transferred to the tribal court
- Pay attention to the heritage and identity needs of the child
- Remember that ASFA timelines do not apply to Indian children

Federal Child Abuse & Neglect Laws, Cont'd.

1978: Indian Child Welfare Act (ICWA), Public Law 95-608 (Cont'd)

This law: • Was designed to implement the federal government's trust responsibility to the nations by protecting and preserving the bond between Indian children and their tribe and culture • Sets up placement preference schemes for foster care placements and adoptions of children who have been determined to be Indian children • Establishes the right of certain entities, including the tribe and the Indian custodian, if one exists, to appear as parties to child welfare cases • Determines when and if a case should be transferred to tribal court • Describes rights of the Indian child and the child's tribe	*For CASA/GAL volunteers:* • Keep in mind that ICWA takes precedence over other federal and state laws • The National Indian Child Welfare Association has several excellent packets of ICWA information available for a small charge
This law requires that states: • Recruit culturally diverse foster and adoptive families • Comply with the Indian Child Welfare Act • Establish standards for foster family homes and review the standards periodically • Set goals and plan for the number of children who will be in foster care for more than 24 months	*For CASA/GAL volunteers:* • Consider possible placements that respect child's cultural heritage but do not limit his/her options • Learn the name of the data collection system used in your state

Federal Child Abuse & Neglect Laws, Cont'd.

1978: Indian Child Welfare Act (ICWA), Public Law 95-608 (Cont'd)

This law requires that states:

- Provide "reasonable efforts" to prevent or eliminate the need for removal of the child from his/her home or to make it possible for the child to return to his/her home
- Have a data collection and reporting system about the children in care

1980: Adoption Assistance and Child Welfare Act

- Requires that states recruit culturally diverse foster and adoptive families
- Requires that states provide "reasonable efforts" to prevent or eliminate the need for removal of the child from the home or to make it possible for the child to return home

1990: Indian Child Protection and Family Violence Prevention Act

- Establishes federal requirements for the reporting and investigation of child abuse and neglect on tribal lands
- Requires background checks on individuals who have contact with Indian children (including foster and adoptive families)
- Authorizes funding for tribal child abuse prevention and treatment programs

1993: Court Improvement Legislation

Encourages reform in the court system

1994: Multi-Ethnic Placement Act (MEPA)

The goals of this law are to:

- Decrease the time children wait to be adopted
- Prevent discrimination on the basis of race, color or national origin in the placement of children and in the selection of foster and adoptive placements
- Facilitate the development of a diverse pool of foster and adoptive families

Federal Child Abuse & Neglect Laws, Cont'd.

1996: Child Abuse Prevention and Treatment Act (CAPTA) Amended

Amended to include Court Appointed Special Advocates as guardian ad litem

1997: Adoption and Safe Families Act (ASFA), Public Law 105-89

This act embodies three key principles:

- The safety of children is the paramount concern
- Foster care is a temporary setting and not a place for children to grow up
- Permanency planning should begin as soon as the child enters foster care

This act directs timelines within which the child welfare system operates:

- Requires permanency plan within 12 months
- Requires dispositional hearing within 12 months of placement
- Requires court reviews every six months

1997: Volunteer Protection Act

Limits liability of volunteers

1999: Foster Care Independence Act

Addresses needs of older youth in foster care, particularly those aging out of the system

This act does the following:

- Allows states to serve youth up to age 21 regardless of whether or not they are eligible for the Title IV-E Foster Care Program
- Increases federal funding to assist and serve young people transitioning from foster care

Independence Program does the following:

- States explicitly that "enrollment in Independent Living Programs can occur concurrently with continued efforts to locate and achieve placement in adoptive families for older children in foster care," thereby clarifying that independent-living services should not be seen as an alternative to adoption for teens

Federal Child Abuse & Neglect Laws, Cont'd.

- Establishes the John H. Chafee Foster Care Independence Program, which strongly supports the dependency system's capacity to help youth make a healthy transition into adulthood (see information at right)
- Allows states to provide Medicaid to young people between the ages of 18 and 21 who were in foster care on their 18th birthday
- Increases the youth-assets limit from $1,000 to $10,000 without jeopardizing the youth's eligibility for Title IV-E–funded foster care
- Ensures that foster parents have adequate preparation to care for the children placed in their home. This provision can be used to strengthen the preparation of foster parents to care for adolescents.
- Provides additional funding for adoption incentive payments
- Mandates that states use a portion (up to 30%) of their independent-living program funds to provide room and board for youth 18 to 21 who have left foster care
- Requires states to train both foster and adoptive parents (as well as group-care workers and case managers) about the issues confronting adolescents preparing for independent living
- Reinforces the importance of providing personal and emotional support for children aging out of foster care, through the promotion of interactions with mentors and other dedicated adults
- Specifies that independent-living services may be provided to young people at "various ages" and various stages of achieving independence, "including children waiting for adoption or other permanent options"

2008: Fostering Connections to Success and Increasing Adoptions Act

This law:

- Requires child welfare agencies to work with schools to support the education needs of children in foster care
- Increases federal funding to assist and serve young people transitioning from foster care
- Specifies that independent-living services may be provided to young people at "various ages" and various stages of achieving independence, "including children waiting for adoption or other permanent options

Other Laws That Affect CASA/GAL Volunteer Work

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires, among other things, permission or a court order to access "protected health information" for any individual. Your program will have information on how to access health records.

Special Immigrant Juvenile Status (SIJS) assists some children, including those in foster care, in obtaining legal permanent residency.

Title VI of the 1964 Civil Rights Act says that any entity that receives federal funds must provide a professional interpreter in court.

Titles IV-B and IV-E of the Social Security Act: IV-E is the primary federal funding stream that partially reimburses states for foster care for qualified children. IV-B allots funding for targeted case management services. The state must pay all expenses for a child, who is not IV-E eligible, out of state general revenues. These expenses include foster care, therapy, etc.

The Victims of Child Abuse Act of 1990 (VOCAA) protects the privacy rights of child victims or witnesses during the investigation or prosecution of a federal crime.

Alphabet Soup

Commonly Used Acronyms	
A/N	Abuse/Neglect
APPLA	Another Planned Permanent Living Arrangement (sometimes simply PPLA)
CAC	Child Advocacy Center
CAP	Child Abuse Program
CASA	Court Appointed Special Advocate
CHINS	Child in Need of Services and/or Supervision
CINA	Children in Need of Assistance
CPS	Child Protective Services
CSU	Court Services Unit
DCJS	Department of Criminal Justice Services
DCSE	Division of Child Support Enforcement
FASD	Fetal Alcohol Spectrum Disorder
FC	Foster Care
FDTC	Family Drug Treatment Court (may be called DTC: Drug Treatment Court)
GAL	Guardian ad Litem (In some states this is an attorney, in others the volunteer advocate.)
HIPAA	Health Insurance Portability & Accountability Act
ICPC	Interstate Compact on the Placement for Children
IEP	Individual Education Plan
IL	Independent Living
TPR	Termination of Parental Rights

Bleux Case File

CPS Case File

Last Name of Case:			**Bleux**		
Legal Number(s):			**12-0-97542-4**		
Child(ren)'s Name	**DOB**	**Age**	**Ethnicity**	**Sex**	**Current Location**
Deshawn Bleux	March 12	2 months	AA	Male	Foster Care

Current Caregiver(s)	Address	Phone
Emily Padron and Lawrence Cary	8904 Cleveland Ave NW	555-2272

Attorneys for:		
Mother	Samuel Bluestein	555-7622
Father	Jacob Bell	555-6704
CPS	Meghan Fowler	555-9300 ext. 38

Case History

10 days ago: CPS received a referral from the hospital regarding a 2-month-old child who appeared to show symptoms of shaken baby syndrome. Child, Deshawn Bleux, was admitted to the hospital by father, Miles Bleux. In speaking with this social worker (SW), father said he took child to hospital when he could not be woken up for his regular 10 p.m. feeding. SW spoke with Dr. Maronian, who said child suffered a concussion and will be kept overnight for observation.

8 days ago: Child remains in the hospital with an injury more severe than previously thought; due to the child's young age, doctors have said they would like a few additional days of tests and observations before releasing him. Child will be placed in foster home pending CPS investigation. Criminal charges are also pending against the parents, but because various people have various versions of the story, police have not determined who, if anyone, should be

charged. SW attempted to speak with each parent (mother, Toni Bleux; father, Miles Bleux) during today's Family Team Planning Conference (see attached MOU) but they refused to be interviewed on the advice of counsel.

6 days ago: Dr. Maronian has cleared Deshawn to be released from hospital. Child placed in foster care. SW spoke with father, Miles Bleux, who denies shaking the child, but would not comment further on the case. Father told SW that he works as a dishwasher in a local restaurant. He said that he worked as a chef in his father's restaurant "back home" (in Baton Rouge, LA), but has not been able to find employment as a chef since moving here. When asked if he felt his employment situation is a stressor on his family, he replied, "Of course it is, but I have to do what I have to do."

5 days ago: SW spoke with mother. She has refused to say anything other than she was not home at the time of the incident. Mother attends the nursing program at the community college; she works during the day and attends classes at night.

CASA/GAL			
CASA History: Case Initially Assigned to:	You	Date assigned:	Today
Current CAS Volunteer	You	Date terminated:	Today
Initial CPS Social Worker:	Jane Morgan	Date assigned:	
Current CPS Social Worker	Jane Morgan	Date assigned:	

Court Ordered Services

For the Child:

- No court orders at present

For the Father:

- No court orders at present

For the Mother:

- No court orders at present

Memorandum of Understanding

File No. XX-J-172

Allegation(s): A/N

In the matter of:

Deshawn Lee Bleux **Age: 2 months**

MEMORANDUM OF UNDERSTANDING

The PURPOSE of the Family Team Planning Conference and the Memorandum of Understanding is to expedite the court process for children by sharing information and making recommendations regarding the following issues: placement, visitation, services, paternity and child support.

I. **ATTENDANCE**: Present at this conference were the following parties: Kerry Rowan, Family Court Case Coordinator; Jane Morgan, County Child Protective Services (CPS) Investigator; Kim Rytter, CPS Supervisor; Antoinette Bleux, mother of the child; Samuel Bluestein, Attorney for the mother; Miles Bleux, father of the child; Jacob Bell, Attorney for the father; Sandi Freeman, County Health Clinic Coordinator; Ramona Haskins, CASA/GAL Supervisor; Sabine Lee, Maternal Aunt; Adrienne Nikos, CPS Intern

II. **RIGHTS**: For purposes of this Memorandum of Understanding, all defenses that could be made by all parties are preserved. In order to protect the rights of all parties, this Memorandum of Understanding does NOT serve to waive any standard objection by law.

III. **ATTORNEYS**: Have been temporarily appointed to represent the parents in this matter. At the first court hearing, the court will determine whether the parents qualify for court-appointed lawyers. If they do not qualify, the temporarily appointed attorneys will be released.

IV. **PARENTS**: Inquiries have been made as to the identity and location of any missing parent.

- The mother (age: 18) did attend the child planning conference.
- The mother has been served the juvenile petition at the child planning conference. The mother stated that the address on the petition is the correct address.
- The mother can be reached at 555-1790, cell number.

Memorandum of Understanding, Cont'd.

- The father (age: 20) did attend the child planning conference.
- The father was served the juvenile petition at his home.
- The father stated that the address on the petition is the correct address. The father can be reached at 555-3865, cell number.
- According to the father, his name is on the child's birth certificate. According to the parents, they are married.

V. **HISTORY**: CPS said that the agency received a report. The report alleged that the child had been physically abused. The child was admitted to County Hospital and was diagnosed with a subdural hematoma, bleeding on the brain and retinal hemorrhaging. A child medical exam was completed and indicated that the child had been injured by means other than accidental. Detective John Hollowell of the City Police Department is in charge of a criminal investigation.

- CPS stated that both parents had access to the child during the time when the injuries occurred, and that in order to ensure the safety of the child the agency has filed a petition for custody of the child.
- CPS reported that the child is still in the hospital with a proposed release date within the week.
- CASA/GAL volunteer for the child will be [Your Name]; he/she can be reached at XXX- XXXX.
- According to the caseworker, the county medical examiner stated that the injuries could have occurred anytime on last Thursday.

VI. **PLACEMENT**: Inquiries have been made as to whether a relative of the child is willing and able to provide proper care and supervision of the child in a safe home and whether placement with such a relative could be in the child's best interest:

- The child is currently placed in County Hospital.
- CPS stated that the child is doing well.
- The agency is considering other family members for placement of the child

Memorandum of Understanding, Cont'd.

VII. SERVICES FOR THE PARENTS

Services for the mother of the child:

- CPS recommends that the mother attend parenting education and anger management, and that she have a mental health assessment and follow all recommendations, attend medical education concerning shaken baby syndrome and attend visitation.
- The mother stated that she is willing to comply with services, but that she does not see herself as being in need of all of them.

Services for the father of the child:

- CPS recommends that the father attend parenting education and anger management and that he have a mental health assessment and follow all recommendations, attend medical education concerning shaken baby syndrome and attend visitation.
- The father stated that he is willing to comply with services.

VIII. SERVICES FOR THE CHILD

Medical Background

- The child was born at County Hospital.
- The child's doctor is Early Years Peds in the city.
- The child has no diagnosed medical conditions.
- According to the parents, the child has no known affiliation with a recognized Native American group.

Recommendations

- CPS recommends that the child participate in the Children's Health and Development Program and continue to receive all medical and developmental services. The mother requested that if needed she would like the physical therapist to come to the home. The mother requested that the child be maintained on the formula he is accustomed to.

Memorandum of Understanding, Cont'd.

IX. VISITATION

- All visits are to be supervised at this time.
- Visitation would be twice weekly, at the agency at a minimum of 45 minutes. The parents may visit together if they choose. Any family placement will be informed of the agency's policies for visitation. The aunt may also visit with the child.

X. AUTHORITY

The parties agree that County Child Protective Services shall be granted authority to arrange, provide and/or consent to any medical treatment, psychiatric treatment, psychological service, educational needs or any other remedial evaluations required by the child, including a physical examination to be conducted as mandatory by licensure requirements; and County Child Protective Services has the authority to request and be provided with any medical, mental health and educational records pertaining to the child.

XI. FUTURE COURT DATES

- The next court hearing in this case will be at 2:00 p.m. next Tuesday in Courtroom B of the County Courthouse. The purpose of that hearing will be to determine the need for continued nonsecure custody.
- The matter will be adjudicated at 2:00 p.m. on three weeks from Tuesday in Courtroom B of the County Courthouse. If allegations are founded, disposition hearing will immediately follow.

FAMILY TEAM PLANNING CONFERENCE SIGN-IN & CONFIDENTIALITY AGREEMENT

I understand that juveniles will be discussed in the Family Team Planning Conference. Through their signatures, the undersigned acknowledge and agree that the privacy of children and their families should be strictly maintained.

Deshawn Lee Bleux

Juvenile(s) Name(s)

Date

Name		Agency	Address	Phone #
1.	Kerry Rowan-	FC	3rd Flr CCH	555-4567
2.	Sandi Freeman	CHCC	200 Brookdale	555-6789
3.	[Your Name]	CASA/ GAL	5th floor CCH	555-3770
4.	Ramona Haskins	CASA/ GAL	5th floor CCH	555-3770
5.	Sabine Lee		330 Hawkins	555-9752
6.	Antoinette Bleux		330 Hawkins	555-1790
7.	Sam Bluestein		1260 Main St., ste 200	555-7622
8.	Jane Morgan	CPS	200 Brookdale	555-7262
9.	Miles Bleux		740 Center, apt. 204	555-3865
10.	Jacob Bell		7525 Broad	555-6704
11.	Adrienne Nikos	CPS	200 Brookdale	555-7579
12.	Kim Rytter	CPS	200 Brookdale	555-7260

Through their signatures, the undersigned acknowledge that this Memorandum of Understanding has been read to them, accurately reflects what occurred during the Family Team Planning Conference and they have received a copy of the Memorandum of Understanding.	
	XX-J-172
Date	File Number/Name

Mother	Mother's Attorney	Mother's GAL Attorney
Antoinette Bleux		
Father	Father's Attorney	Father's GAL Attorney
Miles Bleux	Jacob Bell	
CASA/GAL Volunteer	CASA/GAL Supervisor	Family Court Case Coordinator
[Your Name]	Ramona Haskins	Kerry Rowan
CPS Caseworker	CPS Supervisor	CHCC Coordinator
Jane Morgan	Kim Rytter	Sandi Freeman
WCPSS Representative	Friends & Relatives	County Attorney
	Sabine Lee (maternal aunt)	
Others		
Adrienne Nikos (CPS intern)		

Incident Report Supplement City Police

1. OFFENSE Child Battery	2. CLASSIFICATION Simple	3. DATE/TIME OF REPORT Thursday 01:10 hrs
4. *VICTIM (LAST, FIRST, M)* *Bleux, Deshawn Lee*	5. ADDRESS 740 Center St., Apt. 204	

Synopsis: The following report contains information concerning child battery. Hospital emergency room reported possible child battery due to shaken baby syndrome.

Victim Info: Deshawn Lee Bleux B/M/2 months 740 Center St., apt. 204

Suspect Info: Miles Bleux, father of victim (same address)

Investigation Notes: We were dispatched to the hospital on a child battery call. Emergency room physician Dr. Saul Maronian informed us that the victim was brought to the hospital by his parents. Victim was unconscious with shallow breathing. Upon examination, retinal hemorrhages were found, indicating possible shaken baby syndrome. Victim was taken for whole body CT scan and MRI which revealed minor swelling of the brain and a subdural hematoma, but no other injury and no signs of previous injury. Oxygen therapy has been started. Infant is expected to be hospitalized for 1 or 2 days. CPS called.

Dr. Maronian informed us that while victim was being scanned, mother became very upset. When he gave parents the diagnosis, mother screamed, “You bastard, how could you!” and began punching father. Father repeated, “I didn’t do anything,” while fending off mother. Dr. Maronian observed that mother is physically smaller, and although father appeared angry, he merely tried to block her blows. Hospital security separated them.

Hospital will provide photographs and scans of victim’s injuries.

We next spoke with mother, Antoinette Lee Bleux, 18, same address as victim and suspect. It appeared that Mrs. Bleux had been crying. Mrs. Bleux informed us that she was out with friends and returned home at approx. 21:30 and went straight to bed. She reports baby was sleeping in crib at that time, and that husband later woke her in a panic because baby would not wake up. They brought the baby in and have since learned that he is stable and not in grave danger. She admitted to hitting her husband and screaming at him in the emergency room. “I just lost it. I’m sorry I acted like that.” Mother expressed strong need to see child. Nurse escorted mother to infant’s bedside for a short visit. Antoinette Bleux was released to her sister—they left the hospital together.

We next spoke with father (suspect), Miles Bleux, in hospital security holding room. He informed us that he did not hurt his child, but he could not explain the injuries. He then informed us that two days previously his wife fell down their front steps while holding the infant, releasing him before she hit the ground so that he experienced only a short fall. Mr. Bleux suggested that infant may have been injured in this fall, though infant showed no symptoms at the time.

He informed us that he was hosting a poker game earlier this evening, that the game broke up at 22:00 hrs and after his friends left, he attempted to wake child for a feeding. When child would not wake, he and wife rushed the child to hospital, which is only three blocks from home.

On further questioning, Miles Bleux informed us that he and his wife have been "having problems" since the end of the pregnancy, that "she's been kind of crazy with the hormones," and that the couple sometimes fights, but he doesn't lose control. "She does, as anyone in the emergency room can tell you." The suspect was not taken into custody at this time because there was no witness who could say what happened. Deshawn was released into the custody of CPS.

CASA
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THE NATIONAL COURT APPOINTED SPECIAL ADVOCATE ASSOCIATION

CASA/GAL Pre-Service Volunteer Training Curriculum

Pre-Work Handouts

CHAPTER TWO

HEARST foundations

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This project was supported by Award No. 2015-CH-BX-K001 awarded by the Office of Juvenile Justice and Delinquency Prevention, Department of Justice.

Version 2, November 2017

CHAPTER 2

Pre-Work Handouts

CONTENTS

Pre-Work Instructions

Prior to attending the second session of the volunteer training, please read through the Pre-Work handouts found in this document. Reading this information prior to the session will give you a foundation in children's growth and development, children's needs, the importance of attachment in childhood, recognizing child abuse and neglect, your state's definition of abuse and mandatory reporting laws, risk factors for child abuse and neglect and your program's court report.

How Children Grow and Develop

1. No two children are alike. Each one is different. Each child is a growing, changing person.
2. Children are not small adults. They do not think, feel or react as grown-up people do.
3. Children cannot be made to grow. On the other hand, they cannot be stopped from growing.
4. Even though children will grow in some way no matter what care is provided for them, they cannot reach their best growth possibilities unless they receive care and attention appropriate for their stage of development from a consistent figure in their life.
5. Most children roughly follow a similar sequence of growth and development. For example, children scribble before they draw. But no two children will grow through the sequence in exactly the same way. Some will grow slowly while others will grow much faster. Children will also grow faster or slower in different areas of development. For example, a child may be very advanced in language development but less advanced, or even delayed, in motor coordination.
6. During the formative years, the better children are at mastering the tasks of one stage of growth, the more prepared they will be for managing the tasks of the next stage. For example, the better children are able to control behavior impulses as 2-year-olds, the more skilled they will be at controlling behavior impulses as 3-year-olds.
7. Growth is continuous, but it is not always steady and does not always move forward smoothly. You can expect children to slip back or regress occasionally.
8. Behavior is influenced by needs. For example, active 15-month-old babies touch, feel and put everything into their mouths. That is how they explore and learn. They are not intentionally being a nuisance.
9. Children need to feel that they are loved, that they belong and that they are wanted. They also need the self-confidence that comes from learning new things.

How Children Grow and Develop, Cont'd.

10. It is important that experiences that are offered to children fit their maturity level. If children are pushed ahead too soon, and if too much is expected of them before they are ready, failure may discourage them. On the other hand, children's growth may be impeded if parents or caregivers do not recognize when they are ready for more complex or challenging activities. Providing experiences that tap into skills in which children already feel confident, as well as offering some new activities that will challenge them, gives them a balance of activities that facilitates healthy growth.

Resources for Child Caring, Inc., Minnesota Child Care Training Project, Minnesota Department of Human Services.

When observing a child's development, keep in mind these key points:

- There is a wide range of typical behavior. At any particular age, 25% of children will not exhibit the behavior or skill, 50% will show it and 25% will already have mastered it.
- Some behaviors may be typical (predictable) responses to trauma, including the trauma of separation, as well as abuse and neglect.
- Prenatal and postnatal influences may alter development.
- Other factors, including culture, current trends and values also influence what is defined as typical.
- As a CASA/GAL volunteer, you need to become aware of your values, attitudes and perceptions about what is typical in order to be more objective and culturally sensitive when assessing a child's needs.

Children's Needs

Children served by CASA/GAL programs come to the court's attention because their parents or caregivers are not meeting their most basic needs—for food, clothing, shelter or security. Usually, parents are their children's advocates—a CASA/GAL volunteer is needed only when the parents or caregivers cannot fulfill that advocacy role. To make sure these children are protected from maltreatment, the child protection system removes many of them from their homes and their primary relationships. While removal from the home may be necessary to ensure the children's safety, it does have consequences. Later in this chapter, we will look more closely at the effects of disturbing children's attachments to their primary caregivers.

Hierarchy of Needs

Abraham Maslow believed there are five categories of needs that all people have, and that these needs have to be met in sequence from the first level on up. If the needs at one level are not met, the needs at the next level cannot be met. The first two levels (food, clothing and shelter; protection and security) were described as basic for survival. The remaining three levels were primary relationships, esteem and community and wholeness.

In recent years, Maslow's theory has been questioned and other theories have evolved. Dr. Edward Deci established that there are three universal psychological needs: autonomy, relatedness and competence. Autonomy refers to people's need to perceive that they have choices. Relatedness refers to people's need to feel connected to others. Competence is the need to meet every day challenges with success and growth. Unlike Maslow's theory, these three needs are not sequential, but are all necessary.

Other researchers have redesigned Maslow's pyramid. If you would like to read additional information on this research, please follow this link: psychcentral.com/news/2010/08/23/updated-maslows-pyramid-of-needs/17144.html

As a CASA/GAL volunteer it is important to fully understand the needs of the child you are assigned, to best advocate for the child's best interests. Understanding these theories can provide a framework for you to refer to when working with the child and family.

Children's Needs, Cont'd.

Important Points About Children's Needs

- To be an effective CASA/GAL volunteer, you must keep the child's needs clearly in mind. The child's needs are paramount.
- Healthy growth and development depend on adequately meeting basic needs (e.g., the development of friendships depends on more basic needs being met).
- Children's needs depend on their age, stage of development, attachment to their family/caregivers and reaction to what is happening around them.
- The essence of your role as a CASA/GAL volunteer is to identify the child's unmet needs and to advocate for those needs to be met.

Cultural Considerations

Maslow developed his hierarchy of needs based on a study of participants in the United States, an individualistic society where primary importance is put on the self, immediate family and individual achievement as an indicator of success. Many cultures are considered collectivist societies, where belonging to a group and harmony within the group is of primary importance. No matter what kind of culture a child comes from, your primary concern as a CASA/GAL volunteer is that the child's basic needs—for food, shelter and clothing—are being met.

P. Gambrel and R. Cianci. "Maslow's Hierarchy of Needs: Does It Apply in a Collectivist Culture?"
Journal of Applied Management and Entrepreneurship, April 2003.

Importance of Attachment in Child Development

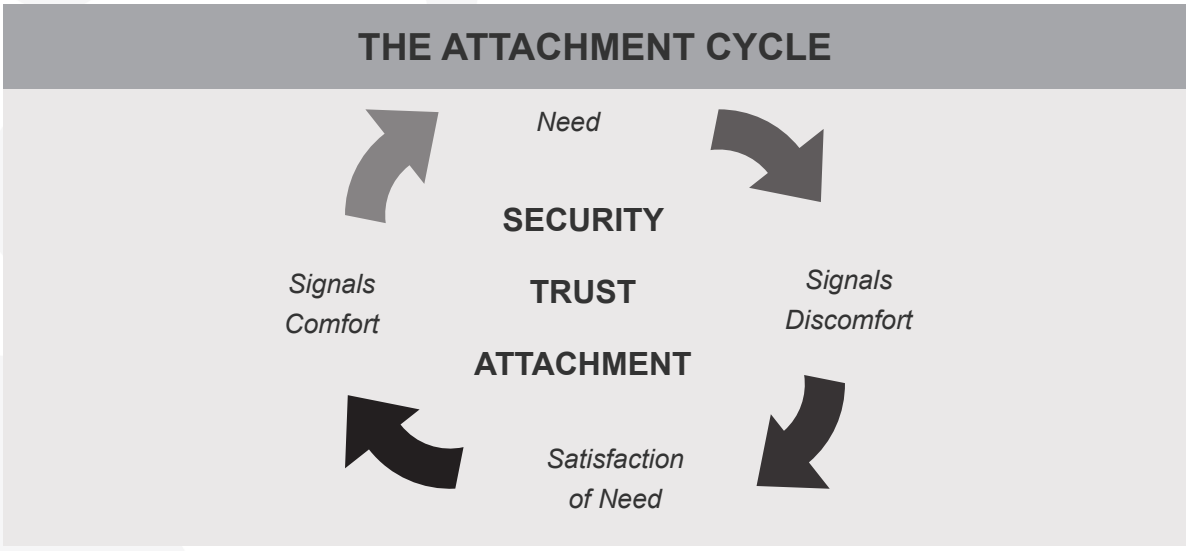
What Is Attachment?

Attachment is an emotional and psychological connection between two people that endures through space and time. In child development, attachment refers to a strong, enduring bond of trust that develops between a child and the person(s) he/she interacts with most frequently.

Attachment develops intensely throughout the first three years of life. After age 3, children can still learn how to attach; however, this learning is more difficult. The child's negative experiences with bonding will strongly influence the child's response to caregivers and other individuals throughout the child's lifetime.

Children who are learning to attach will be influenced by three specific factors:

1. The child's genetic predisposition: Some children have a naturally "sunny" or easy personality that draws adults to them. In rare circumstances, children may have a condition that would make it difficult for them to form attachments, such as autism spectrum disorders or other disorders.
2. The conditions under which the child is cared for: Children whose needs are regularly met have an easier time trusting their world.
3. The child's parents or caregivers: Some adults have a nurturing or outgoing disposition and can establish relationships easily with adults and children. Substance abuse or mental health problems can interfere with the adult's ability to attach to a child. Interruption or loss of a caretaking relationship can affect a child's attachment.



Importance of Attachment in Child Development, Cont'd.

When a baby cries, the caregiver responds by picking up the child. The caregiver continues to stroke, talk to and hold the baby during feeding or diaper changing. After several days of this routine the child learns that to get needs met, all he/she has to do is cry. The caregiver responds and immediately begins to soothe the infant, resulting in an increased sense of trust and security. This cycle of consistently meeting a child's needs creates a secure attachment between the infant and caregiver. It is referred to as the "attachment cycle" or the "trust cycle."

Cultural Considerations

Healthy attachments are based on the nature of the relationship between the child and the caregiver. They are not based on genetic ties to or the gender or culture of the caregiver. Attachment behaviors may look different in different cultures. Keep this in mind as you work with children and families as a CASA/GAL volunteer.

Disrupted Attachment

The attachment cycle may be disrupted or inconsistent for many of the children in the child protection system. Some children may cry for hours at a time without getting their needs met; others may get hit when they cry. As a result, a child may stop crying when hungry and may not trust adults. This child might turn away from the caregiver, refuse to make eye contact, push away or fight to avoid being close with another individual. When this type of child is distressed, he/she may not seek out a caregiver for soothing or comfort, or may seek satisfaction from any potential caregiver, including a total stranger.

Prevalent Signs and Symptoms of Disrupted Attachment

- Lack of trust for caregivers or others in a position of authority
- Resistance to being nurtured or cared for
- Difficulty giving or receiving genuine affection
- Difficulty or inability to interpret facial or social cues
- Poor social skills
- Reduced ability to recognize emotions of others
- Poor or reduced emotional self-regulation
- Low self-esteem or feelings of inadequacy

Importance of Attachment in Child Development, Cont'd.

- Demanding, clingy or over-controlling behaviors
- Chronic lying, stealing or other behaviors to provoke anger in others
- Impulsive behavior
- Difficulty understanding cause and effect
- Decreased capacity for emotional self-reflection
- Limited compassion, empathy and remorse

Developmental Variations in Children with Disrupted Attachment

Early Childhood

- Delayed development of motor skills
- Severe colic and/or feeding difficulties; failure to thrive
- Resistance to being held, touched, cuddled or comforted
- Lack of response to smiles or other attempts to interact
- Lack of comfort seeking when scared, hurt or sick
- Excessive independence; failure to re-establish connection after separation

Elementary School Years

- Frequent complaints about aches and pains
- Age-inappropriate demands for attention
- Disinvestment in school and/or homework
- Inability to reflect on feelings or motives regarding behaviors
- Inability to understand the impact of behavior on others, lack of response to consequences
- Inability to concentrate or sit still
- Difficulty with reciprocity (give and take) in relationships

Importance of Attachment in Child Development, Cont'd.

- May appear amoral (lacking moral development)
- Lying and stealing

Adolescence

- Aggressive, anti-social, impulsive, risk-taking or delinquent behavior
- Substance abuse
- Higher levels of disengagement
- Related depression and/or anxiety

From Students FIRST Project, Quick Facts on Disrupted Attachment:
www.studentsfirstproject.org

Recognizing Child Abuse and Neglect

It is not the CASA/GAL volunteer's role to determine whether or not certain actions constitute child abuse or neglect; the court will decide this. It is, however, necessary for CASA/GAL volunteers to be able to recognize signs of abuse and neglect in order to advocate for a safe home for a child. Some of these indicators, although often associated with abuse, are not specific to abuse and neglect and can occur with other kinds of trauma or stress. In any case, they indicate that a child is in need of help and support. The following information will assist you in identifying potential signs of abuse or neglect.

What Constitutes Abuse and Neglect?

Child abuse can be seen as part of a continuum of behaviors. At the low end of the continuum are behaviors you might consider poor parenting or disrespectful behavior; at the high end are behaviors that lead directly or indirectly to the death of a child. See the table on the following pages in order to examine some specific examples of various types of child maltreatment.

Recognizing Abuse and Neglect

	Description	Indicators
Physical Abuse	Intentionally harming a child, use of excessive force, reckless endangerment.	• Unexplained bruises, welts and scars • Injuries in various stages of healing • Bite marks • Unexplained burns • Fractures • Injuries not fitting explanation • Internal damage or head injury

Recognizing Abuse and Neglect

	Description	Indicators
Sexual Abuse	Engaging a child in any activity for an adult's own sexual gratification.	• Age-inappropriate sexual knowledge • Sexual acting out • Child disclosure of abuse • Excessive masturbation • Physical injury to genital area • Pregnancy or STD at a young age • Torn, stained or bloody underclothing • Depression, distress or trauma • Extreme fear
Emotional Abuse	The systematic diminishment of a child. It is designed to reduce a child's self-concept to the point where the child feels unworthy of respect, friendship, love and protection, the natural birthrights of all children.	• Habit disorders (thumb sucking, biting, rocking, soiling or wetting clothes or bedding) • Conduct disorders (withdrawal or antisocial behavior) • Behavior extremes • Overly adaptive behavior • Lags in emotional or intellectual development • Low self-esteem • Depression, suicide attempts

Recognizing Abuse and Neglect

	Description	Indicators
Neglect	Failure of a person responsible for a child's welfare to provide necessary food, care, clothing, shelter or medical attention. Can also be failure to act when such failure interferes with a child's health and safety.	*Physical Signs:* • Malnourishment • Missed immunizations • Lack of dental care • Lack of supervision • Consistent dirtiness • Constant tiredness/ listlessness *Material Signs:* • Insufficient/ improper clothing • Filthy living conditions • Inadequate shelter • Insufficient food/ poor nutrition

Risk Factors for Child Abuse and Neglect

There is rarely a single cause of child abuse or neglect. Risk factors for child abuse and neglect include child-related factors (factors that may increase a child's vulnerability to maltreatment), parent/caregiver related factors, social-situational factors, family factors and triggering situations. These factors frequently coexist.

CHILD-RELATED FACTORS

- Chronological age of child: 50% of abused children are younger than 3 years old; 90% of children who die from abuse are younger than 1 year old; firstborn children are most vulnerable.
- Mismatch between child's temperament or behavior and parent's temperament or expectations.
- Physical or mental disabilities.
- Attachment problems or separation from parent during critical periods or reduced positive interaction between parent and child.
- Premature birth or illness at birth can lead to financial stress, inability to bond and parental feelings of guilt, failure or inadequacy.
- Unwanted child or child who reminds parent of absent partner or spouse.

PARENT/CAREGIVER-RELATED FACTORS

- Low self-esteem: Neglectful parents often neglect themselves and see themselves as worthless people.
- Abuse as a child: Parents may repeat their own childhood experience if no intervention occurred in their case and no new or adaptive skills were learned.
- Depression may be related to brain chemistry and/or a result of having major problems and limited emotional resources to deal with them. Abusive and neglectful parents are often seen and considered by themselves and others to be terribly depressed people.
- Impulsiveness: Abusive parents often have a marked inability to channel anger or sexual feelings.
- Substance abuse: Drug and/or alcohol use serves as a temporary relief from insurmountable problems but, in fact, creates new and bigger problems.

Risk Factors for Child Abuse and Neglect, Cont'd.

MENTAL ILLNESS

- Ignorance of child development norms: A parent may have unrealistic expectations of a child, such as expecting a 4-year-old to wash his/her own clothes.
- Isolation: Abusive and neglectful families may tend to avoid community contact and have few family ties to provide support. Distance from, or disintegration of, an extended family that traditionally played a significant role in child rearing may increase isolation.
- Sense of entitlement: Some people believe that it's acceptable to use violence to ensure a child's or partner's compliance.
- Intellectual disability or borderline mental functioning.

SOCIAL-SITUATIONAL FACTORS

- Structural/economic factors: The stress of poverty, unemployment, restricted mobility and poor housing can be instrumental in a parent's ability to adequately care for a child. The child needs to be protected from separation from his/her family solely because of stressed economic conditions. Middle- and upper-income parents may experience job or financial stress as well—abuse is not limited to families in poverty.
- Values and norms concerning violence and force, including domestic violence; acceptability of corporal punishment and of family violence.
- Devaluation of children and other dependents.
- Overdrawn values of honor, with intolerance of perceived disrespect.
- Unacceptable child-rearing practices (e.g., genital mutilation of female children, father sexually initiating female children).
- Cruelty in child-rearing practices (e.g., putting hot peppers in child's mouth, depriving child of water, confining child to room for days or taping mouth with duct tape for "back talk").
- Institutional manifestations of inequalities and prejudice in law, healthcare, education, the welfare system, sports, entertainment, etc.

Risk Factors for Child Abuse and Neglect, Cont'd.

FAMILY FACTORS

- Domestic violence: Children may be injured while trying to intervene to protect a battered parent or while in the arms or proximity of a parent being assaulted. Domestic violence can indicate one parent's inability to protect the child from another's abuse, because the parent is also being abused.
- Stepparent, or blended, families are at greater risk: There is some indication that adult partners who are not the parents of the child are more likely to maltreat. Changes in family structure can also create stress in the family.
- Single parents are highly represented in abuse and neglect cases: Economic status is typically lower in single-parent families, and the single parent is at a disadvantage in trying to perform the functions of two parents.
- Adolescent parents are at high risk because their own developmental growth has been disrupted: They may be ill-prepared to respond to the needs of the child because their own needs have not been met.
- Punishment-centered child-rearing styles have greater risk of promoting abuse.
- Scapegoating of a particular child will tend to give the family permission to see that child as the "bad" one.
- Adoptions: Children adopted late in childhood, children who have special needs, children with a temperamental mismatch or children not given a culturally responsible placement.

TRIGGERING SITUATIONS

Any of the factors above can contribute to a situation in which an abusive event occurs. There has been no systematic study of what happens to trigger abusive events. Some instances are acute, happen very quickly and end suddenly. Other cases are of long duration. Examples of possible triggering situations include:

- A baby will not stop crying.
- A parent is frustrated with toilet training.
- An alcoholic is fired from a job.
- A mother, after being beaten by her partner, cannot make contact with her own family.
- A parent is served an eviction notice.

Risk Factors for Child Abuse and Neglect, Cont'd.

- A prescription drug used to control mental illness is stopped.
- Law enforcement is called to the home in a domestic violence situation, whether by the victim or a neighbor.
- A parent who was disrespected in the adult world later takes it out on the child.

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CHAPTER THREE

HEARST foundations

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Version 2, November 2017

CHAPTER 3

Pre-Work Handouts

Contents

Pre-Work Instructions

Prior to attending the third session of the volunteer training, please read through the Pre-Work handouts found in this document. Reading this information prior to the session will give you a foundation in understanding child trauma, basic communication and CASA/GAL volunteer work, open-ended vs. closed-ended questions, the CASA/GAL interview and initial case notes for the Black-Smith case.

Also be sure to complete the Assignment Sheet for Interviewing a Child (see page 17), which will help you to prepare for interviewing children. Please bring the completed sheet to class with you.

Shane's Story Video

View Shane's Story video.

Prepare a list of traumatic experiences for the child.

Understanding Child Trauma

According to the National Child Traumatic Stress Network, child trauma occurs when a child witnesses or experiences an event that poses a real or perceived threat to the life or well-being of the child or someone close to the child.

Examples of child trauma could include:

- Witnessing domestic violence
- Being physically or sexually abused
- The death or loss of a loved one
- Being in an automobile accident
- Being present for a life-threatening natural disaster

The traumatic event often causes feelings of fear, helplessness or horror in the child, which may be expressed in a variety of ways. Overall, the child isn't able to cope with the intense feelings and becomes overwhelmed by the event.

Types of Trauma

Trauma may be described in one of four ways. Each describes how often or to what level the person experiencing the trauma is affected.

- **Acute Trauma**: A single incident that is limited in time (e.g., a car accident). The effects may include physical and emotional stress leading to feelings of being overwhelmed.
- **Chronic Trauma**: Repeated traumatic events (e.g., witnessing recurring domestic violence between parents over several years). Because of the recurring and longstanding nature of chronic trauma, the effects can be cumulative and build up over time. Children at this level are often more vulnerable to everyday stress and have diminished ability to cope.
- **Complex Trauma**: Includes both the exposure to chronic trauma and the lasting impact the trauma has on the child's well-being. Complex trauma usually begins when a child is very young (under the age of 5) and often is a part of a child's relationship with a caregiver (e.g., physical abuse by a parent).
- **Historical Trauma**: A personal or historical event that causes emotional and psychological injury and can be transmitted from one generation to the next (e.g., slavery, forced placement in boarding schools).

Understanding Child Trauma, Cont'd.

By the time children are involved in the child protection system, they have often experienced chronic and complex trauma, often at the hands of the people entrusted with their care.

Understanding How Trauma Affects Children

Children are affected by traumatic events they've witnessed or experienced in numerous ways. Two children may have very different reactions to the same traumatic event. The way a child is affected may depend on any or all of the following:

- The child's age or developmental stage
- The child's perception of the danger faced
- Whether the child was a victim or a witness
- The child's relationship to the victim or perpetrator
- The child's past experience with trauma
- The adversities the child faces following the trauma
- The presence/availability of adults who can offer help and protection

NCTSN, Child Welfare Trauma Toolkit, January 2013, Slide 36.

For many children, exposure to traumatic events may have long-term consequences that can affect behavior, school performance, participation in high-risk behavior, health problems and relationship difficulties.

For young children unable to communicate emotions associated with experiencing trauma, the effects may be manifested as physical tension or health complaints.

Cultural Considerations

It is important to understand the cultural background of a child when assessing a child's trauma history. Culture can influence how the trauma is experienced by the child. The way a child or family interprets the meaning of the trauma will influence how they respond to the traumatic stress. Because some families' interpretations

Understanding Child Trauma, Cont'd.

may differ from yours, it is best to ask children and families about what the traumatic experience means to them.

What a CASA/GAL Volunteer Can Do

Exposure to trauma can have lasting impacts on children, affecting their behavior, worldview and sense of safety. In your role as a CASA/GAL volunteer, working with children who have experienced trauma, it is important that you treat them as individuals, rather than seeing them as victims of the traumatic event.

Because the children you will work with may have long histories of trauma, it's important that you consider their past experiences. While your work may initially focus on the event that brought a child into the child protection system, you may consider requesting or recommending that the child have a trauma screening. Consider that what others are seeing as misbehavior or lack of age appropriate development may be trauma related. Trauma screenings or assessments are most often completed by therapists or clinicians to screen for a child's history of exposure to traumatic events and can help all involved understand the child's behaviors in the context of his or her life's experiences. You must have frequent communication with therapists and others involved in the treatment of the child. However, you have to observe boundaries, i.e. the volunteer should not try to provide therapy.

Parents within the system will often have their own unresolved trauma histories, which may have contributed to their circumstances. It may be appropriate for the parent to undergo a trauma screening as well. Viewing the parent's behaviors and/or the child's reactions in the context of their trauma histories is integral to having compassion and understanding for their situation.

The following questions can help you determine whether to recommend an assessment for a child or parent:

- Has the child experienced early and repeated exposure to overwhelming events in the context of a caregiver/family setting or in the community?
- Is the child having difficulty regulating or controlling behavior, sometimes appearing hyperactive, engaging in risky behaviors or having difficulty complying with rules?
- Is the child having difficulty with sustaining attention, concentration or learning?

Understanding Child Trauma, Cont'd.

- Is the child showing persistent difficulties in relationships with others? Does the child have difficulty regulating bodily states and emotions, including problems with sleep, eating, sensory processing and/or identifying/expressing feelings?
- Does the child have multiple mental health diagnoses without any one sufficient diagnosis explaining his/her problems?

From the National Child Traumatic Stress Network website: www.nctsn.org/trauma-types/complex-trauma/assessment.

Communication and CASA/GAL Volunteer Work

You will come into contact with many people as you gather information and monitor a child's case. Relationships characterized by respect and credibility will assist you in doing your job. Respect is earned as others on the case see your commitment to the child and to your role as a CASA/GAL volunteer. Credibility is established when you do what you say you will do in a timely manner, when you make recommendations built on well-researched and independently verified information, and when you maintain your proper role as the child's advocate.

Effective communication is critical to your ability to advocate for children. Good communication requires:

- Self-awareness
- Sensitivity
- Skills

Understanding the basic elements of communication can increase your skills in gathering the information you need to successfully advocate for a child.

The Basics of Communication

Effective communication is critical to your ability to advocate for children. Communication is defined as an interchange or an exchange of thoughts and ideas. Often the message a person intends to send is not the message that is received. What is said can be interpreted differently depending on the receiver's understanding of the words and the nonverbal cues that accompany the words.

Communication has three components:

1. The **verbal** component refers to the actual words spoken.
2. The **nonverbal** component refers to gestures, tone of voice and other unspoken means of conveying a message. The nonverbal code can easily be misread.
3. The **feelings** component refers to the feelings experienced as a result of the communication.

Communication and CASA/GAL Volunteer Work, Cont'd.

While the verbal and nonverbal can be observed, feelings are not easy to observe. Whenever there is a discrepancy between the verbal, the nonverbal and the feelings components of a message, the receiver of the message will tend to believe the nonverbal.

As a CASA/GAL volunteer, you will communicate with children, their families and professionals involved in the case, among others. It is important that you deliver messages that are consistent in all three components of communication. You must also train to listen for meaning, which requires three sets of ears—one set for receiving the spoken message, one for receiving the silent message(s) conveyed, and one for receiving the feelings of the sender.

Adapted from "Learning to Listen to Trainees," Ron Zemke, and "Learn to Read Nonverbal Trainee Messages," Charles R. McConnell.

Cultural Considerations

There are differences in nonverbal communication from culture to culture. Hand and arm gestures, touch, proximity and eye contact (or lack of) are a few of the aspects of nonverbal communication that may vary depending upon cultural background. For example, in some cultures:

- Pointing with one finger is considered to be rude.
- Patting a child's head is inappropriate.
- Eye contact is thought to be disrespectful.

Open-Ended vs. Closed-Ended Questions

Open-ended questions invite others to engage in a dialogue with you. In your work as a CASA/GAL volunteer, using open-ended questions allows children and adults to give more thoughtful answers since these questions cannot be answered with a simple yes, no or one-word answer. Sometimes open-ended questions are phrased as a statement that requires a response (for example, "Tell me about…" or "Describe for me…").

Examples of open-ended questions:

For child: *"Please describe what your morning is like from the time you wake up until you go to school."*

For adult: *"How did your family come to be involved with the court system?"*

Closed-ended questions are useful when you are trying to obtain factual information. They can be answered with a simple yes or no, or with a single word or short phrase.

Examples of closed-ended questions:

For child: *"Is your aunt still living nearby?"*

For adult: *"How many times has Johnny been to the emergency room this month?"*

Clarifying questions are used to gather additional details or clear up any confusion.

Examples of clarifying questions:

"I didn't understand the phrase you just used. Could you explain it?"

"You mentioned someone named James. What is his relationship to the child?"

Do not ask **leading questions! A leading question** is one that suggests a desired answer.

Example of a leading question:

"Your favorite weekends are spent with your dad, right?"

Leading questions are never appropriate in any CASA/GAL volunteer interview.

Open-Ended vs. Closed-Ended Questions, Cont'd.

More Examples

Closed-Ended Question:

- (For a child): Do you want to live with your mother or your father?

Open-Ended: Question:

- Who would you like to live with?
- Who do you think you'd be happiest living with?

Closed-Ended Question:

- (For a parent): You seem unhappy lately. Are you?

Open-Ended Question:

- How have you been feeling lately?
- How are you doing emotionally?

Closed-Ended Question:

- (For a child): Does your mom leave you alone at night a lot?

Open-Ended Question:

- Tell me what it's like at home at night.
- Who is around when you're at home at night?

Closed-Ended Question:

- (For a parent): Do you understand the difference between a CASA/GAL volunteer and a caseworker?

Open-Ended Question:

- Tell me your understanding of my role as a CASA/GAL volunteer.
- How do you think my role is different from that of the caseworker?

The CASA/GAL Interview

In your role as a CASA/GAL volunteer, you will have the chance to interview many people related to a case: the child, the parent(s), other relatives, the child's teacher, medical professionals, the caseworker and so on. Because you may have a limited amount of time to seek information and interview everyone you deem necessary before your first hearing or report is due, it is important that you make the best possible use of interview time by determining what information is needed and crafting questions to ask ahead of time.

The interview is a powerful tool in your CASA/GAL volunteer toolbox and should be controlled by you, the fact gatherer. CASA/GAL volunteer interviews are neither friendly chats nor inquisitions. The structure of the interview should be non-threatening. Start with comfortable material and lead to more sensitive areas. You may face the tendency to turn the interview into a personal conversation, but keep in mind that it is possible to make someone feel at home and to show an interest in him or her while still presenting yourself as the one in charge, the professional. It is rarely appropriate to discuss your personal life or your past experiences. Never discuss your own attitudes or biases. Your goal is to gather enough information, in a respectful manner, to produce a factually sound, insightful report and recommendations for the court.

Basic Tips for a Productive CASA/GAL Interview

1. Display empathy and concentration. Portray an accepting, believing, non-judgmental demeanor.
2. Observe gestures, expressions and other forms of nonverbal communication.
3. Make notes about the environment. Does the room contain family photos, toys and so on?
4. Prepare questions beforehand, but be flexible, asking clarifying questions as needed.

The CASA/GAL Interview, Cont'd.

5. Do not ask leading questions. A leading question assumes a point of view on your part.
6. Listen to understand. Do not interrupt.
7. Do not expect to gather all the information needed in one session.
8. Encourage subjects to keep talking with phrases such as, “Okay,” “Go on,” or “Please continue,” or allowing five seconds of silence. Do not be afraid of silences.
9. Check to make sure you understand what the speaker is trying to convey, using phrases such as “What I’m hearing is . . .” or “It sounds like you are saying . . . Is that right?”
10. Do not preach or teach. Avoid arrogance.

Interviewing Children

As a CASA/GAL volunteer, you do not directly ask a child about incidents of abuse. A professional forensic interviewer, trained social worker or police officer will handle those inquiries as a part of an investigation. A badly conducted interview of a child-victim can alienate and upset the child. The Center for Problem-Oriented Policing (POP) website states that common errors interviewing children include reinforcing certain answers, relaying what others believe about the allegation and asking complicated questions. They advise the following:

1. Make the interview setting child-friendly.
2. Recognize the developmental capabilities of children of different ages.
3. Exercise patience.
4. Avoid “why” questions and focus instead on clear, open-ended questions.
5. Make efforts to offset any guilt the victim may experience for “causing trouble.”

Your role as a CASA/GAL volunteer is to get a sense of a child’s past and current circumstances and how the child is doing presently. Some children can talk about their situations and their wishes, but other children do not have sufficient verbal and developmental skills sufficient to express themselves. For that reason, fact-based observations about a child are important to your role in gathering information about a case.

The CASA/GAL Interview, Cont'd.

During the initial part of the interview, focus on helping the child feel comfortable and relaxed. Introduce yourself and explain your role and why the interview is taking place. This is a good time to play an age-appropriate game. It is important to remember that what you observe may raise questions about the child and the child's life. Be careful not to misinterpret a child's play or take their words literally. As a CASA/GAL volunteer, you do not want to reach conclusions based on any one piece of information. Information that emerges in play needs to be corroborated by other sources.

In the article "Interviewing Children," Rosemary Vasquez suggests that since you cannot "interview" infants, CASA/GAL volunteers should consider the following:

- What does direct observation of the child tell you?
- What do you observe about the child relating to parent(s), caregiver, siblings and strangers?
- What is the infant's affect?
- Does the baby make eye contact or avoid eye contact?
- How does the parent relate to the child and vice versa?

This type of "interview" with an infant and parent should provide you with a sense of whether the parent provides the child with appropriate stimuli, enhances the security of the child and meets the child's physical and emotional needs.

Tips for Interviewing Children

1. Ask a child a question or two to which you know the answer. Such questions can help you determine the competence level of a younger child and/or an older child's willingness to tell the truth.
2. Establish parameters to obtain more accurate information. For example, you might ask a child, "Was it bigger than a football?" "Did it happen before the school bus came?" or "Was there snow on the ground?"
3. Break questions down into parts to help a child remember more detail. Just asking a child, "What happened?" may not elicit a useful answer.
4. If you think a child has been coached, you may want to end the interview with this question: "Is there anything else you are supposed to tell me?"
5. Let the child tell his/her story.

Adapted from Lucas County, Ohio CASA/GAL.

Initial Case Notes for the Black-Smith Case (for Pre-Work)

CPS Case File

Last Name of Case:	**Black/Smith**
Legal Number(s):	**3AN-15-154/155**

Child(ren)'s Name	DOB	Age	Ethnicity	Sex
Tammy Black	9/1	6	White	F
Grace Smith	8/19	4 months	White	F

Current Placement	Address	Phone
Foster Parents: Linda and Dave Gilbert	4206 Front Street	555-4413

Attorneys for	Attorneys	Phone Numbers
Mother	Megan Miller	555-9894
Father	Ben Bryant	555-1337
CPS	Heather Stafford	555-7344

Case History

Sept 15: Six-year-old Tammy made a call to 911 due to domestic violence in the home. Police found two children on the scene (Tammy, age 6; Grace, 4 months) and removed the children from the home based on evidence at the scene, including parents too inebriated to provide a safe home for their children and mother's bruises and bleeding as a result of a fight between her and her husband. The father, Mr. Alan Smith, was arrested on DV charges. CPS was notified and the children were placed together in emergency foster care.

Sept 22: Tammy and Grace were moved from the emergency foster care placement and placed with licensed foster parents Linda and Dave Gilbert. Foster parents reported that upon arrival, Tammy cried the first six hours and was inconsolable.
Sept 25: Due to where the new foster home is located, Tammy moved to a new school. Linda reported this change has been very difficult for Tammy.

Sept 29: Following an initial hearing, parents were ordered to receive drug/alcohol screenings, attend any recommended substance abuse treatment programs, and provide random urinalysis. The biological father of Tammy is deceased. Mr. Smith, Grace's biological father, was ordered to attend a domestic violence program. The mother, Francis Smith, was ordered to attend domestic violence survivor's program.

Nov 29: Parents stipulated to adjudication, thereby acknowledging the issues are substance abuse, physical abuse and anger management.

CASA History: Case Initially Assigned to:	You	Date Assigned:	Today
		Date assigned:	N/A
Current CASA volunteer:	You	Date terminated:	Today
CASA/GAL Program Coordinator:	Jessica Clarkson	Date assigned:	9/15
Initial CPS Social Worker:	Becky Howard	Date assigned:	10/20

Case History, Cont'd.

Court-Ordered Services

For the Children:

Educational needs met as appropriate

For the Father:

Drug/alcohol screening and substance abuse treatment

Anger management classes

For the Mother:

Domestic violence survivor's program

Interviewing Skills: Talking with a 4-Year-Old Child (Part 1 of Video)

Watch Part 1 of the video showing CASA/GAL volunteer interviewing a 4-year-old child.

Assignment Sheet for Interviewing a Child (for Pre-Work)

In order to enhance your interviewing skills as a CASA/GAL volunteer, you will need to practice conducting interviews. Use this assignment sheet to prepare an interview for a child between the ages of 5 and 17. To ensure your questions are age-appropriate, review the child development information for the age of the child you choose. Please bring this to class with you.

Age of child to be interviewed: _____

How do you plan to introduce yourself to the child and state the purpose of your meeting?

_____

_____

_____

_____

Write five age-appropriate questions for the interview.

1. _____

   _____

   _____.

2. _____

   _____

   _____.

3. _____

   _____

   _____.

4. _____

   _____

   _____.

5. _____

   _____

   _____.

How would you close the interview?

_____

_____

First Impressions: Exposure to Violence and a Child's Developing Brain (Video)

Watch First Impressions: Exposure to Violence and a Child's Developing Brain video.

CASA
Court Appointed Special Advocates
FOR CHILDREN

THE NATIONAL COURT APPOINTED
SPECIAL ADVOCATE ASSOCIATION

CASA/GAL Pre-Service Volunteer Training Curriculum

Pre-Work Handouts

CHAPTER FOUR

HEARST foundations

OJJDP

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Version 2, November 2017

CHAPTER 4

Pre-Work Handouts

CONTENTS

Pre-Work Instructions

This section details the work you need to complete before the fourth classroom session. Completing this work prior to the session will allow you to fully participate during the training session and build the knowledge and skills you need to be an effective and successful CASA/GAL volunteer.

Prior to attending the fourth session of the volunteer training, please read through the pre-work handouts found in this document. This will give you a foundation in concepts such as: mental illness in families, mental health of children in care, a multimodal approach to managing mental health disorders in children, questions to ask regarding mental health of children, why poor children are more likely to be in the care system, how to obtain confidential case-related records of children and parents, confidentiality in CASA/GAL volunteer work, the need for timely and effective communication, the fine art of team work and the initial case notes for the Greene case. You should also complete the activity of examining poverty vs. neglect scenarios. Optionally, if the facilitator assigns the activity, you should also complete the activity of visiting an agency by taking public transportation.

Mental Illness in Families

Definition

According to the National Alliance on Mental Illness (NAMI), “A mental illness is a condition that impacts a person’s thinking, feeling or mood and may affect his or her ability to relate to others and function on a daily basis. Each person will have different experiences, even people with the same diagnosis.”

Definitions of mental illness have changed over time, across cultures and across national—and even state—boundaries. Mental illness is diagnosed based on the nature and severity of an individual’s symptoms according to definitions published in the The Diagnostic and Statistical Manual of Mental Disorders (DSM -5), currently in its fifth edition, Serving as the American Psychiatric Association's (APA) classification and diagnostic tool, in the United States, the **DSM** serves as a universal authority for psychiatric diagnosis. r. The term “dual diagnosis” indicates that an individual has both a psychiatric disorder and a substance abuse problem.

Causes

A mental health condition usually has its origins in multiple, overlapping causes, which may include genetics, biology, environment and life stressors. Mental illness is not caused by personal weakness or a character defect. No single model or perspective accounts for all instances of mental illness. Some disorders have a predominately biological or neurological basis; others seem to be related to life experiences, trauma or difficulties in communication. The most helpful stance for you to take in your CASA/GAL volunteer work is to accept that mental illness can affect a person—mentally, physically, psychologically, socially, emotionally and spiritually.

Impact of Parental Mental Illness on Children

A parent’s mental illness can significantly affect a child, potentially leading to social, emotional or behavioral problems. According to Healthy Place, children of a parent with mental illness may experience the following impacts:

- Inappropriate levels of responsibility (also known as “parentification”)
- Self-blame for their parents’ problems
- Anger, anxiety or guilt

Mental Illness in Families, Cont'd.

- Embarrassment, shame or isolation
- Increased risk of school-related problems, drug use and poor social relationships
- Risk of mood disorders, alcoholism and personality disorders

However, parental mental illness doesn't automatically sentence children to a life of problems. Whether a child can thrive despite these challenges depends on the strengths and protective factors present in the family, as well as the child's level of resilience. As a CASA/GAL volunteer, you can recommend services that build on a family's strengths and help them overcome the challenges they face.

Untreated Mental Illness

The biggest obstacle facing those suffering from mental illness is the lack of appropriate, effective treatment. This lack may result from misunderstanding the need for treatment or being afraid to seek it due to the stigma associated with mental illness in American culture. It may also result from a lack of access to treatment. There may not be treatment available in a person's community, or the person may not be able to pay for it.

Untreated mental illness can lead to isolation and despair for individuals and families. Some parents may be so incapacitated by anxiety or depression that they are unable to care for their children. Or, some may hallucinate or have delusions, which make them a danger to themselves or their children. It is critical for you as a CASA/GAL volunteer to focus less on a parent's diagnosis and more on his/her ability to provide a safe home for the child. The degree to which a parent's functioning is impaired will vary from mild to severe. It is important to note that with medication and/or therapy most people can function normally.

Mental Illness and Child Welfare

According to Mental Health America, "A higher proportion of parents with serious mental illness lose custody of their children than parents without mental illness. There are many reasons why parents with a mental illness risk losing custody, including the stresses their families undergo, the impact on their ability to parent, economic hardship and the attitudes of mental health providers, social workers and the child protective system.

Mental Illness in Families, Cont'd.

Supporting a family where mental illness is present takes extra resources that may not be available or may not be offered. Also, a few state laws cite mental illness as a condition that can lead to loss of custody or parental rights. One unfortunate result is that parents with mental illness might avoid seeking mental health services for fear of losing custody of their children."

To understand the impact of mental illness in a family, it is critical to examine if a parent's level of functioning is sufficient to keep a child safe, and whether another competent adult is present in the home. A person's level of functioning is the result of many factors; not all are related to mental illness. It is important to distinguish between mental illness and other kinds of limitations. For example, many adults have limited intellectual abilities or specific learning disabilities. These limitations range in severity. By looking beyond the diagnosis, to level of functionality, you can make recommendations to remedy the problems that caused family involvement in the child protective services system.

Assessment

It is not your task to diagnose mental illness. However, it is important to be aware of warning signs or indicators that may affect the health or safety of the child so that you can alert the child protective services caseworker about your concerns. The following are some indicators that may point to the need for professional assessment:

- Social withdrawal: "Sitting and doing nothing"; friendlessness (including abnormal self-centeredness or preoccupation with self); dropping out of activities; decline in academic, vocational or athletic performance
- Depression: Loss of interest in once pleasurable activities, expressions of hopelessness or apathy; excessive fatigue and sleepiness or inability to sleep; changes in appetite and motivation; pessimism; thinking or talking about suicide; a growing inability to cope with problems and daily activities
- Thought disorders: Confused thinking; strange or grandiose ideas; an inability to concentrate or cope with minor problems; irrational statements; peculiar use of words; excessive fears or suspicions

Mental Illness in Families, Cont'd.

- Expression of feeling disproportionate to circumstances: Indifference even in important situations; inability to cry or excessive crying; inability to express joy; inappropriate laughter; anger and hostility out of proportion to the precipitating event
- Behavior changes: Hyperactivity, inactivity or alternating between the two; deterioration in personal hygiene; noticeable and rapid weight loss; changes in personality; drug or alcohol abuse; forgetfulness and loss of valuable possessions; bizarre behavior (such as skipping, staring or strange posturing); increased absenteeism from work or school

Treatment

Availability of mental health treatment varies, and its effectiveness depends on a variety of factors. Treatment options can include medication, counseling or therapy, social support and education. A well-designed treatment plan takes individual differences into account.

Cultural Considerations

Different cultural communities perceive mental health conditions differently. Cultural background can affect whether people seek help, what kind of help they turn to, their ways of coping, the kinds of treatment that work and the barriers to receiving effective care. It's crucial that professionals take culture into account when evaluating mental illness and providing treatment options.

What a CASA/GAL Volunteer Can Do

- When you're concerned that a mental illness has gone undiagnosed, you can recommend a mental health assessment of a parent or child.
- You may request consultations with a parent's or child's mental health care provider. Although a parent's mental health care providers are ethically and legally required to maintain their client's confidentiality, they may be willing—with their client's permission—to talk to you about their perspective on the situation and any concerns you may have. Your CASA/GAL volunteer supervisor will be able to answer your questions about gaining access to this confidential information.

Mental Illness in Families, Cont'd.

- When you encounter resistance to a label, diagnosis or treatment, you can become aware of ethnic or cultural considerations. The standards for research and definitions of health, illness and treatment have historically derived from a white, middle-class perspective.
- When appropriate, you can ensure that children are provided age-appropriate explanations of their own or their parent's mental illness diagnosis by a qualified individual.
- When appropriate, you can advocate for holistic treatment that considers all aspects of an individual, including mental, spiritual, emotional and physical, as opposed to one-dimensional treatment.
- You can create documentation of a parent's or child's mental health issues by reviewing history and case files, and listing all diagnoses, noting the year diagnosed and the medication prescribed, and recording the prescribing provider's name.

California Moves to Stop Misuse of Psychiatric Meds in Foster Care

By the time DeAngelo Cortijo was 14, he had been in more than a dozen foster homes. He had run away and lived on the streets for months, and he had been diagnosed with bipolar and anxiety disorders, attachment disorder, intermittent explosive disorder or posttraumatic stress disorder. He had been in and out of mental hospitals and heavily medicated.

Cortijo, who was born in San Francisco, was taken from his mother after she attempted suicide when he was 3.

After his later diagnoses, he was prescribed a combination of antipsychotics, antidepressants and stimulants, and was told that taking them was his only hope of being normal. Instead, he said, medication made him feel "doped up and completely lost."

It was not until he spent several months developing a relationship with a horse — "and it was huge," said Cortijo with a smile — that he began to really acknowledge his own feelings. "Animals sense you, your fears, anxieties and insecurities," he said.

Finding help through equine-assisted therapy — riding a horse, feeding, grooming and communicating with it — helped Cortijo to gain a better perspective on himself. "It allowed me to understand what a bond was, to realize I am an individual who is capable of caring, capable of being normal," said Cortijo.

He's now 22, off all medication, and is helping troubled youth as a juvenile justice intern at the National Center for Youth Law.

Children in foster care are prescribed antipsychotic drugs at double to quadruple the rate of that not in foster care, according to a Government Accountability Office report. Hundreds of children were found to be taking five or more psychotropic medications at a time, although there is no medical evidence to support such a drug regimen. Thousands of children were prescribed doses that exceeded FDA-approved guidelines. The report found monitoring programs for psychotropic drugs provided to foster children fell short of guidelines established by the American Academy of Child and Adolescent Psychiatry.

California Moves to Stop Misuse of Psychiatric Meds in Foster Care, Cont'd.

In March, a report by the inspector general at Health and Human Services found quality of care concerns in more than two-thirds of claims for psychotropic drugs paid for by Medicaid, the health insurer for most children in foster care. That included too many drugs (37 percent); wrong dose (23 percent); poor monitoring (53 percent); or wrong treatment (41 percent). The OIG recommended that the Centers for Medicare & Medicaid Services (CMS) work with the states to enhance oversight, medical reviews and utilization reviews of psychotropics prescribed to children.

In California, a sweeping package of laws to regulate the prescribing of powerful psychiatric medications to children and teens in the child-welfare system has passed the Senate and is heading to the state assembly, where it faces no formal opposition. The reforms also are being eyed as a template for federal legislation. Anna Johnson, a social analyst at the Oakland, Calif., -based National Center for Youth Law, which helped write the legislation, said an enforcement mechanism is needed to change prescribing practices.

"The legislation describes in detail the oversight function — what everyone's role is, from the juvenile court judge and the social workers, to the care providers, the lawyers, the doctors," said Johnson. "And it names specifically the prescribing practices we want to see reduced: the use of multiple drugs on children, dosages that exceed maximums and the use of antipsychotics where not medically necessary because of physical health risk factors."

The push for tougher laws follows last year's publication of a series of investigative articles in the San Jose Mercury News, which alleged widespread use of antipsychotics and other psychiatric drugs without proper evaluation and monitoring among the estimated 63,000 California children in foster care.

"It is well beyond time for us to be having this discussion and intervening," said Ken Berrick, president and CEO of the Seneca Family of Agencies, which provides mental health and other services for children in California. According to Berrick, overuse of medication has been a problem for decades, often because better alternatives simply weren't available. "Medication is available right now on demand, and other services are not," he said. "When you don't have a choice, you rely on what you have."

California Moves to Stop Misuse of Psychiatric Meds in Foster Care, Cont'd.

Under the reforms, there would be better monitoring of children on medication and closer scrutiny of physicians to identify doctors who rely most heavily on medication. The bill also calls for stricter oversight of group homes to determine if psychotropic medications are used to control children's behavior. "Drugging and sedating children should never be considered the primary option in lieu of counseling, therapy and appropriate treatment," said the bill's author, Sen. Jim Beall, D-San Jose.

In addition, social workers and caregivers in California would receive training in the risks, benefits and side effects of psychiatric medications. A mix of state and federal dollars would establish a structure to provide second medical opinions.

Beyond reining in prescribing outliers, the legislation also places a new emphasis on defining what comprises appropriate care for vulnerable youth. "It's no longer a drugs-only approach," explained Johnson, who said the legislation would require that children who are being given powerful medications also receive other services.

"We're saying, you have to do something else — either first or at the same time — to really help a troubled child," said Johnson. "Swallowing a pill doesn't help with grief or trauma. It may contain symptoms, but it doesn't help you move forward and be functional in life."

In legislative hearings, former foster youth testified about negative side effects from taking psychotropic medications, sometimes unwillingly. And they described how alternatives to drug therapy often led to better outcomes.

For Tisha Ortiz, 22, help finally came in the form of a therapeutic behavioral services worker who took a genuine interest in her. "I felt loved by her, that she actually cared," said Ortiz.

Ortiz had a chaotic childhood filled with emotional and sexual abuse. While she lived in various group homes, she often lashed out at adults and resorted to self-harm when her emotions got the better of her. For years she lived with flashbacks to traumatic events, which her caregivers and social workers misinterpreted. "They considered the flashbacks as hearing voices, so I got put on psychotropic meds for that, when I wasn't hearing voices at all."

California Moves to Stop Misuse of Psychiatric Meds in Foster Care, Cont'd.

On medication, Ortiz gained weight and found it hard to stay awake, yet she continued to feel abandoned and depressed. "I just felt sedated, and I wasn't really dealing with the problems," she said.

According to Ortiz, she did not begin to get better until she was connected with a behavioral services worker who encouraged her to talk about her past. "She helped me understand that what I was feeling was because of the situations I went through and not because there's all these things wrong with me."

Since then, Ortiz has had other therapists who she felt really listened to her, whom she still occasionally calls if she's had a bad day. But the self-harm has stopped, and she's tapering off the one medication that she still takes. Ortiz says it was human interaction, not drugs, that helped her. "Having that love was one of the first steps that put me on the road to getting better."

There are a lot of good evidence-based treatments that work, said Shadi Houshyar, vice president for child welfare policy at First Focus, a national children's advocacy organization. "States are just struggling with finding the providers, the resources and the dollars to pay for these interventions," she said.

Some states resort to Medicaid waivers or use their child welfare general funds to match Medicaid dollars, but that's not enough, Houshyar said. That's why First Focus and other advocacy groups have been big proponents of a White House program aimed at curbing the misuse of psychiatric medication in foster care.

The Obama administration has called on states to advance alternative treatments in their child welfare systems. In his 2015 and 2016 budget proposals, President Obama unveiled a two-pronged plan allocating $750 million in grant dollars and incentive payments to address the overprescribing of psychotropics.

The demonstration project would bring child welfare and Medicaid agencies together to provide more coordinated services, including behavioral therapies, to foster kids with a history of trauma or mental health problems. "If we really want to solve this problem, we have to make the alternative interventions available at the same level at which medication is available," said Berrick. "It's really a question of access. When that happens, people will make the right decision."

A Multimodal Approach to Managing Mental Health Disorders in Children

Managing mental health issues and the symptoms experienced by children and adolescents involves many modalities:

- Medication treatment, or psychopharmacology, can alleviate or lessen the symptoms that accompany many mental health disorders. -If behavior is deemed appropriate for drug therapy and accurately prescribed, medication may decrease the impulse to tantrum, help a child regulate physiologic responses to emotions or eliminate auditory hallucinations. Proper medication support can provide behavioral stability and support with emotional regulation that a child or teen may need to readily engage in other forms of therapy. For example, a very depressed teen who cannot control her crying when she needs to be able to talk about her abuse and history can feel more in control emotionally with the right medication, allowing her to discuss the important issues and aid in her healing.
- Behavioral therapy can help increase positive behaviors and decrease negative acting out.
- Cognitive behavioral therapy can help correct a pattern of negative thoughts that interfere with the ability to relate to others.
- Play therapy can help heal past trauma and facilitate a child's return to normal functioning.
- Child-parent psychotherapy—working directly with the parent and child together can help the child learn healthy ways of interacting and functioning. Parents can be coached to become more reflective, develop a deeper understanding of their child's needs and their role in their child's life. They also learn how to interact with their child to promote a healthy, secure attachment and to support healthy growth and development.
- Dialectical behavioral therapy (DBT) can provide important skills, such as distress tolerance and emotional regulation, in struggling adolescents and help them integrate new coping skills into their daily interactions.

These treatments can help manage symptoms, facilitate healing and return children to optimal functioning.

Reprinted from "Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges," by JoAnne Solchany, ABA Center on Children and the Law, October 2011.

Questions Advocates Should Ask

Children and teens have little, if any, power over their lives when they enter care. They generally lack the knowledge to understand what they need medically, regardless of the type of treatment needed. Asking the following questions will help identify their needs and determine which recommended treatments are in their best interests.

- What is this medication needed for?
- Were you able to obtain an accurate medical, behavioral and psychological history from parents and past providers?
- What else has been tried?
- What other modes of treatment or intervention will also be provided?
- Who will monitor the ongoing use of this medication? How often will this child be seen?
- What are the possible side effects of this medication and how will they be handled?
- What evidence supports the use of this medication with children?
- Will this child be able to comply with the prescribed medication?
- Does the child agree with taking this medication?
- Who has given permission to begin this child on medication?
- What other medications is this child on? Can this medication be safely combined with the current medication(s)?
- How will this medication help improve this child's functioning?
- What are the risks versus benefits of using this medication? What are the risks versus benefits of not using the medication?
- Is a second opinion warranted in this case?

Adapted from "Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges," by JoAnne Solchany, ABA Center on Children and the Law, October 2011.

Poverty in Your Community Research Activity

Research answers to these questions:

- What is the minimum wage in your state?
- What are the current poverty guidelines for a family of four in your state?
- What percent of people of color in your state fall within the poverty guidelines? What percent of the white population in your state fall within the poverty guidelines

To find additional information about children in poverty, you can refer to the website of the National Center for Children in Poverty.

Higher Rates of Poor Children in the System

Why Are Poor Children More Likely to Be in the System?

Many of the children you will encounter as a CASA/GAL volunteer will be living at or below the poverty level. Developing a better understanding of the realities of poverty will assist you in being a better advocate. Keep in mind, knowing people's socioeconomic status—like knowing their race, ethnicity or other group membership—does not necessarily mean you can predict their attitudes or behavior or their fitness as a parent long term. However, knowing their socioeconomic status does help you better understand their life experience, specifically some of the hardships they face.

While abuse and neglect occur in families at all socioeconomic levels, poor children are more likely to come to the attention of the child protection system. This happens for a variety of reasons. One reason is that middle- and upper-income families have access to many more resources within their families than poor people do. Even though family crisis, including abuse, happens at all income levels, it is poor people who often have to turn to the system for support. For people living in poverty, initial contact with "the system" is usually for reasons other than abuse. The contact may be about accessing medical care, food stamps, housing, etc. Once this contact is initiated, these families are communicating with many "mandated reporters," increasing the likelihood that issues of child abuse and neglect will be investigated.

Poverty causes great stress in families. Because of this stress, poverty itself is a major risk factor of abuse, which increases the likelihood of both immediate and lasting negative effects on children. Children who live in poverty are far more likely to have reports of abuse and neglect and substantiated incidents of abuse and neglect in their lives, and poor families of color are more likely to be reported for abuse and neglect and to have their children removed than white families in similar situations. However, poverty is not a causal agent of abuse. Most poor parents do not abuse their children.

Children living in families in poverty are more likely:

- To have difficulty in school
- To become teen parents
- To earn less and be unemployed more as adults

Higher Rate of Poor Children in the System, Cont'd.

Poverty in the first years of life can have critical consequences. Research in brain development shows the importance of the first years of life for a person's overall emotional and intellectual well-being. Poor children face a greater risk of impaired brain development due to their increased exposure to several other risk factors. These risk factors include:

- Inadequate nutrition
- Parental substance abuse
- Maternal depression
- Exposure to environmental toxins (because of where they are forced to live)
- Low-quality daycare

Examining Poverty vs. Neglect Scenarios Activity

Consider the circumstances in which each scenario listed below would and would not constitute a child safety issue. Complete the sentence for both "Yes, if . . . " and "No, if . . ".

A family does not have a refrigerator. Is this a child safety issue?

Yes, if . . ._____

No, if . . . _____

A family lives in a rental unit with holes in the floor. Is this a child safety issue?

Yes, if . . ._____

No, if . . . _____

A family lives in a car. Is this a child safety issue?

Yes, if . . ._____

No, if . . . _____

A family does not have electricity. Is this a child safety issue?

Yes, if . . ._____

No, if . . . _____

A family does not have beds for their children. Is this a child safety issue?

Yes, if . . ._____

No, if . . . _____

Examining Poverty vs. Neglect Scenarios Activity, Cont'd.

A family does not have money to buy the mother's antidepressant medication. Is this a child safety issue?

Yes, if . . ._____

No, if . . . _____

A family does not have a crib for their infant. Is this a child safety issue?

Yes, if . . ._____

No, if . . . _____

A family has one parent who uses drugs. Is this a child safety issue?

Yes, if . . ._____

No, if . . . _____

Obtaining Confidential Case-Related Records

Your appointment as a CASA/GAL volunteer will advise information keepers that you are allowed access to records—even records that would otherwise be confidential—pertaining to the child in your assigned case. Present photo identification and copies of your legal appointment when you visit an agency from which you seek information.

The court order appointing you as the child's advocate provides fairly wide latitude to access that child's records. Parents' records are often more difficult to obtain. They or their attorneys may resist your efforts to access certain records if the information might damage the parents' credibility and their chance to have their child returned home. The best way to ensure your ability to obtain confidential records for a parent or other adult party to a case is to submit a release of information (signed by the parent) to the agency from which you request records. A release of information is a signed statement by a client authorizing the indicated third party access to the client's confidential information. Many agencies require that you use their form.

The process for obtaining information from child protective services agencies and schools differs from program to program. For example, information may be obtained through a legal process called "discovery," or it may be up to the individual CASA/GAL volunteer to obtain those records. Follow the direction of your local CASA/GAL program on how best to access child protective services documents, school records and other information involving the child(ren) and family to whom you've been assigned.

Many child welfare agencies, hospitals and schools do not honor walk-in records requests. Plan to call ahead and request that records be pulled for you to read at a certain date and time. Some hospitals and agencies will allow you to make copies on their machines; others will ask you to mark the requested pages and will send the copies to you. If you are denied access to records, contact your CASA/GAL volunteer supervisor.

Your local program will advise you on how to access medical records. They may post hospital names and contact information on the program's website or provide a handout with that information. There are some caregiver records that you will not be able to access due to law. This is most likely to occur with drug information, doctor and hospital records and mental health records.

Confidentiality and the CASA/GAL Volunteer

As a CASA/GAL volunteer, you will have access to confidential information about children and the people involved in their lives. You will need to understand your responsibilities in dealing with the confidential information you have gathered. The law governs who has access to confidential information. The CASA/GAL volunteer may not release this information except to the child, CASA/GAL program staff, the attorney(s) on the case, the caseworker, the court and others as instructed by law or local court rule. There will be times when it will be tempting to share information with others, for example, when a person has just finished sharing information with you or when you believe doing so might help your assigned child. However, your role is to be an information gatherer for the court—not a transmitter of information to people with whom you are not authorized to share it. If certain information needs to be shared, consult with your supervisor to determine how you might facilitate communication among others without violating confidentiality yourself. Mistakes in handling confidential information can be detrimental to the children involved and can bring criminal action against the people who misuse the information. When in doubt, discuss any confidentiality concerns with your supervisor!

What Information Should the CASA/GAL Volunteer Share with the Child?

The CASA/GAL volunteer is expected to develop a meaningful relationship with the child in order to make sound, thorough and objective recommendations in the child's best interest. The volunteer also ensures that the child is appropriately informed about relevant case issues, considering both the child's age and developmental level. The child is informed in an age-appropriate manner of impending court hearings, the issues to be presented, the recommendations of the volunteer and the resolution of those issues. If there is any question about what information should be shared with the child, ask your supervisor.

What Is Confidential?

The legal definition of "confidential" varies from state to state. Some laws are quite clear and others vague. The facilitator will share with you the definitions and rules in your state. As a CASA/GAL volunteer, you must regard as confidential any information that the source deems confidential. If any source

Confidentiality and the CASA/GAL Volunteer, Cont'd.

from which you obtain information requires you to show the court order of appointment or inquiries about why you are entitled to get such information, you should respectfully produce your court order and photo identification. Your appointment order gives you the authority to obtain a great deal of information that is, in fact, confidential. Child protective services records are confidential and are not available for public inspection. It is especially important that the name of any person who has made a report of suspected child abuse and neglect not be revealed. School records are also confidential. There are legal privileges that protect attorney/client, doctor/patient, clergyperson/congregation member, psychologist/patient and caseworker/client communications. Such communication, whether verbal or written, is all confidential and must remain so unless a court order specifically states otherwise. You are not allowed to share information with anyone other than the child, CASA/GAL program staff and attorney(s), the caseworker and the court unless a local or state order allows for a broader sharing of information.

You need not treat conversations with neighbors and friends who voluntarily give information as legally confidential. Also, if you speak with a teacher who is not providing confidential school records, but rather sharing impressions, these impressions would not be confidential unless the teacher requested that they be kept as such. This information, although not legally confidential, is still private and should not be shared except on a “need to know” basis, and then only with those people who need the information to better serve the child.

Should You Tell a Source That You Intend to Share Their Information?

There does not appear to be any legal requirement that you disclose to a source your intent to share information. However, it is important to be respectful of the source and to be honest about your intentions with regards to the use of the information. When introducing yourself as a CASA/GAL volunteer, mention that your role includes gathering information in order to make recommendations to the court. Never promise that you will not share information received.

Confidentiality and the CASA/GAL Volunteer, Cont'd.

Sharing Information with Foster Parents

As a CASA/GAL volunteer, you are not the foster parents' source of information about the child's case, nor are you their advocate. That is the responsibility of the social services department. Your job is to focus on the child's needs and keep the child informed about the case.

Foster parents may seek information from you about the children in their care, but foster parents' contractual relationship is with the child protective services agency or a private licensing agency. To provide adequate care, foster parents do need to know relevant information regarding the child. In fact, federal law requires that the child protective services agency provide the foster parent with the child's health and education records at the time of placement. The records should be updated periodically and each time the child is moved to another placement. These records must include, at a minimum, the following:

- Names and addresses of the child's health care provider and school
- The child's immunization record, known medical problems and medications
- The child's school record with current grade level performance
- Other relevant health and education information (e.g., behavioral problems and/or disabilities)

There may be instances, however, where you have information that would help a foster parent care for a child. Suppose, for instance, that you know the child has a history of sexual victimization and that he/she has been moved from an earlier foster home after being found in bed with a younger child. The current foster parent does not have this information and there is another young child in the home. In such a case, it is clearly in the best interest of both the child and other children in the home that this information be shared. After discussing the issue with your supervisor to determine the best approach, you should contact the caseworker and state a clear expectation that this critical background information be shared with the current foster care provider. As a CASA/GAL volunteer, you should not share this information yourself.

The Necessity of Timely, Effective Communication

The juvenile court system functions on strict timelines, which are in place so children progress toward a safe, permanent home and do not languish unnecessarily in out-of-home care. Guidelines intended to protect children can make successful completion of a case plan difficult for parents, especially those with drug and mental health issues. Children and parents need services put in place as quickly as possible. Every person on a case needs to understand where the case stands—including roadblocks, setbacks and successes—to give the parents the best chance at reunification and the child the best chance at finding a safe, permanent home in a timely manner.

As a CASA/GAL volunteer, you will need to speak with numerous people during the life of a case, many of whom will have different mandates and rules to follow. Each may have critical information that you need. Keeping lines of communication open with all parties and professionals is essential. If communication breaks down, case progress is invariably affected in a negative way. There is no time to waste on anyone's part in a child welfare case. As a CASA/GAL volunteer, you should be a facilitator of communication and avoid being part of a communication breakdown. Open, respectful communication among everyone involved in a case is critical to serving the child's best interests.

The Fine Art of Team Work

Common Sense Ideals

- We are all working toward the same goal: protecting children.
- We are all human beings—we will have some moments to shine and will make some mistakes along the way.
- Decisions should be based on the safety of the child, not on personal likes or dislikes.
- We will disagree sometimes; avoid being defensive or feeling personally attacked.
- We are all diverse, unique individuals who bring different thoughts, experiences and knowledge to the case.
- Lack of trust, openness and honesty will quickly kill any sense of teamwork.
- Be civil if you can't be friendly. Being curt, short or insensitive to others should not be tolerated.

Team Building Practices

- Make sure team goals are clear and unambiguous.
- Make sure there is complete clarity about individual vs. shared responsibilities
- Build trust with your team members to facilitate more open and honest communication.
- Try to involve the whole team in the process and discussion; everyone's input is crucial.
- Be careful when bringing personal issues to the table; leave personal feelings aside and be considerate.
- Empower each member by listening to each other and being courteous.
- Point out when someone has a good idea or suggestion; be friendly with each other.
- Be comfortable in asking questions or clarifying others' points of view; make no assumptions.

The Fine Art of Team Work, Cont'd.

Open and Successful Decision Making

- Attend or provide input at any team meetings regarding your case.
- Be open to new ideas and information that may change your thoughts or recommendations
- Evaluate each suggestion based on merit, probability and safety for the child.
- Act on the decision that was made.
- If you disagree with a plan, make it clear in a professional, non-emotional manner, explaining why and what your intended plan of action is.

What to Do If Someone Isn't Being a Team Player

Start by talking with that person in a non-confrontational manner. Begin by stating how much you appreciate their input and how important it is to the child and family.

Advise your immediate supervisor of the issues you have encountered and ask for assistance and direction.

Adapted from material created by Kelly Hickle-Lentz, Wood County, OH Job and Family Services and Lucas County CASA Program.

Initial Case Notes for the Greene Case

CPS Case File

Last Name of Case:	**Greene**
Legal Number(s):	**08-5-54321-5**

Child(ren)'s Name	DOB	Age	Ethnicity	Sex	Current Placement Location
Marky Greene	02/15	8 years	C	M	Home of bio mother & father

Current Caregiver(s)	Address	Phone
Bio Mother: Judy Greene Bio Father: Roy Greene	4810 Old Mill Rd	555-5454

Attorneys for	Attorneys	Phone Numbers
Mother	Darlene Wright	555-6000
Father	Walt Harris	555-8727
CPS	Robin Jackson	555-6552

Indian Child Welfare Act Status:
Court has established that ICWA does not apply in this case.

Case History

Two weeks ago: A call was made to the CPS hotline by the kindergarten teacher and school nurse at Parkside Elementary. The callers stated that one of their students, Marky Greene, often comes to school with poor hygiene, that much of his clothing is not his size, and that he's just come in with his third case of head lice in three months.

This CPS social worker (SW) interviewed the child's parents, Judy and Roy Greene. The family is Caucasian; the parents are in their late twenties. Per medical records, mother was diagnosed with bipolar disorder as a senior in high school. The Greene family moved here from a few states away. They have no extended family living nearby.

SW found conditions in the home deplorable but not dangerous. CPS decided to file a petition for neglect but to allow the child to remain at home for the time being.

Adjudication and disposition hearings were held the same day. Both parents attended. It was determined that the child's placement will continue in their home until the 3-month review hearing. Parents were ordered to cooperate with CPS treatment plan. Judge admonished them to work hard and pointed out that Marky was still under court's jurisdiction. He ordered CPS to not hesitate to take physical custody, should conditions in the home or family deteriorate.

CASA History: Case Initially Assigned to:	You and your team	Date Assigned:	Today
		Date Terminated:	N/A
Current CASA volunteer:	You and your team	Date Assigned:	Today
Initial CPS Social Worker:	Ryan Headon		
Current CPS Social Worker:	Ryan Headon		

Case History, Cont'd.

Court-Ordered Services

For the Child:

Educational needs met as appropriate

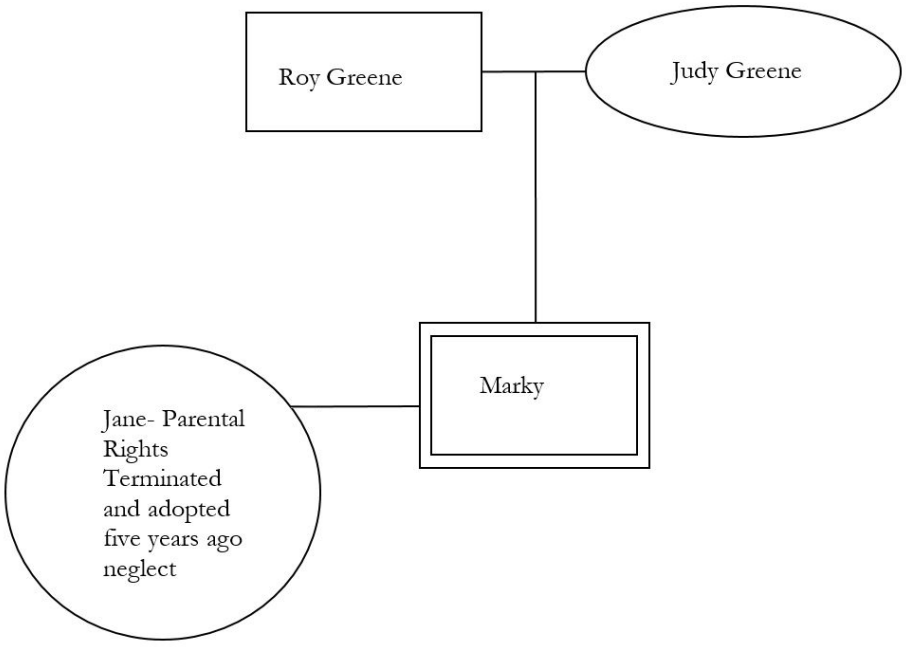
For the Father:

Psychological evaluation and counseling (if recommended)

For the Mother:

Psychological evaluation and treatment/counseling (if recommended)

Greene Family Genogram



Visiting an Agency by Taking Public Transportation Activity (Optional)

Many of the parents that you will work with do not have personal vehicles and must rely on public transportation when traveling to and from case-related appointments. It's helpful for you to experience public transportation first-hand to be able to understand these parents' experiences. We will ask you to share about your experience in a later class. You must complete this assignment by _____.

- The facilitator will either assign you an agency to visit or ask you to sign up for an agency.
- Take public transportation to the agency. You may catch transit from your home, the mall, or the local juvenile justice center.
- Once you arrive, sit and observe what's happening—who is in the room, how long they wait for services and how they are treated. Then introduce yourself as a CASA/GAL volunteer trainee and ask for a few copies of agency brochures and/or other pertinent information describing the agency and its services.
- Bring the brochures/information to the next training session to share with the class. The CASA/GAL program will keep them for reference.

At the next training session, you will share information about the agency you visited, your observations of their interactions with clients, any observations about the clients and your experience riding public transportation.

CASA
Court Appointed Special Advocates
FOR CHILDREN

THE NATIONAL COURT APPOINTED SPECIAL ADVOCATE ASSOCIATION

CASA/GAL Pre-Service Volunteer Training Curriculum

Pre-Work Handouts

CHAPTER FIVE

HEARST foundations

OJJDP

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Version 2, November 2017

CHAPTER 5

Pre-Work Handouts

CONTENTS

Pre-Work Instructions

This section details the work you need to complete before the classroom session. Completing this work before the session will allow you to fully participate during the training session and build the knowledge and skills you need to be an effective and successful CASA/GAL volunteer.

Prior to attending the fifth session of the volunteer training, please read through the Pre-Work handouts found in this document. Reading this information before the session will give you a foundation in substance abuse, substance abuse statistics, diversity, National CASA Vision Statement and Guiding Principles, disproportionality in the child welfare system, disproportionality statistics, cultural competency glossary terms, initial case notes for the Lavender case and sample court orders.

Substance Abuse—American Addiction Center

Definitions

Psychoactive substances, whether legal (alcohol and prescription medications) or illegal, impact and alter moods, emotions, thought processes and behavior. These substances are classified into different types (for example, stimulants, depressants, hallucinogens) based on the effects they have on the people who take them.

Substance abuse occurs when a person displays behavior harmful to self or others as a result of using the substance. This can happen with only one instance of use, but it generally builds over time, eventually leading to addiction. Addiction, also called chemical dependency, involves the following:

- Loss of control over the use of the substance
- Continued use despite adverse consequences
- Development of increasing tolerance to the substance
- Withdrawal symptoms when the drug use is reduced or stopped

Causes

There are different theories about how abuse/addiction starts and what causes substance abuse/dependency. According to the American Society of Addiction Medicine, substance-related disorders are biopsychosocial, meaning they are caused by a combination of biological, psychological and social factors.

It is important to remember that people suffering from abuse/addiction are not choosing to be in the situation they are in. Try to see those who are addicted as separate from their disease. In other words, you should consider them as "sick and trying to get well," not as "bad people who need to improve themselves." This will help you remember to be compassionate and nonjudgmental in your approach.

Treatment

The field of addiction treatment recognizes an individual's entire life situation. Treatment should be tailored to the needs of the individual and guided by an individualized treatment plan based on a comprehensive assessment of the affected person, as well as his/her family. Treatment can include a range of services depending on the severity of the addiction, from a basic referral to

Substance Abuse, Cont'd.

12-step programs to outpatient counseling, intensive outpatient/day-treatment programs and inpatient/ residential programs.

Treatment programs use several methods, including assessment; individual, group and family counseling; educational sessions; aftercare/continuing-care services; and referral to 12-step or Rational Recovery support groups. Recovery is a process, and relapse is part of the disease of addiction.

The process of recovery includes holding substance abusers accountable for what they do while using. While it is important to act in an empathetic manner toward people with addictions, they must be held accountable for their actions. For example, a mother who is successfully participating in treatment, may have to deal with her children being temporarily taken from her because of how poorly she cared for them when using. In most cases, successful recovery efforts can be rewarded.

Impact on Children

According to the Child Welfare League of America, "Parental addiction is a significant factor in child abuse and neglect cases, with studies suggesting 40% to 80% of families in the child welfare system are affected by addiction."

It is helpful to remember that children of parents with abuse/addiction problems still love their parents, even though the parents may have abused or neglected them. However, the volunteer must always consider the impact that substance abuse has on children.

Commonly Abused Drugs

The National Institute on Drug Abuse provides detailed information on commonly abused drugs. This information can be accessed at the following link:

https://www.drugabuse.gov/drugs-abuse/commonly-abused-drugs-charts

Substance Abuse Statistics

Quick Facts on Drug Addiction (American Addiction Centers)

- According to the National Survey on Drug Use and Health (NSDUH), 21.5 million American adults (aged 12 and older) battled a substance use disorder in 2014.
- Almost 80 percent of individuals suffering from a substance use disorder in 2014 struggled with an alcohol use disorder, NSDUH.
- Over 7 million Americans battled a drug use disorder in 2014, per NSDUH.
- One out of every eight people who suffered from a drug use disorder in 2014, according to NSUDH, struggled with both alcohol and drug use disorders simultaneously.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) published that in 2014, almost 8 million American adults battled both a mental health disorder and a substance use disorder, or co-occurring disorders.
- The Office on National Drug Control Policy (ONDCP) reports that drug abuse and addiction cost American society close to $200 billion in healthcare, criminal justice, legal and lost workplace production/ participation costs in 2007.
- The World Health Organization (WHO) estimates the global burden of disease related to drug and alcohol issues to be 5.4 percent worldwide.

Statistics on Specific Population Demographics and Addiction

Adolescents (aged 12-17):

- NSDUH reports that in 2014, approximately 5 percent of the American adolescent population suffered from a substance use disorder; this equates to 1.3 million teens, or 1 in every 12.
- Almost 700,000 American youths between ages 12 and 17 battled an alcohol use disorder in 2013, according to the National Institute on Alcohol Abuse and Alcoholism (NIAAA).
- An estimated 867,000 adolescents suffered from an illicit drug use disorder in 2014, which was a decline from previous years, according to NSDUH.

Substance Abuse Statistics, Cont'd.

- Individuals who tried marijuana or alcohol before the age of 15 were almost four times as likely to suffer from a marijuana use disorder as an adult than those who waited until after age 18 to try these substances, according to data published in the 2013 NSDUH.

Young adults aged 18-25:

- About one out of every six American young adults (between the ages of 18 and 25) battled a substance use disorder in 2014 according to NSDUH. This represents the highest percentage (16.3%) out of any age group.
- Heroin addiction among young adults between 18 and 25 years old has doubled in the past 10 years, according to AARP.
- In college students studied in 2010, the Treatment Episode Data Set (TEDS) found that alcohol was the number one substance this group received specialized treatment for. 72 percent of those admitted to public substance abuse programs, did so for an alcohol use disorder (marijuana was second at 55.7 percent and prescription drugs were third at 31.6 percent).

Over age 25:

- Approximately 14.5 million adults aged 26 or older struggled with a substance use disorder in 2014, according to NSUDH.
- College graduates, aged 26 or older, battled drug addiction at lower rates than those who did not graduate from high school or those who didn't finish college, according to data published in the 2013 NSDUH.

Elderly individuals:

- An estimated 15 percent of elderly individuals may suffer from problems with substance abuse and addiction, according to Today's Geriatric Medicine.
- Over 3 percent of the older adult population may struggle with an alcohol use disorder.

Substance Abuse Statistics, Cont'd.

- This generation takes more prescription drugs than younger ones, has lower metabolisms, potentially suffers from social isolation and ageism, may struggle with many medical issues, and therefore may be at a high risk for prescription drug abuse and dependence, according to Psychiatric Times.
- Two-thirds of the population over the age of 65 who struggle with alcohol addiction, battled an alcohol use disorder at a younger age and carried it with them as they aged.
- Between 21 and 66 percent of elderly individuals battling a substance use disorder also suffer from a co-occurring mental health disorder.

Men vs. women:

- In 2013, adult men in the United States struggled with an alcohol use disorder at rates double those of women, 10.8 million as compared to 5.8 million, according to NIAAA.
- For boys and girls between the ages of 12 and 17, both genders battled substance use disorders at similar rates, making it the only age bracket that men did not significantly outweigh women, according to the 2013 NSDUH.
- Close to 70 percent of treatment admissions for substance abuse in 2010 were male, according to TEDS.
- Men may be more likely to abuse illicit drugs than women, but women may be just as prone to addiction as men when they do abuse them, according to NIDA.

Ethnicity/race:

- The 2013 NSDUH reports that American Indians and Alaska natives had the highest rate of substance abuse and dependence at 14.3 percent.
- Approximately 11.3 percent of Native Hawaiians and other Pacific Islanders suffered from substance abuse and dependence in 2013, according to NSDUH.
- According to NSDUH, Hispanics and whites suffered from substance abuse and dependence at similar rates in 2013, around 8.5 percent, while about 7.4 percent of African Americans struggled with it.

Substance Abuse Statistics, Cont'd.

- Asians were the least likely to suffer from substance abuse and dependency with rates around 4.5 percent, per the 2013 NSDUH.
- A study of undergraduate college students, published in the Journal of Ethnicity in Substance Abuse, found that whites and Hispanics were more likely to have issues surrounding drug abuse than their Asian and African American counterparts.

Criminal justice/employment status:

- Almost twice as many people who are unemployed struggle with addiction than those who are full-time workers, CNN Money reports; around 17 percent of the unemployed and 9 percent of the employed population struggled with a substance use disorder in 2012.
- About half of the population of American prisons and jails suffer from addiction, according to NCAAD.
- Around three-quarters of individuals in a state prison or local jail who suffer from a mental illness also struggle with substance abuse, and the opposite is also true, according to the National Institute of Health (NIH).

Statistics on Addiction to Specific Substances

Cocaine:

- Over 900,000 American adults (over age 11) struggled with a cocaine use disorder in 2014, per NSDUH.
- In 2010, TEDS reported that 8 percent of all treatment admissions were for cocaine abuse or dependency issues.

Heroin:

- The American Society of Addiction Medicine (ASAM) reports that in 2015, approximately 586,000 Americans aged 12 and older struggled with a substance use disorder involving heroin.
- Almost a quarter of people who abuse heroin will become addicted to it, according to ASAM.

Substance Abuse Statistics, Cont'd.

- Over the past few years, heroin abuse and addiction have risen in all population and demographic groups in the United States, according to the Centers for Disease Control and Prevention (CDC).
- Individuals addicted to alcohol are two times more likely to also be addicted to heroin, while those addicted to marijuana are three times more likely. Individuals addicted to cocaine are 15 times more likely to also be addicted to heroin, and people addicted to prescription drugs are 40 times more likely, per the CDC.
- The highest at-risk population for heroin addiction, as reported by S. News, is non-Hispanic white males between the ages of 18 and 25 who live in large cities.
- According to the 2010 TEDS, almost three-fourths of individuals admitted to treatment for a heroin abuse or dependency concern, cited injection as the primary method of abuse.

Prescription drugs:

- Prescription drugs are abused at high rates. NSUDH reports that the most common types of psychotherapeutic drugs abused in 2013 were pain relievers, tranquilizers, stimulants and sedatives in that order. Pain relievers are the most common cause of a substance use disorder among prescription drugs.
- ASAM publishes that over 2 million Americans over the age of 11 struggled with an opioid pain reliever abuse disorder in 2014.
- ASAM also reports that women may more rapidly develop a prescription painkiller addiction than men.
- On average, according to studies published in the journal Substance Abuse Treatment, Prevention, and Policy, individuals who were admitted to opioid treatment programs who abused only prescription opioids, or those who abused both heroin and prescription opioids, were about five years younger than individuals admitted solely for heroin abuse or dependency.

Substance Abuse Statistics, Cont'd.

Marijuana:

- Almost 6 percent of full-time college students in the United States smoked marijuana daily in 2014, NIDA publishes; this is more than triple the number of daily smokers 20 years prior.
- Approximately 4.2 million American adults (over the age of 11) battled a marijuana use disorder in 2014, according to NSDUH.
- The majority of people struggling with marijuana addiction in 2014 were between the ages of 12 and 25, according to NSDUH.
- TEDS reported that marijuana use disorders accounted for the third highest number of treatment admissions (at 18 percent) to substance abuse programs in 2010.

Alcohol:

- According to NCADD, alcohol is the most abused addictive substance in America.
- In 2013, an estimated 16.6 million American adults (18 and older) battled an alcohol use disorder, according to NIAAA.

In 2010, TEDS published that 41 percent of all substance abuse treatment admissions were for alcohol.

- The Center for Behavioral Health Statistics and Quality (CBHSQ) reported that in 2010, among American military veterans between the ages of 21 and 39, who admitted to substance abuse treatment programs, more than half cited alcohol as the primary substance of concern.
- Over half of all American adults have a personal family history of problem drinking or alcohol addiction, according to NCADD.

Diversity

National CASA Vision Statement and Guiding Principles

As a general term "diversity" refers to difference or variety. In the context of CASA/GAL volunteer work, "diversity" refers to differences or variety in people's identities or experiences: ethnicity, race, national origin, language, gender, religion, ability, sexual orientation, socioeconomic class and so on. The term "cultural competence" refers to the ability to work effectively with people from a broad range of backgrounds, experiences and viewpoints.

The United States is becoming increasingly multicultural. According to the 2010 US Census, approximately 36.3% of the population currently belongs to a racial or ethnic minority group. The Census Bureau projects that by the year 2100, non-Hispanic whites will make up only 40% of the US population. As you work through the activities in this chapter, keep in mind the particular cultural groups you will work with as a CASA/GAL volunteer. Keep in mind that "culture" is not limited to race and ethnicity. According to the Pew Research Center, Americans are more racially and ethnically diverse than in the past, and the U.S. is projected to be even more diverse in the coming decades. By 2055, the United States will not have a single racial or ethnic majority. Time Magazine reports that the country's minority population increased from 32.9% of U.S. residents in 2004 to 37.9% in 2014, according to the Census, and four states—Hawaii, California, New Mexico and Texas—along with Washington, D.C., are now majority-minority. As you work through the activities in this chapter, keep in mind the particular cultural groups you will work with as a CASA/GAL volunteer. Keep in mind that "culture" is not limited to race and ethnicity.

Understanding issues related to diversity and culturally competent child advocacy is critical to your work as a CASA/GAL volunteer. It can enhance your ability to see things from new and different perspectives and to respond to each child's unique needs. Developing cultural competence is a lifelong process.

National CASA Association Vision

The National Court Appointed Special Advocate Association "stands up" for abused and neglected children. Building on our legacy of quality advocacy, we acknowledge the need to understand, respect and celebrate diversity, including race, gender, religion, national origin, ethnicity, sexual orientation, socioeconomic status, and the presence of a sensory, mental or physical

Diversity, Cont'd.

disability. We also value diversity of viewpoints, life experiences, talents and ideas.

A diverse CASA/GAL network helps us to better understand and promote the well-being of the children we serve. Embracing diversity makes us better advocates by providing fresh ideas and perspectives for problem solving in our multicultural world, enabling us to respond to each child's unique needs.

Guiding Principles for Achieving a Diverse CASA/GAL Network

1. Ethnic and cultural background influences an individual's attitudes, beliefs, values and behaviors.
2. Each family's characteristics reflect adaptations to its primary culture and the majority culture, the family's unique environment and the composite of the people and needs within it.
3. A child can be best served by a CASA/GAL volunteer who is culturally competent and who has personal experience and work experience in the child's own culture(s).
4. To understand a child, a person should understand cultural differences and the impact they have on family dynamics.
5. No cultural group is homogeneous; within every group there is great diversity.
6. Families have similarities yet are all unique.
7. In order to be culturally sensitive to another person or group, it is necessary to evaluate how each person's culture impacts his/her behavior.
8. As a person learns about the characteristic traits of another cultural group, he/she should remember to view each person as an individual.
9. Most people like to feel that they have compassion for others and that there are new things they can learn.
10. Value judgments should not be made about another person's culture.
11. It is in the best interest of children to have volunteers who reflect the characteristics (i.e., ethnicity, national origin, race, gender, religion, sexual orientation, physical ability and socioeconomic status) of the population served.

Disproportionality in the Child Welfare System

Disproportionality is the experience of overrepresentation or underrepresentation of various groups in different social, political or economic institutions. For example, women in the United States are overrepresented as single heads of household, and African Americans and Latinos are overrepresented in the US prison population.

There is no difference between races in the likelihood that a parent will abuse or neglect a child, but there is a great difference between races in the likelihood that a child will be removed from home and placed in foster care. Most statistics show that African American children, American Indian and Native Alaskan children, and children of two or more races are overrepresented in the system.

Disproportionality Statistics

Though African American children make up 14% of the child population, they constitute 28% of the children in foster care. American Indian children make up 1% of the child population and 2% of the foster care population. Children with more than one race make up 6% of the child population and 7% of the foster care population. This imbalance is referred to as disproportionality.

Adoption and Foster Care Analysis Reporting (AFCARS) 2011.

Race has been identified as a primary determinant for decision making in five out of six stages in child protective services: reporting, investigation, substantiation, placement and exit from care.

R.B. Hill, Synthesis of Research on Disproportionality in Child Welfare: An Update and National Study of Protective, Preventive and Reunification Services Delivered to Youth and Their Families.

Children of color make up almost two-thirds of the children in the foster care system, although they constitute just over one-third of the child population in the US.

W.K. Kellogg Foundation, Families for Kids Project, www.wkkf.org.

Disproportionality Statistics, Cont'd.

The number of white children entering foster care in a given year is greater than the number of African American children. Yet, African American children make up a disproportionate, and increasing, share of those who remain.

Adoption and Foster Care Analysis and Reporting System (AFCARS).

Although the length of time in foster care for African American children has declined considerably from FY 2000 to FY 2012 (40.6 months to 29.0 months), the average length of stay in foster care is still higher than that percentage for white children (18.3 months).

Adoption and Foster Care Analysis Reporting (AFCARS) 2013 Data Brief.

Research revealed that with all factors the same, African American and Hispanic Latino children are placed in foster care at a higher rate than whites. Poverty is a factor; however, research also reveals there are deeply embedded stereotypes about Black family dysfunction. Instead of being referred to foster care, 72% of Caucasian children receive services in their own homes. Just 40% of Hispanic children and 44% of African-American children receive in-home services in lieu of removal.

Child Welfare Information Gateway, National Study of Protective, Preventive and Reunification Services Delivered to Youth and Their Families.

Children of color experience a higher number of placements than white children, and they are less likely to be reunified with their birth families.

Casey Family Programs, www.casey.org.

Disproportionality Statistics, Cont'd.

The National Incidence Study found race differences in maltreatment rates, with African American children experiencing maltreatment at higher rates than white children. Maltreatment rates have likely never been comparable for African American and white children due to the gap between African American and white children in economic well-being. Income, or socioeconomic status, is the strongest predictor of maltreatment rates and incomes of African American families have not kept pace with the incomes of white families. These findings imply that nearly all the multi-factor findings on the interaction of race and social economic status arise not because Black children in not-low SES households are at greater risk for maltreatment because they are Black; they are at greater risk because they are poorer than the White children in similar households.

National Incidence Study of Child Abuse and Neglect (NIS-4), 2004–2009.

Cultural Competence Glossary

Developing a working vocabulary related to issues of diversity can help you communicate more effectively with other people and examine what more you have to learn.

Ableism: Discrimination or prejudice based on a limitation, difference or impairment in physical, mental or sensory capacity or ability

Afrocentric: Emphasizing or promoting emphasis on African culture and the contributions of Africans to the development of Western civilization

Ageism: Discrimination or prejudice based on age, particularly aimed at the elderly

Bias: A personal judgment, especially one that is unreasoned or unfair

Biracial: Of two races; usually describing a person having parents of different races

Classism: Discrimination or prejudice based on socioeconomic status

Cultural Dominance: The pervasiveness of one set of traditions, norms, customs, literature, art and institutions, to the exclusion of all others

Cultural Competence: The ability to work effectively with people from a variety of cultures, ethnicities, races, religions, classes, sexual orientations and genders

Cultural Group: A group of people who consciously or unconsciously share identifiable values, norms, symbols and some ways of living that are repeated and transmitted from one generation to another

Cultural Sensitivity: An awareness of the nuances of one's own and other cultures

Culturally Appropriate: Demonstrating both sensitivity to cultural differences and similarities and effectiveness in communicating a message within and across cultures

Culture: The shared values, traditions, norms, customs, arts, history, folklore and institutions of a group of people who are unified by race, ethnicity, language, nationality, sexual orientation and/or religion

Cultural Competence Glossary, Cont'd.

Disability: A limitation, difference, or impairment in a person's physical, mental or sensory capacity or ability

Note: It is preferable to use people-first language—that is, language that puts the person before the disability. For example, the phrase "people with disabilities" is preferred over "the disabled."

Discrimination: An act of prejudice or a manner of treating individuals differently due to their appearance, status or membership in a particular group

Disproportionality: Overrepresentation or underrepresentation of various groups in different social, political or economic institutions

Dominant Group/Culture: The "mainstream" culture in a society, consisting of the people who hold the power and influence

Ethnicity: The classification of a group of people who share common characteristics, such as language, race, tribe or national origin

Ethnocentrism: The attitude that one's own cultural group is superior

Gender: A social or cultural category generally assigned based on a person's biological sex

Gender Identity: A person's innate, deeply felt psychological identification as a man or woman, which may or may not correspond to the gender assigned to them at birth (some individuals identify as neither male nor female as our society generally understands these terms, and instead identify as a third or other gender)

Heterosexism: An ideological system that denies, denigrates and stigmatizes any non-heterosexual form of behavior, identity or relationship

Homophobia: Fear of, aversion to, or discrimination against homosexuality, homosexuals or same-sex relationships

Institutional Racism: Biased policies and practices within an organization or system that disadvantage people of a certain race or ethnicity

LGBTQ: Lesbian, Gay, Bisexual, Transgender, Questioning/Queer

Language: The form or pattern of communication—spoken, written or signed—used by residents or descendants of a particular nation or geographic area or by any group of people. Language can be formal or informal and includes dialect, idiomatic speech and slang.

Cultural Competence Glossary, Cont'd.

Minority: The smaller in number of at least two groups; can imply a lesser status or influence and can be seen as an antonym for the words “majority” and “dominant”

Multicultural: Designed for or pertaining to two or more distinct cultures

Multiracial: Describing a person, community, organization, etc., composed of many races

National Origin: The country or region where a person was born

Person of Color: A term used primarily in the United States to describe any person who does not identify as white

Prejudice: Over-generalized, oversimplified or exaggerated beliefs associated with a category or group of people, which are not changed, even in the face of contrary evidence

Questioning: A term that can refer to an identity, or a process of introspection, whereby one learns about their own sexual orientation and/or gender identity

Race: A socially defined population characterized by distinguishable physical characteristics, usually skin color

Racism: The belief that some racial groups are inherently superior or inferior to others; discrimination, prejudice or a system of advantage and/or oppression based on race

Sexism: Discrimination or prejudice based on gender or gender identity

Sexual Orientation: The culturally defined set of meanings through which people describe their sexual attractions. Sexual orientation is not static and can shift over time. Sexual orientation has at least three (3) parts:

a. **Attraction**: One’s own feelings or self-perception about to which gender(s) one feels drawn; can be sexual, emotional, spiritual, psychological and/or political
b. **Behavior**: What one does sexually and/or with whom
c. **Sexual Identity**: The language and terms one uses to refer to their sexual orientation, which may or may not be based on either of the above and can also be influenced by family, culture and community

Cultural Competence Glossary, Cont'd.

Heterosexual: A person who is primarily or exclusively attracted to people of a different sex romantically, affectionately and sexually; sometimes referred to as straight

Homosexual: A term used to refer to a person based on his or her same-sex sexual orientation, identity or behavior (many LGBTQ people prefer not to use this term because of its historically negative use by the medical establishment)

Bisexual: Attracted to either gender

Socioeconomic Status: Individuals' economic class (e.g., poor, working-class, middle-class, wealthy) or position in society based on their financial situation or background

Stereotype: A highly simplified conception or belief about a person, place or thing, based on limited information

Transgender: An umbrella term for people whose gender identity or expression is different from those typically associated with the sex assigned to them at birth (e.g., the sex listed on their birth certificate)

Values: What a person believes to be important and accepts as an integral part of who he/she is

Xenophobia: A fear of all that is foreign, or a fear of people believed to be "foreigners"

Initial Case Notes for the Lavender Case

CPS Case File

Last Name of Case:	**Lavender Bass**
Legal Number(s):	**1-30-275645-3**

Child(ren)'s Name	DOB	Age	Ethnicity	Sex	Current Location
Lavender Bass	October 8	6 years	Unknown	F	Foster Placement Bonnie Matthews

Current Placement	Address	Phone
Foster Parents: Bonnie Matthews	52 Greylock Rd.	555-5874

Attorneys for	Attorneys	Phone Numbers
Mother	Sara Johnson	555-6498
Father	Fred Thompson	555-6644
CPS	Lisa Kelly	555-6298

Case History

Three weeks ago: Child, Lavender Bass, age 6, came into care following a complaint made by her paternal grandmother. On her tip, the CPS investigator located the mother and child behind the bar where mother is employed. Mother, Susan Mailer, was passed out drunk sleeping in her parked car. Lavender was sitting in the shade of a nearby tree waiting for her mom to wake up and take her home. The police were called and mother arrested for public drunkenness.

Susan and Lavender reside with Susan's mother, Rebecca Mailer; her sister, Leah Mailer; and Leah's children. Because no one in the home was available the day of the arrest, Lavender was placed in foster care with Bonnie Matthews.

The CPS investigator found that Susan Mailer's criminal record reflected a tendency toward violence; she'd been in a couple of physical fights in the bar where she's employed. She's also been arrested for dealing marijuana and was once caught huffing inhalants when police busted a party.

Your First Interview with CPS Worker

You arrange to meet with Lisa Kelly, the CPS worker, to discuss this case and review the file. She's a cheerful young woman, new to the agency and full of enthusiasm for her task—saving the world from itself. Lisa shows you the paperwork for the Lavender Bass case. Lavender's paternal grandmother made the initial report, complaining that the child's mother wasn't looking after her and tipping CPS about where to find them. Paternal grandmother adamantly stated that she does not want to be involved in the case, "so please don't call her." You take her number down anyway. The mother was arrested and kept in jail overnight. Lavender and her mother live with Rebecca Mailer, maternal grandmother; Leah Mailer, maternal aunt; and Leah's children. The CPS investigator substantiated the case, took Lavender into care and gave the case to Lisa, who hasn't met the mother yet.

Court History

You are preparing for the combined Adjudication/Disposition Hearing.

Sample Court Reports

Example 1

John Bass (alleged father) is in the county jail approximately 100 miles from the foster placement. He was busted for pot. Admittedly, he has a history of using inhalants. According to Mr. Bass, he was not with Ms. Mailer very long but claims Lavender is his child. He has never been a father to Lavender. Mr. Bass claims that he is Native American and Lavender is too. He claims he is of a mixed background and the Mailers are not from his tribe. He has had limited contact with Lavender throughout her life, stating Ms. Mailer would not give him "the time of day."

Example 2

Lavender Bass (child): Six year-old Lavender Bass has been in foster care for about three weeks and is not adjusting well. Lavender spends a lot of time in the yard and is not very engaged. Lavender sometimes ignores the foster mother and doesn't listen to her when she is talking. The foster mother states she has to call her time after time to get her attention. This is not the best foster placement for Lavender. According to the foster mother, she had never attended school and this is her first time in a "real school." Lavender seems on target developmentally. She is washing and dressing herself and keeping up with her school work. The child could be Native American and this will need to be investigated.

Example 3

Susan Mailer (biological mother) has a history of drug abuse and violent behavior. Three weeks ago, CPS found her passed out in her car from alcohol. A criminal records check confirmed Ms. Mailer has a tendency toward violent behavior. Ms. Mailer did not show up for court during the preliminary hearing and the CPS worker continues to leave messages via the telephone. CASA/GAL volunteer is able to reach mother via telephone. Ms. Mailer acknowledges that she works at a bar and sometimes takes Lavender to work with her. She states she likes to party from time to time with alcohol and drugs. She has had no visits with her child since she was taken into foster care. According to Ms. Mailer's sister, Ms. Mailer is working long hours and makes good money. CASA/GAL volunteer feels like drugs are being done at the home of the maternal aunt and grandmother. The children are also fearful of the aunt and grandmother.

CASA
Court Appointed Special Advocates
FOR CHILDREN

THE NATIONAL COURT APPOINTED SPECIAL ADVOCATE ASSOCIATION

CASA/GAL Pre-Service Volunteer Training Curriculum

Pre-Work Handouts

CHAPTER SIX

HEARST foundations

OJJDP

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Version 2, November 2017

CHAPTER 6

Pre-Work Handouts

CONTENTS

Pre-Work Instructions

This section details the work you need to complete before the next classroom session. Completing this work prior to the session will allow you to fully participate during the training session and build the knowledge and skills you need to be an effective and successful CASA/GAL volunteer.

Please read through the Pre-Work handouts found in this document. Reading this information prior to the session will give you a foundation in several concepts covered in the chapter, including: domestic violence, cultural prejudices, preconceived notions and the impact of these perceptions on information disclosure to volunteers by the accused in cases, importance of practicing culturally competent child advocacy, risks associated with stereotyping and implications of institutional bias. You will also have hands-on practice activities that explore culture and perceptions, culturally competent child advocacy, and an individual action plan designed to increase your cultural competence.

Understanding Domestic Violence

Domestic violence is the willful intimidation, physical assault, battery, sexual assault and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another. It includes physical violence, sexual violence, psychological violence and emotional abuse. The frequency and severity of domestic violence can vary dramatically; however, the one constant component of domestic violence is one partner's consistent efforts to maintain power and control over the other.

Domestic violence ranges from threats of violence to hitting to severe beating, rape and even murder. Victims and perpetrators range in age, racial, socioeconomic status, sexual orientation, education level, occupational attainment, and geographic and religious affiliation. Abuse by men against women is by far the most common form, but domestic violence does occur in same-sex relationships, and some women do abuse men.

The Power & Control Wheel…

Abusive relationships are based on the mistaken belief that one person has the right to control another. When the actions described in the spokes of this wheel don't work, the person in power moves on to actual physical and sexual violence. The relationship is based on the exercise of power to gain and maintain control. The dignity of both partners is stripped away.

Adapted from a model developed by the Domestic Abuse Intervention Project, Duluth, Minnesota.

Understanding Domestic Violence, Cont'd.

Causes

Domestic violence is not caused by illness, genetics, gender, alcohol or other drugs, anger, stress, the victim's behavior or relationship problems. However, such factors may play a role in the complex web of factors that result in domestic violence. Domestic violence is learned behavior; it is a choice. It is learned through observation, experience and reinforcement (perpetrators perceive that it works). It is learned in the family, in society and in the media.

Legal System Response

The legal system can respond to domestic violence as a violation of criminal and/or civil law. While definitions and procedures differ from one state to another, physical assault is illegal in all states. Law enforcement can press charges in criminal court with the victim as a witness. Victims may also secure a restraining/protective order and, in rare instances, may bring a civil lawsuit.

Availability and willingness of court personnel to act in domestic violence cases vary widely. Unless judges and attorneys, including prosecutors, have been educated about the dynamics of domestic violence, protective laws are inconsistently enforced. The repeated pattern of the abused spouse bringing charges and subsequently dropping them, often discourages law enforcement personnel from giving these cases their immediate attention. Thus, the victim is re-victimized.

The other setting in which the legal system and domestic violence may intersect is a court hearing regarding allegations of child abuse and/or neglect. As a CASA/GAL volunteer, you should be aware that a determination of domestic violence within the child's home will significantly influence placement decisions and what is expected of the non-abusing parent to retain/regain custody. The standard risk assessment, conducted by child welfare agencies to evaluate whether a child needs to be removed from his/her home, generally includes domestic violence as a factor that negatively relates to the child's safety at home. A child found to be living in a violent home is more likely to be removed. A child abuse or neglect case may also be substantiated against the battered parent for "failure to protect" the child because the victim did not leave the batterer, even if the victim lacked the resources to do so or it was not safe to do so.

Understanding Domestic Violence, Cont'd.

Barriers to Leaving a Violent Relationship

For people who have not experienced domestic violence, it is hard to understand why the victim stays—or returns again and again to reenter the cycle of violence. The primary reason given by victims for staying with their abusers is fear of continued violence and the lack of real options to be safe with their children. This fear of violence is real; domestic violence usually escalates when victims leave their relationships. In addition to fear, the lack of shelter, protection and support creates barriers to leaving. Other barriers include lack of employment and legal assistance, immobilization by psychological or physical trauma, cultural/religious/family values, hope or belief in the perpetrator's promises to change and the message from others (police, friends, family, counselors, etc.) that the violence is the victim's fault and that she could stop the abuse by simply complying with her abuser's demands. Leaving a violent relationship is often a process that takes place over time, as the victim can access resources she needs. The victim may leave temporarily many times before making a final separation.

Adapted from Domestic Violence: A National Curriculum for Children's Protective Services,

Anne Ganley and Susan Schechter, Family Violence Prevention Fund.

Domestic Violence Statistics

Read the statistics on domestic violence at:

http://nc.casaforchildren.org/files/secure/community/programs/Training/2016%20Pilot/Domestic%20Violence%20Statistics.PDF

Sorting People Activity

In the Online Resources, click the link to the exercise called “Sorting People: Can You Tell Somebody’s Race by Looking at Them?”. Follow the instructions to complete the activity, and then consider the following questions:

- How did you do?
- What surprised you about the exercise?
- Think about the cases you’ve worked on so far. Did you observe any stereotyping in the Black, Bleux, Greene or Lavender cases? If so, how did it affect the families?

Exploring Culture and Perceptions Activity

For each of the categories from the list below, think about your culture and life experiences, and how you would describe yourself, your family of origin or your current family situation to someone you know well. After you have some thoughts in mind, consider the following questions:

- Are there categories that you would be uncomfortable sharing in front of the large group?
- What contributes to your feelings of safety when you are asked to disclose personal information?
    - Race
    - Family Form (single parent, married with no children, etc.)
    - Ethnicity (cultural description or country of origin)
    - Gender
    - Geographic Identity (rural, urban; in the US, eastern, Midwestern, etc.)
    - Age
    - Sexual Orientation
    - Religion or Spirituality
    - Language
    - Disabilities
    - Socioeconomic Status (low-income, working-class, middle-class, wealthy)

Now imagine that you are Susan Mailer, the mother in the Lavender case, and you are describing yourself to someone who has power over your life—for instance, the caseworker, a judge, or an attorney. Answer the following questions:

- How do you think a caseworker or others might perceive you and what would be the implications?
- When you describe yourself to this person, what might you leave out or try to make fit what you think might be more acceptable to them? Why?
- If you had to do this often, what do you think would happen to these characteristics of yourself?

Stereotyping vs. Cultural Competence

Stereotypes based on appearances can impact how a volunteer approaches and builds relationships with families and children. Stereotypes are rigid and inflexible. Stereotypes hold even when a person is presented with evidence contrary to the stereotype. Stereotypes are harmful because they limit people's potential, perpetuate myths and are gross generalizations about a particular group.

For instance, a person might believe that people who wear large, baggy clothes shoplift. Because some teenagers wear large, baggy jackets, this person may assume that teenagers shoplift. Such stereotypes can adversely affect a volunteer's interactions with children and others in the community. Even stereotypes that include "positive" elements (e.g., "they" are quite industrious) can be harmful because the stereotypes are rigid, limiting and generalized.

Unlike stereotyping, cultural competence can be compared to making an educated hypothesis. An educated hypothesis contains what you understand about cultural norms and the social, political and historical experiences of the children and families you work with. You might hypothesize, for example, that a Jewish family is not available for a meeting on Yom Kippur, or that they would not want to eat pork. However, you recognize and allow for individual differences in the expression and experience of a culture; for instance, some Jewish people eat pork and are still closely tied to their Jewish faith or heritage. Another example might be that some African American families celebrate Kwanzaa, while others do not.

As an advocate, you need to examine your biases and recognize that they are based on your own life and do not usually reflect what is true for the stereotyped groups. Everyone has certain biases. Everyone stereotypes from time to time. Developing cultural competence is an ongoing process of recognizing and overcoming these biases by thinking flexibly and finding sources of information about those who are different from you. Being aware of differences allows you to be informed about culturally competent child advocacy.

It is important to recognize that child-rearing practices vary across cultures. For instance, the following mainstream US child-rearing practices may be viewed as harmful to children by people from other countries: isolating children in beds or rooms of their own at night, making children wait for food when they are hungry, requiring children to wear painful braces on their teeth, forcing young children to sit in a classroom all day or allowing infants to "cry it out."

Stereotyping vs. Cultural Competence, Cont'd.

Conversely, practices that are culturally acceptable elsewhere may be misunderstood in the United States. One example is the Southeast Asian practice of "coin rubbing," a traditional curing method in which heated metal coins are pressed on a child's body. This practice is believed to reduce fevers, chills and headaches. Because it generally leaves red streaks or bruises, it can easily be misdiagnosed as child abuse by those who don't understand the intention behind this cultural practice.

Practicing culturally competent child advocacy entails being aware and respectful of the cultural norms, values, traditions and parenting styles of those with whom you work. Striving to be culturally competent means cultivating an open mind and new skills and meeting people where they are, rather than making them conform to your standards. Each child and each family is made up of a combination of cultural, familial and personal traits. In working with families, you need to learn about an individual's or family's culture. When in doubt, ask the people you are working with. It might feel awkward at first, but learning how to ask questions respectfully is a vital skill to develop as you grow in cultural competence. Once people understand that you sincerely want to learn and be respectful, they are usually very generous with their help.

10 Benefits of Practicing Culturally Competent Child Advocacy

1. Ensures that case issues are viewed from the cultural perspective of the child and/or family:
   - Considers cultural norms, practices, traditions, intra-familial relationships, roles, kinship ties and other culturally appropriate values
   - Advocates for demonstrated sensitivity to this cultural perspective on the part of caseworkers, service providers, caregivers or others involved with the child and family
2. Ensures that the child's long-term needs are viewed from a culturally appropriate perspective
   - Takes into account the child's need to develop and maintain a positive self-image and cultural heritage
   - Takes into account the child's need to positively identify and interact with others from his/her cultural background
3. Prevents cultural practices from being mistaken for child maltreatment or family dysfunction
4. Assists with identifying when parents are truly not complying with a court order and when the problem is culturally inappropriate or a result of non-inclusive service delivery
5. Contributes to more accurate assessment of the child's welfare, family system, available support systems, placement needs, service needs and delivery
6. Decreases cross-cultural communication clashes and opportunities for misunderstandings
7. Allows the family to utilize culturally appropriate solutions for problem solving
8. Encourages participation of family members in seeking assistance or support
9. Recognizes, appreciates and incorporates cultural differences in ways that promote cooperation
10. Allows all participants to be heard objectively

Adapted from a document created by CASA for Children, Inc., Portland, Oregon.

Institutional Bias Checklist for Volunteers

As a CASA/GAL volunteer, ask yourself:

- What assumptions have I made about the cultural identity, genders and background of this family?
- What is my understanding of this family's unique culture and circumstances?
- How are my recommendations specific to this child and this family?
- Would I make the same recommendations if this were a white child or a white family versus an African American, Latino, Asian American or Native child or family?
- What evidence has supported the conclusions I have drawn and how have I challenged unsupported assumptions?
- Have reasonable efforts (or active efforts in ICWA cases) been made in an individualized way to match the needs of the family?
- Have relatives been fully explored as preferred placement options as long as they can protect the child and support the permanency plan?
- Are there family members and/or other important people who have not been contacted who should be involved in this process?
- What services are being offered to allow the child to remain at home or reunify the family (as applicable)? Are these services culturally appropriate? How are these services related to the safety threat?
- Are this child and family receiving the same level and tailoring of services as other children and families?

Other things to consider:

- If applicable, has Special Immigration Juvenile Status (SIJ) been filed?
- If applicable, have individualized efforts been made to ensure the needs and safety of LGBTQ youth?
- Have all resources available to the family of the child been explored (military, federal, tribal, state/local, etc.)?
- Are there organizations in the community that might serve as resources for the child?
- What active efforts have been made to determine if the child is covered under the Indian Child Welfare Act? Has there been communication with the relevant tribe(s)? If not, has the Bureau of Indian Affairs been notified?

Adapted from material created by the National Council of Juvenile and Family Court Judges.

Culturally Competent Child Advocacy Activity

Think about a time when you felt categorized because of the way you identify yourself, and write responses to the following reflection questions. How did you feel? How would a foster child feel?

Think of concrete ways to incorporate culturally competent advocacy into the Lavender case. Referring to the article on 10 Benefits of Practicing Culturally Competent Child Advocacy, what are three (3) things a CASA/GAL volunteer could do to practice culturally competent advocacy in the Lavender case? Some examples are:

- Learning about the spiritual practices of Lavender's family in order to address the caseworker's potential assumptions about the smell in their house
- Educating yourself about Lavender's family's culture regarding adult-child relationships so that the lack of eye contact between adults and children isn't misconstrued as a child safety issue or family dysfunction
- Informing yourself about the requirements of the Indian Child Welfare Act and how it applies to the case; verifying whether or not Lavender and her mom are enrolled in a tribe; informing the tribe about the case
- Recognizing the importance of cultural ties
- Understanding the role of extended family in Lavender's culture
- Objectively assessing the safety of Lavender's home situation

Tips on How to Become More Culturally Competent

- Learn about your culture and values, focusing on how they inform your attitudes, behavior and verbal and nonverbal communication.
- Don't think that "good" and "right" values exist in your own culture exclusively; acknowledge that the beliefs and practices of other cultures are just as valid.
- Question your cultural assumptions: Check their reality, rather than immediately acting on them.
- Accept cultures different from your own and understand that those differences can be learned.
- Learn to contrast other cultures and values with your own.
- Learn to assess whether differences of opinion are based on style (communication, learning or conflict) or substance (issue).
- Practice the communication loop; don't rely on your perceptions of what is being said.
- Examine the circle in which you live, work, and play (this reflects your choice of peers). Expand your circle to include people of other races, cultures, values, and beliefs.
- Learn more about the history of racism and oppression in the United States.
- Continue to read and learn about other cultures. Do your homework: Know something about another culture group prior to approaching them.
  - Follow appropriate protocol: Know and demonstrate respectful behavior based on the values of the group.
  - Use collaborative networks—churches, synagogues, mosques and other spiritual groups, community organizations or other natural support groups of that culture.
  - Practice respect.
- Understand that any change or new learning experience can be challenging, unsettling and tiresome; give yourself a break and allow for mistakes.
- Remember the reciprocal nature of relationships—give something back.
- See developing cultural competence as a fulfilling and resourceful way to live.
- Be courageous enough to address biased thinking when you hear it in others.

Adapted from materials developed by CASA for Children, Inc., Portland, Oregon.

Individual Action Plan for Cultural Competence

Prepare a plan to become more culturally competent. Use the following format to create the plan.

Name _____

Date _____

Specific: Write a very specific goal that clearly defines what you are going to do to improve your cultural competence skills.

Measurable: Identify how you will measure your progress. (How will you know when you have achieved your goal? Will something look different? Will you receive certain types of feedback?)

Attainable: Is this goal within your reach? The goal should stretch you slightly so you feel challenged, but it should be realistic and within your ability to achieve.

Realistic: Identify personal strengths or favorable factors in your environment that will support your progress.

Timely: Set a deadline by which you will accomplish this plan of action.

Benefits: What are the benefits (for you, for others) of setting and accomplishing this goal?

_____

Signature/Date

Initial Case Notes for the Amarillo Case

CPS Case File

Last Name of Case:	**Amarillo**
Legal Number(s):	**11-7-012345-6**

Child(ren)'s Name	DOB	Age	Ethnicity	Sex	Current Location
Maria Amarillo	May 18	16 years	Hisp	F	Foster Care Placement Stanley & Karen Becker
Joanna Amarillo	Sept 1	6 years	Hisp	F	Same
Graciela Amarillo	Aug 19	4 years	Hisp	F	Same

Current Placement	Address	Phone
Foster Parents: Stanley & Karen Becker	406 N. Dale Street	555-5874

Attorneys for	Attorneys	Phone Numbers
Mother	Jody Franken	555-9894
Father	Mary Holzer	555-1337
CPS	Jordan Myers	555-7344

Case History

July 3 (three years ago): Neighbor called police as a result of “loud shouting” in the home of Jose and Myrian Amarillo. Police found three children on the scene (Maria, age 13; Joanna, age 3; Graciela, age 1) and removed the children from the home based upon evidence at the scene including parents too inebriated to provide a safe home for their children and mother’s bruises and bleeding as a result of a fight between her and her husband. CPS was notified and the children were placed together in emergency foster care.

July 6 (three years ago): Following an emergency shelter care hearing, the Amarillo children were placed in three separate placements. Joanna and Graciela were each placed in separate foster homes, and Maria was placed in a group home for girls. The Amarillo parents and Maria are all undocumented citizens. The youngest siblings were born in the United States and have full citizenship.

September 17 (three years ago): Following a dispositional hearing, parents were ordered to receive drug/alcohol screening, attend a substance abuse treatment program and provide random urine analysis. Mr. Amarillo was ordered to attend a domestic violence program. Mrs. Amarillo was ordered to attend a domestic violence survivors program. Joanna was placed in the same foster home placement as Graciela. Maria remained in group home placement.

November 20 (three years ago): Group home of Maria Amarillo reported Maria ran away on 11/9. Maria has not been in contact with group home or social worker. Parents have reported that they received several calls from Maria but would not disclose her location.

November 27 (three years ago): Maria returned to the group home but was expelled for violating group home policies. Maria was placed in a short-term foster home.

January 8 (two years ago): Following a review hearing, it was ruled that parents have made no progress toward completing court-ordered services. Children will remain in out-of-home placement. A maternal aunt in El Salvador has come forward as a potential placement for the two younger siblings. Maria has been moved from a short-term foster home to a long-term placement.

March 6 (two years ago): Maria called social worker to complain of verbal and physical abuse by foster family. Social worker visited foster home the same evening

Case History, Cont'd.

and interviewed the foster parents and children in the home. Maria was unavailable to talk (drama practice at school). Social worker found no evidence of physical abuse.

March 13 (two years ago): Foster family of Maria Amarillo reported that she did not return home after school.

March 17 (two years ago): County General Hospital called CPS to report Maria Amarillo had been admitted after a 911 call from the home of a friend. Maria was admitted following a severe asthma attack. Social worker visited hospital and found that Maria had been staying with maternal relatives, Pedro and Anna Valdez. Maria has inquired as to the feasibility of placement with the Valdez family.

March 29 (two years ago): Foster family of Maria Amarillo has asked for her to be removed from their home after a second episode of running away.

April 4 (two years ago): Foster family of Joanna and Graciela Amarillo have asked for a new foster placement because they are expecting a baby of their own.

May 3 (two years ago): Following a review hearing, Joanna and Graciela Amarillo have been placed in a new foster setting. Foster family has acknowledged a willingness to serve as a placement for Maria Amarillo. Maria Amarillo has been transitioned from her previous foster placement into a transitional housing center for teenage girls. Parents were ruled to be out of compliance with court-ordered services. The department has filed a petition to terminate parental rights.

July 17 (two years ago): The department studied the feasibility of placement with kinship relatives, the Valdez family, and it was determined this would not be an appropriate placement due to their immigration status (undocumented), the number of people currently residing in their home and their reported level of income.

August 9 (two years ago): Parental rights were terminated.

September 26 (two years ago): Maria Amarillo was placed in the same foster home as her younger siblings.

Today: CASA volunteer assigned to this case.

Case History, Cont'd.

Current CASA	You and your team	Date Assigned:
Initial CPS Social Worker	Gerri Grady	7/3 (three years ago)
Previous CPS Social Worker	Danielle Mancuso	9/19 (three years ago)
Current CPS Social Worker:	Alberta Gillis	Last month

Court-Ordered Services

For the Child (Maria):

Medical health needs reviewed per physician's orders due to issues with asthma

Educational needs to be met as appropriate

For the Child (Joanna):

Educational needs to be met as appropriate

For the Child (Graciela):

Age-appropriate childcare to ensure educational needs are met

For the Father:

Rights have been terminated

For the Mother:

Rights have been terminated

CASA
Court Appointed Special Advocates
FOR CHILDREN

THE NATIONAL COURT APPOINTED SPECIAL ADVOCATE ASSOCIATION

CASA/GAL Pre-Service Volunteer Training Curriculum

Pre-Work Handouts

CHAPTER SEVEN

HEARST foundations

OJJDP

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Version 2, November 2017

CHAPTER 7

Pre-Work Handouts

Contents

Pre-Work Instructions

This section details the work you need to complete before the next classroom session. Completing this work prior to the session will allow you to fully participate during the training session and build the knowledge and skills you need to be an effective and successful CASA/GAL volunteer.

Please read through the Pre-Work handouts found in this document. Reading this information prior to the session will give you a foundation in several concepts covered in the chapter, including: resilience, how relationships in youth build resilience, how adverse childhood experiences affect resilience, permanence, concurrent planning, the educational challenges that children in child welfare system face, advocacy for children across age ranges, advocacy for children across age ranges, and advocacy for LGBTQ youth. You will also get familiar with working on a case of LGBTQ youth and writing the resources section of a court report.

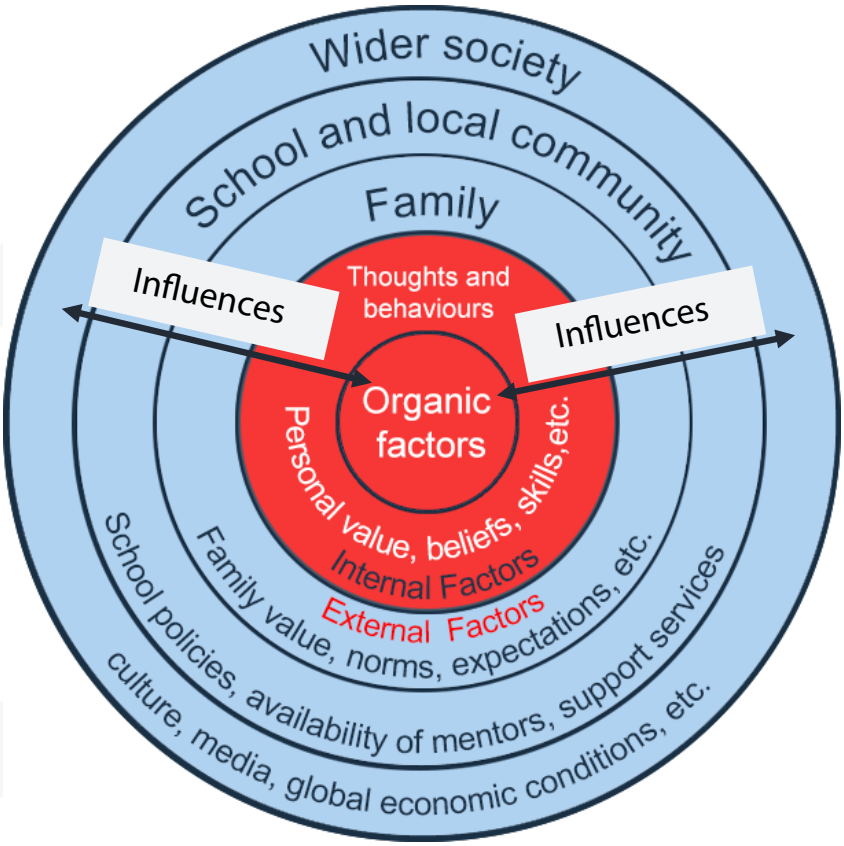
Statistics on Youth Aging Out of Foster Care

According to Casey Family Programs, about 25,000 young people between the ages of 18 and 21 must leave foster care each year. These young people have experienced maltreatment and have lived with instability and are unprepared for the social and financial demands of emancipation.

Aging out of foster care without a permanent home is the highest risk outcome for a foster youth.

Ecological Model of Factors Affecting Resilience

Resilience research has increasingly embraced an ecological model, in which the child's functioning and behavior is viewed within the context of the child's relationships, including family, school, peers, neighborhood and the wider society. While genetic factors do play a role in resilience, ultimately much more important is the quality of interpersonal relationships and the availability of networks of support.



From www.embracethefuture.org.au/resiliency

Concurrent Planning

Given the two possible permanent resolutions to a case—return to parent and adoption by a relative or nonrelative—your role is to encourage the court and child welfare professionals to do what is called "concurrent planning," which means working on two plans at the same time from the very beginning of a case: one to return the child home and another to find an alternative permanent placement. Traditionally, case management in child welfare has consisted of efforts to reunite children with their parent(s), and if those efforts failed, a second plan would be pursued. This created a process that kept many children in foster care for too many years.

Concurrent planning was developed as an alternative that moves a case more quickly through the system with better results. The concurrent planning approach is family-centered, with parents involved in decision making from the start. Throughout the case, parents are regularly given direct, culturally sensitive feedback about their progress. From the start of the case, while providing services to the parents, the caseworker explores kinship options, the applicability of the Indian Child Welfare Act and possible foster/adoptive situations for the child.

Concurrent Planning (Cont'd)

Permanent Resolutions: Questions to Consider

There are only two truly permanent options: return to parents and adoption. These resolutions are most possible when the following questions can be answered and the underlying issues they suggest have been dealt with.

Return to Parents	Adoption
• Have issues that brought the child into care been addressed by the agency?	• Are we ready to proceed with a termination of parental rights (TPR) case?
• Have the parents made the changes that the child protection agency requested?	• Do legal grounds exist?
• Has the child protection agency caseworker observed and documented a reduction of risk?	• Have we also considered the best interest issues that must be presented to the judge?
• What have the visits we observed told us about the parents' ability to care for the child?	• How long will the court process take?
• Have we considered recommending a trial placement as a way to observe actual changes in childcare?	• Have the parents been asked to release the child for adoption?
• Have new issues that relate to risk been observed and addressed?	• Is the child already living with caregivers who are willing and able to adopt?
• Has the child protection agency changed the rules or "raised the bar" in reference to expectations that are not related to risk?	• Are there relatives who are available to adopt?
• Would the child protection agency remove this child today?	• How soon can the child be placed?

Concurrent Planning (Cont'd)

Permanent Resolutions: Questions to Consider, Cont'd.

Return to Parents	Adoption
• Is this a multi-problem family that is likely to relapse?	• Who can help the child through the placement process?
• What services can be put in place to prevent relapse?	• Have we assessed and evaluated the child's particular needs and strengths?
• Have the legal and/or biological father(s) been identified?	• What is the child's relationship with his/her siblings?
• Have we recognized the child's grief and need to reconnect to the family of origin?	• Should the child be placed with siblings? Can the child be placed with siblings?
	• Have we identified a placement option that will be able to meet the child's needs?
	• Have the child's ethnic and cultural needs been considered and addressed?
	• Are we holding up the child's placement waiting for a specific type of family?
	• Are the child's needs so severe that finding appropriate parents is unlikely?
	• Is the child able to accept "parenting"?

Concurrent Planning (Cont'd)

Placement with Relative or Kin: Questions to Consider

Living with someone the child already knows and feels safe with can mitigate the child's feelings of loss, which are part of any placement. The use of a relative or kin placement should be evaluated from the beginning of agency involvement. The following questions should serve as guidance in considering both the pitfalls and benefits involved with kin and relative placements:

- Have the relatives/kin been carefully evaluated?
- Is there a written home study?
- What are the parents' thoughts and wishes in reference to this relative?
- What will be the ongoing relationship with the parents?
- Will the parents create problems with the placement or compromise the child's safety?
- Will the relative be able to protect the child from hostile or inappropriate parental behavior?
- Will the relative be able to be positive about the parent to the child?
- Will there be an "unofficial" return to the biological parents?
- Will this relative support the present service plan?
- If the plan changes, will the relative support the change?
- How will visitation be accomplished?
- Are the relatives able to understand and cooperate with agency expectations?
- Have the relatives of both parents been considered, regardless of the removal home?
- Is placement with relatives a way we can protect the child's roots in his/her community?
- Will placement with a particular relative mean that the child must leave the community?
- Will placement with a particular relative mean that the child will lose other important relative or kinship ties?

Concurrent Planning (Cont'd)

Placement with Relative or Kin: Questions to Consider, Cont'd.

- Will a relative placement mean that the child will have to endure another move?
- What losses will the child experience if another move is required?
- Have we considered sibling attachments, as well as any "toxic" sibling issues?
- Is this potential caregiver related to all the siblings?
- Is this relative able and willing to take all the siblings?
- Will placement with the siblings be positive for this child?
- Will this placement support the child's ethnic and cultural identity?
- Is this seen as permanent by the potential caregivers?
- Would this relative consider adoption?
- Are there the same issues in the extended family that existed with the parents?
- What pre-placement relationship existed?
- Does the child have any attachment to these relatives?
- Have the child's wishes been considered?

Concurrent Planning (Cont'd)

Long-Term Foster Care—An Impermanent Solution: Questions to Consider

When faced with long-term foster care as the "only" alternative, it is our obligation to insist that this not be the end of the planning process, but rather the beginning of a new dialogue around how to make permanence a reality. Begin this dialogue with these questions:

- What other options have been explored?
- Does the child need specialized care? Is it possible for him/her to have a legal and emotional attachment with a person with whom he/she does not live?
- Is there a significant role model or mentor involved with this child? What barriers exist to this person becoming the legal parent?
- What are the barriers to the caregiver adopting? How can these barriers be removed?
- Have all adoption subsidies, other financial resources and continuing services been explored and offered?
- Who have been the child's support and attachments in the past? Can any of them be involved now?
- Who are the child's attachments and support in the present? What is their current involvement?
- What family or kin connections are available—especially with siblings?
- Can parents or other kin be involved anew in this stage of the child's life?
- What does the child want?
- What resources and persons will be available when this child is an adult?
- Who will be this child's family for the rest of his/her life?

Adapted from materials created by Jane Malpass, consultant, North Carolina Division of Social Services, and Jane Thompson, attorney, North Carolina Department of Justice. Used with permission.

Educational Challenges for Children in the Child Welfare System

Most children have parents who monitor their academic progress, attend parent-teacher conferences, enroll them in appropriate classes and generally ensure they receive a high-quality education. When these children do not receive appropriate educational opportunities, their parents speak up on their behalf. Foster youth frequently lack such educational advocates. As a consequence, they often fail to receive the educational opportunities they need to succeed in school and, as a result, fall behind their peers academically. As a CASA/GAL volunteer, you can help advocate for a child's educational needs.

Teachers who see the child every day have a wealth of knowledge about the child's behavior, attitude, likes and dislikes, and about the best ways to communicate with that child. As you inquire about a child's progress in school, you may discover that the child has special educational needs and should be referred for an evaluation. In some areas, an abundance of resources may be available for special-needs children; in other areas, you may have to advocate for the creation of needed resources.

Cultural Considerations

Children from racial, ethnic or cultural backgrounds, different from the majority culture, may also have special needs based on discriminatory practices in the educational system. For instance, children may face racist or homophobic taunts, teachers who believe they can't learn, and testing that is racially or culturally biased. Many studies have found that children from minority racial or ethnic groups are overrepresented in the special education population and underrepresented in gifted and talented programs. Additionally, according to the National Education Association report Truth in Labeling, students of color experience "excessive incidence, duration, and types of disciplinary actions, including suspensions and expulsions."

It is important to realistically assess the school difficulties of a child and determine how the educational system, as well as the child's particular school setting, may be creating or sustaining those problems.

Educational Challenges for Children in the Child Welfare System (Cont'd)

Questions Based on K-12 Experiences

Reflect on your own K-12 school experience by thinking about the following questions:

- What enabled you to succeed in school? If school was difficult for you, what would have been helpful?
- Did you ever have to move from one school to another? How did it feel or how might it feel to be the “new kid” in school, particularly in the middle of the school year?
- Did you have someone at home who helped you with homework, attended parent-teacher conferences or advocated for additional services if you needed them?

Write down your experiences.

Initial Case Notes for the Brown Case (Homework)

CPS Case File

Last Name of Case:	**Brown**
Legal Number(s):	**11-7-012345-5**

Child(ren)'s Name	DOB	Age	Ethnicity	Sex	Current Location
Jessica Brown	February 20	15 years	White	F	Kinship Care Candice Clark

Current Caregiver(s)	Address	Phone
Paternal Cousin (Kinship): Candice Clark (not married)	19004 Coltfield Court	555-1018

Attorneys for:		
Mother	Dawn Schute	555-6542
Father	Nancy Andrews	555-9870
CPS	Chris Johnson	555-5428

Case History

August 7 (last year): Urgent Care Center notified CPS of 14-year-old Jessica Brown, who had been treated for broken ribs. Jessica told CPS social worker (SW) that she had run away from home the night before after being beaten "for the last time" by her mother's live-in boyfriend, Wayne Pender. According to police records, there is a history of violence between Mr. Pender and the youth's mother, Helen Brown.

August 8 (last year): Child released from hospital and placed by CPS into emergency foster care.

August 19 (last year): Youth removed from foster home after a series of arguments with the foster family. Youth explained to SW that the arguments originated because she attempted to confide to her foster mother that she is lesbian. The foster mother said she didn't feel comfortable with Jessica sharing a room with her 13-year-old daughter. Jessica has been placed in Abigail Barton Home for Girls.

November 8 (last year): Abigail Barton Home for Girls notified SW that Jessica Brown did not return to the group home after school.

December 21 (last year): SW received call from Jessica asking for assistance. Youth had been living on the street since running away from the group home. Youth stated she had been "harassed and bullied" by other girls in the group home. When SW asked youth to explain, the youth said other girls "hit me with batteries, sticks and their fists" and teased her with names such as "Jessie the Lessie" and "dyke." SW located emergency foster care for Jessica.

December 29 (last year): Youth placed with paternal cousin, Candice Clark (age 30).

Case History, Cont'd.

CASA History: Case Initially Assigned to:	June Miller	Date Assigned: Date Terminated:	8/14 (last year) Four months ago
Current CASA:	You and your team	Date Assigned:	Today
Initial CPS Social Worker: Current CPS Social Worker:	Angela Rodriguez Angela Rodriguez	Danielle Mancuso	

Court-Ordered Services

For the Child:

Psychological evaluation and counseling (if recommended)

Educational needs met as appropriate

For the Father:

N/A

For the Mother:

Domestic violence survivor's classes

Parenting classes

Beyond Alphabet Soup: Some Key Acronyms in Education Advocacy

Below are some terms that are used often in educational settings. You need not memorize them, but be aware that they might be included in a child's school records. You can use the information below as reference material.

BIP: Behavior Intervention Plan

A Behavior Intervention Plan (BIP) takes the observations made in a Functional Behavioral Assessment and turns them into a concrete plan of action for managing a student's behavior. This plan guides teachers and school staff in addressing behavior issues. It is especially important for children who have experienced trauma and/or removal from their parents, as standard school disciplinary procedures may not work or may further traumatize the child. A BIP may include ways to change the environment to keep behavior from starting in the first place, provide positive reinforcement to promote good behavior, employ planned ignoring to avoid reinforcing bad behavior, and provide supports needed so that the student will not be driven to act out due to frustration or fatigue. Once a behavior plan is agreed to, the school and staff are legally obligated to follow it.

CPSE: Committee on Preschool Special Education

A Committee on Preschool Special Education (CPSE) coordinates special education evaluations and services for children ages 3 to 5. Referrals to a CPSE often come from early-intervention programs if they determine that the child continues to need services after age 3. The goal is to provide services that will best ensure that the child enters kindergarten prepared to learn. Required participants are the same as those listed for the CSE (below).

CSE: Committee on Special Education

The Committee on Special Education (CSE) is a multidisciplinary team appointed by a school's board of education. The CSE is responsible for students with disabilities from ages 5 to 21. The CSE is authorized to identify students in need of services by determining eligibility, develop an Individualized Education Plan (IEP), place students in the least restrictive environment in which they can succeed, and provide appropriate services to meet the child's educational needs.

Beyond Alphabet Soup, Cont'd.

The team meets at least annually to review a child's IEP and determine a program from that point forward. CSE meetings should include the parent or guardian of the student (including the foster parent), the district's CSE chairperson, a school psychologist, a parent member (someone who is a parent of another student in the district—often a student with an IEP), the child's general education teacher, the child's special education teacher or service provider and the student (especially older youth). As a CASA/GAL volunteer, you should also be able to attend CSE meetings.

504 Plan

A 504 Plan is a plan developed to ensure that a student who has a disability identified under the law and needs accommodations that will ensure academic success and access to the learning environment, is provided with such accommodations. These plans are often used for students who need additional services that do not rise to the level of an Individualized Education Plan.

FAPE: Free, Appropriate Public Education

This is part of the IDEA (Individuals with Disabilities Education Act) requirement, in which "appropriate" means "providing meaningful educational progress." A student with disabilities has the right to receive special education and related services that will meet his or her individual learning needs, at no cost to the parents.

FBA: Functional Behavioral Assessment

An assessment process for gathering information regarding a child's behavior, its context and consequences, variables, the student's strengths, and the expression and intent of the behavior for use in developing behavioral interventions. An FBA is performed when a child is having behavioral challenges in school.

Beyond Alphabet Soup, Cont'd.

IEP: Individualized Education Plan

This is a written educational plan of special education for students from age 3 to 21 who are eligible under IDEA and state laws. The IEP is tailored to each child's needs and identifies goals and objectives, necessary accommodations and related services.

The IEP is developed by a team of people, including but not limited to foster parents, parents, guardians, special education and regular education teachers, therapists, psychologists and the child, when appropriate. Sometimes the CASA/GAL volunteer will participate in these IEP meetings. An educational surrogate may be appointed if the family is not available, but even with a surrogate assigned to the child, the parents still have a right to involvement. Knowledge of the child's schooling is one way for parents to stay connected to a child's progress even when the child is in out-of-home placement.

IFSP: Individualized Family Service Plan

This is a written developmental plan of early intervention services for children from birth to age 3, and their families who are eligible under IDEA and state laws. The plan must involve and include the family of the child involved.

LRE: Least Restrictive Environment

This refers to the services identified in an IEP, which must be provided in the least restrictive environment for the child or youth involved. It is part of the IDEA requirement that children with disabilities shall be educated to the maximum extent possible with their non-disabled peers.

Beyond Alphabet Soup, Cont'd.

RTI: Response to Intervention

Based on a problem-solving model, Response to Intervention (RTI) is the practice of providing high-quality instruction and interventions matched to student need, monitoring progress frequently to make decisions about changes in instruction or goals, and applying child response data to important educational decisions. Schools should have an RTI team or teams, which look at students who are struggling with learning and/or behavior, and develop tailored plans that head off the need for greater invention (such as an IEP). Often used as a first step before making a referral to a school's CSE.

Laws Related to Older Youth in Foster Care

Preventing Sex Trafficking and Strengthening Families Act of 2014

The Preventing Sex Trafficking and Strengthening Families Act includes several provisions relevant to children removed from their parents' care or at risk of removal. Focusing on providing support and services for youth at risk of sex trafficking, the law requires child welfare agencies to locate children missing from care, to ensure that children in care have the opportunity to participate in "normal" age-appropriate activities, and for states to provide family strengthening services.

Key Provisions of This Legislation

- State agencies must report to law enforcement, within 24 hours, information on children or youth identified as victims of sex trafficking.
- State child welfare agencies must develop and implement procedures to locate children and youth who have run away or are missing from foster care. Further, they must determine the factors that led to the child or youth running away and determine what happened to the child while absent from foster care.
- The law defines a standard for reasonable and prudent care (also referred to as normalcy) to mean the careful and sensible parental decisions necessary to maintain the health, safety, well-being and best interest of the child. It provides for foster parents or caregivers to make decisions about the child's participation in extracurricular, enrichment, cultural and social activities including sports, field trips and overnight activities. It requires that states must provide training for caregivers related to this standard.
- The law requires states to develop policies related to foster parent liability and the reasonable and prudent care standard.
- The law eliminates APPLA (Another Planned Permanent Living Arrangement) as a permanency goal for children under 16. This has typically been used as a permanency goal for youth who will "age out" of the system.
- The law requires consultation of youth age 14 or older in the development and revision of his or her case plan. The youth may choose up to two members of the case planning team who are not the youth's foster parent or caseworker. The youth may designate one of these two people as an

Laws Related to Older Youth in Foster Care, Cont'd.

advisor who may advocate for the youth regarding the application of the reasonable and prudent parent standard. These roles could be filled by the youth's CASA/GAL volunteer if they so choose.

- The case plan must include a document describing the rights of the youth and signed acknowledgment that the youth has received a copy of the plan.
- Youth leaving foster care at age 18 or older must be provided with an official copy of their birth certificate, their social security card, health insurance information (including a health insurance card), their medical records and a driver's license or identification card issued by the state in which they reside.
- The law allows subsidy payments approved as part of a kinship guardianship agreement to go to a successor guardian upon the death or incapacity of the original guardianship. Adoption subsidy payments are already subject to this rule.
- States must collect data on adoption or kinship guardianship disruption and the return of child or youth to foster care.
- All parents of siblings of a child or youth brought into care must be identified and notified within 30 days after removal of the child from the custody of their parent(s). This includes individuals who would have been considered siblings if not for the termination or other disruption of their parents' rights. The only exception is in cases where a sibling's parent does not have legal custody of the sibling. The idea is to ensure that all potential resources within the extended family are explored, including the parents of half-siblings, and that children do not lose contact with siblings or half-siblings while in foster care.

Key Impact of This Legislation on CASA/GAL Advocacy

Advocacy concerns center primarily on the second part of this act. Specifically, there is added strength in advocating for experiences that create a sense of normalcy for children in care and that promote their well-being. Youth under age 16 should no longer have Alternative Planned Permanent Living Arrangement (APPLA) as their permanency goal. Youth age 14 and up must be a participant in their case planning and they must sign the case plan.

Laws Related to Older Youth in Foster Care, Cont'd.

Furthermore, there is an opportunity for CASA/GAL volunteers to participate in case planning for these youth if the youth so wishes.

Fostering Connections to Success and Increasing Adoptions Act, P.L. 110-351

The Fostering Connections to Success Act is a significant and far-reaching law enacted in 2008 that is designed to improve outcomes for youth in care, particularly older youth. The legislation is a series of building blocks, based on evidence-based practices that have demonstrated positive outcomes. The focus is on connections to family, to siblings and to other adults to foster successful transitions to adulthood.

Key Provisions of This Legislation

- State agencies are required to provide notice to relatives within 30 days of the child's removal from the home and to explain the options for the relative's participation in the child's care, from acting as a placement to engaging in the child's case in other ways. This can be the beginning of establishing a permanent connection for the child with the extended family, perhaps even as a permanent placement option.
- In addition to maintaining the child's connection with family, the legislation maintains the child's connection with siblings. Interviews of youth have consistently revealed that the greatest loss they experienced when removed from home is the loss of their connection with their siblings. Too often, they are never able to reconnect with them. With this law in place, state agencies must make reasonable efforts to place sibling groups together in foster, family or adoptive placements, if in the children's best interests. If placement together is not feasible, the agency must ensure continuing contact among siblings, at least once a month.
- A new, specific transition plan must be developed at least 90 days prior to the youth's transition out of foster care (at age 18 or older). This is over and above the plan that should normally begin around the age of 16. The new, personalized plan should be developed with the caseworker and other appropriate representatives. The plan should be as detailed as the youth directs, and include specifics on housing, health insurance, education,

Laws Related to Older Youth in Foster Care, Cont'd.

opportunities for mentors and continuing support services, workforce supports and employment services.

- Educational stability for children in care is underscored by requiring that the child's case plan include provisions to ensure that the child remains in the school of origin, unless not in the child's best interest. The child's placement should take into account the appropriateness of the educational setting and proximity of the school in which the child is enrolled at the time of placement. If the school of origin is not in the child's best interest, then the agency must provide immediate enrollment in a new school and provide all educational records.

For children in care who are IV-E* eligible (varies from state from state; nationally about 50% of children in care):

- States may choose to extend support for youth in care to age 19, 20 or 21 and receive federal assistance to provide such support, including the extension of Medicaid. Youth must be enrolled or participating in an eligible program.
- States also have the option of receiving federal assistance to provide payments to qualified grandparents and other kin who are willing to become legal guardians and who meet state requirements for placement.

Once state budgets allow sufficient resources to cover the match requirement, it is anticipated that states will expand these provisions to all children in care, and not exclusively to IV-E* eligible children, as the federal law allows.

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* Title IV-E eligibility hinges on the family's income at the time the child was removed from the home. Generally, if the family is or would be eligible for Aid to Families with Dependent Children (AFDC), the child is then Title IV-E eligible. As the summary points out, this generally should not matter in terms of CASA/GAL advocacy, as federal guidelines anticipate that states will have uniform guidelines for all children removed from their parents' care, regardless of Title IV-E eligibility.

Laws Related to Older Youth in Foster Care, Cont'd.

Key Impact of This Legislation on CASA/GAL Advocacy

Search and notification of relatives does not end after 30 days; birth relatives need to understand that there are multiple ways they can be involved beyond acting as a placement option (examples include attending school events, providing transportation and celebrating holidays). When appropriate, volunteers should keep family engaged and informed.

Carl Perkins Vocational Education Act

This law requires integrated academic and vocational education that ensures full and equal access for special populations, including special services that might be needed to succeed.

Family Educational Rights and Privacy Act (FERPA)

This federal law protects the privacy of a student's education records. It also ensures a parent's right to inspect and review these records and to consent to disclosures of personally identifiable information about themselves and their children. FERPA allows schools to disclose those records, without consent, to comply with a judicial order. This may be applicable to CASA/GAL volunteers pursuant to state law.

Indian Education Act

This act provides funding to local educational agencies to support special education programs for Native Americans. It requires tribe or parent involvement in planning, development and operation.

Individuals with Disabilities Education Act (IDEA)

This act ensures that all children with disabilities have access to a free, appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for employment and independent living.

Laws Related to Older Youth in Foster Care, Cont'd.

McKinney-Vento Act

This law ensures that homeless children and youth have equal access to the same free, appropriate public education that is provided to other children. This can be applied to children in foster care.

No Child Left Behind Act

Passed in 2001, this law ensures that all children and youth have a fair, equal and significant opportunity to obtain a high-quality education and reach proficiency on challenging state academic achievement standards and state academic assessments. In addition, this act requires that all schools be safe and drug free.

School-to-Work Opportunities Act

This law provides funds to states for planning grants and for state subgrants to local partnerships to give all students the chance to complete a career major. It assures equal access to the full range of program components for all students, including youth in out-of-home care.

LGBTQ Glossary

The following are terms and expressions that you may find useful when working with youth or family members who identify as LGBTQ:

Bisexual: A person who is emotionally, romantically and sexually attracted to both men and women.

Coming Out: The process of disclosing one's sexual orientation or gender identity to others. Because most people in our society are presumed to be heterosexual, coming out is not a discreet life event but often a longer process. Coming out may also be experienced by heterosexual family members or allies of LGBTQ people, who may decide to disclose to others that they have friends or relatives who are LGBTQ.

Femme: A term used by some gay men or lesbians to identify their more typically feminine qualities. May also be used to help define one's chosen role within a relationship.

Gay: A person whose emotional, romantic and sexual attractions are primarily for individuals of the same sex. This term typically refers to men, but in some contexts it is used as a general term for gay men and lesbians.

Gender Expression: An individual's characteristics and behaviors (such as appearance, dress, mannerisms, speech patterns and social interactions) that are perceived as falling somewhere along a continuum of feminine and masculine.

Gender Identity: A person's innate, deeply felt psychological identification as a man or woman, which may or may not correspond to the gender assigned to them at birth. Also, some individuals identify as neither male nor female as our society generally understands these terms, and instead identify as a third or other gender.

Heterosexism: An ideological system that denies, denigrates and stigmatizes any non-heterosexual form of behavior, identity or relationship.

Heterosexual: A person who is primarily or exclusively attracted to people of a different sex romantically, affectionately and sexually. Sometimes referred to as straight.

LGBTQ Glossary, Cont'd.

Homophobia: Fear of, aversion to, or discrimination against homosexuality, homosexuals or same-sex relationships.

Homosexual: A term used to refer to a person based on his or her same-sex sexual orientation, identity or behavior. Many LGBTQ people prefer not to use this term—especially as a noun—because of its historically negative use by the medical establishment.

In the closet: Keeping one's sexual orientation or gender identity secret.

Intersex: An individual born with reproductive or sexual anatomy that does not conform exclusively to male or female norms in terms of physiological sex.

Lesbian: A woman whose emotional, romantic and sexual attractions are primarily for other women.

LGBTQ: An acronym for lesbian, gay, bisexual, transgender and questioning or queer.

MTF/FTM: These abbreviations, for male-to-female and female-to-male, refer to an individual's gender transition from the gender assigned at birth to the self-identified present gender. For example, an individual previously identified as a man who is transitioning to an identity as a woman is MTF.

Queer: Queer is an umbrella term for sexual and gender minorities. Originally meaning "strange" or "peculiar," queer was a pejorative word for those who were attracted to members of the same sex from the second half of the 19th century until the late 1980s when activists reclaimed the word as the umbrella term it has become.

Transgender: An umbrella term for people whose gender identity or expression is different from those typically associated with the sex assigned to them at birth (e.g., the sex listed on their birth certificate).

CASA
Court Appointed Special Advocates
FOR CHILDREN

THE NATIONAL COURT APPOINTED
SPECIAL ADVOCATE ASSOCIATION

CASA/GAL Pre-Service Volunteer Training Curriculum

Pre-Work Handouts

CHAPTER EIGHT

HEARST foundations

OJJDP

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CHAPTER 8

Pre-Work Handouts

CONTENTS

Pre-Work Instructions

This section details the work you need to complete before the next classroom session. Completing this work prior to the session will allow you to fully participate during the training session and build the knowledge and skills you need to be an effective and successful CASA/GAL volunteer.

Please read through the Pre-Work handouts found in this document. Reading this information prior to the session will help you review the concepts covered in the entire course. You will review the competencies that you built during the course and make plans for those competencies that you still need to strengthen. You will also get familiar with working on one last case and writing a complete court report.

Initial Case Notes for the Redd Case

CPS Case File

Last Name of Case:	**Redd**
Legal Number(s):	**11-7-012345-7**

Child(ren)'s Name	DOB	Age	Ethnicity	Sex	Current Location
Mariah Redd	February 1	5 months	AA	F	Foster Care Placement Julia Budd

Current Caretaker(s)	Address	Phone
Foster Mother: Julia Budd (not married)	1776 Grimes Creek Rd.	555-1766

Attorneys for:		
Mother	Darlene Wright	555-9898
Father	Walt Harris	555-1334
CPS	Robin Jackson	555-7544

Case History

Ms. Clarissa Ann Redd, African American, age 25, reported to SW that she has been using “sherm” (cigarettes dipped in PCP) on and off since she was 18. She has a 10 year-old son, Buddy, who is in the legal custody of her mother, Lela Jones. Lela is married to Clarissa’s stepfather, Charles Jones. Clarissa stays with them when she isn’t with a boyfriend. Clarissa’s second child, a 7-year-old boy named Tyrone, lives with his father, Willy Monroe.

The local hospital notified CPS of an infant born on 2/1 who tested positive for PCP. The infant, named Mariah Redd, is the third child born to Clarissa Redd. She was removed from the care of Clarissa Redd and placed in foster care with Julia Budd. When Mariah was 2 months old, she and Clarissa went to Fresh Start, a residential mother/baby treatment program.

CASA History: Case Initially Assigned to:	John Hill	Date Assigned: Date Terminated:	2/19 6/30
Current CASA:	You	Date Assigned:	7/8
Initial CPS Social Worker: Current CPS Social Worker:	Heather Bunning Kim Ellis		

Court-Ordered Services:

For the Child:

Medical health needs reviewed per physician's orders due to high-risk birth

Educational needs met as appropriate

For the Father:

Establish paternity

If applicable, pay child support

For the Mother:

Substance abuse evaluation and follow recommendations of service provider

Urinalysis twice per week

Parenting classes

SERVICE UNIT CONTACT SHEET

IMAGINARY COUNTY DEPARTMENT OF SOCIAL SERVICES

CASE NAME____Redd, Mariah_____ CASE WORKER __Kim Ellis___

CASE NUMBER __07456_____ SIS ID___20094859466_____

2/1/03 Tele: Hospital reports birth of PCP-positive infant, female.

2/2/03 Hospital: Interview with mother, Clarissa Ann Redd, DOB 1/31/78, very hostile. Stated would not leave hospital without her baby. Hospital will discharge mother tomorrow; baby will stay for five-day detox and observation.

2/6/03 Home Visit (HV): Child placed with foster family: Julia Budd (phone and address)

2/14/03 HV: Foster home. Juvenile continues to progress well.

2/14/03 DSS: Visit with Clarissa Redd (mother) and Lela Jones (maternal grandmother). Tearful but appropriate behavior from Clarissa, said she didn't have a drug problem, "just smoked it ["sherm"] once in a while." Supervised visits set for 2 p.m. Friday, weekly.

2/20/03 HV: Maternal grandmother, Lela Jones, present for whole interview, supportive of daughter. Home placement not an option because Lela works. Family agreed Mariah to stay in foster care while Clarissa "gets herself together." Clarissa was cooperative. She turned to her mother for guidance several times. Clarissa had no appointment for substance abuse evaluation so we made one. Clarissa named boyfriend, Johnny Smith, as father for Mariah and asked if he could come to the visits.

Service Unit Contact Sheet, Cont'd.

2/21/03 DSS: Visit with Johnny Smith (alleged father), Clarissa (mother), and juvenile. Mr. Smith polite, cooperative, held the baby a lot, seemed proud. Stated Mariah is his but won't sign papers without a test. He agreed to contact CSE (Child Support Enforcement) for paternity test and voluntary child support. Clarissa spent time holding Mariah but also seemed jealous of her. Notified that volunteer advocate will observe a future visit. This was agreeable.

3/7/03 Tele: S/A counselor called to say Clarissa a "no show" for evaluation. (Also no show for visit with child.)

3/7/03 Tele: Called maternal grandmother, Lela Jones, who said she wasn't sure where Clarissa was, "She's 25 now. I can't be keeping track of her every
move."

3/14/03 DSS: Visit with Johnny, Clarissa, Mariah. Volunteer advocate present.Clarissa said they had car trouble last week. She will reschedule S/A appointment. Told them that CSE has agreed to see them after next visit. Reminded Clarissa adjudication is 3/18. She said, "Yeah I know. After that I'm gonna get my baby back and be done with you." Told her that without the S/A evaluation, the court won't return custody.

3/18/03 Court orders: Clarissa to do S/A evaluation and follow recommendations. Mr. Smith to have paternity test and pay child support. Continue supervised
visits.

3/28/03 DSS: Visit w/ Johnny, Clarissa, Mariah. This worker discussed substance abuse treatment options with Clarissa. Her 3/19 screen was + for PCP. S/A recommended residential mother/baby program, Fresh Start. She agreed to go but said she wasn't ready yet.

Service Unit Contact Sheet, Cont'd.

4/4/03 DSS: Visit with Clarissa, Mariah. Mother tearful, said she failed another drug screen and needs help. Agreed to Fresh Start. Said she can't stop using, that she's been high every weekend for as long as she can remember. Stated she hates stepfather. She doesn't like Buddy living there but that's up to her mom now. I asked her what she was worried about and she said, "Charles isn't a good man. He's mean!"

4/11/03 Fresh Start: Transported mother and baby to Fresh Start Program. Baby transitioned well.

4/16/03 Tele: Call to Fresh Start. Clarissa adjusting to program. Baby is fine.

5/22/03 Fresh Start: Visit. Congratulated Clarissa for hanging in with the program. Mother and baby doing well.

6/20/03 Tele: Fresh Start called to say Clarissa is planning to leave AMA (against medical advice). She had been feuding with another client ("about nothing") and calling home a lot. Staff told her they'd call DSS and hold Mariah if she leaves. Clarissa has packed all her things and is waiting for a ride. Baby secure in building.

6/20/03 Drove to Fresh Start. Clarissa gone. Picked up baby. Julia Budd still available. Returned Mariah to her.

Medical History for Mariah Redd

Prepared by County Health Clinic, Dr. Scott, M.D.

Birth: Tested positive for PCP at birth. APGAR scores: 7/8. Child stayed in hospital for a five-day detox period experiencing tremors and irritability. Nurses reported to SW that mother was hostile and refused services. Mother was discharged the day after the birth and did not return to visit the baby. Rock-a-Baby volunteers held Mariah every day and helped with feeding her.

County Health Clinic: SW referred Mariah to the county program for high-risk infants. Mariah was followed by the County Health Clinic for three months and then released into the regular well-baby program, as she showed no developmental delays or neurological deficits. Other County Health Clinic items of note:

- Clinic ran multiple HIV and Hepatitis-C tests. All were negative.
- Infant tolerates formula with no problem.

Pediatrician: Foster mom has been on schedule with inoculations and well-baby care. Mariah has had only the usual colds and earaches. Recent tests indicate potential abnormalities. A follow-up appointment has been requested.

Criminal Records for Clarissa Redd

STATE AOC CIS CR/IF CASE PROCESSING **** CAUTION ****
999 IMAGINARY STATEWIDE NAME INQUIRY INDEXED SOLELY BY NAME
NO GUARANTEE TO IDENTITY
REDD,CLARISSA,ANN BFO1311978 SSN#: 999 99CR 005729
(ADDRESS) DL#:
CITY, NC CIT#:
TRIAL DT: 041199 SID#: STATUS: U
DISTRICT PROCESS: S SERVED: 022499 CK DIG#: LID#: 9600723
CHG: M SIMPLE ASSAULT C&F: FTA: OFA:
CONV: CLASS: P: V: M:VD DISP:041199
STATE AOC CIS CR/IF CASE PROCESSING **** CAUTION ****
999 IMAGINARY STATEWIDE NAME INQUIRY INDEXED SOLELY BY NAME
NO GUARANTEE TO IDENTITY
REDD,CLARISSA,A BFO1311978 SSN#: 999 98CR 009145
DL#: NC 553638
MADISON NC CIT#: L101
TRIAL DT: 120298 SID#: STATUS:
DISTRICT PROCESS: C SERVED: 112898 CK DIG#:
CHG: M POSSESS MARIJUANA UP TO 1/2 02 C&F:
CONV: M POSSESS MARIJUANA UP TO 1/2 02 CLASS:P:GU V:GU M:JU DISP:120298
FINE: 00050 COST: 0040 REST: M PAID: Y TO BE PAID: NMFTC
CHG: M POSS DRUG PARAPHERNALIA
CONV: M P SS DRUG PARAPHERNALIA
FINE: COST: REST: M PAID: Y TO BE PAID: NMFTC
SPEC COND: J. ALLEN COMP: BULLINS, RL AGY: CPD ORI:
STATE AOC CIS CR/IF CASE PROCESSING **** CAUTION ****
999 IMAGINARY STATEWIDE NAME INQUIRY INDEXED SOLELY BY NAME
NO GUARANTEE TO IDENTITY
REDD,CLARISSA BFO1311978 SSN#:24519XXXX 999 02CR 01786

Criminal Records for Clarissa Redd, Cont'd.

(ADDRESS) DL#:
WILMINGTON, NC 28403 CIT#: C73880
TRIAL DT: 080502 SID#: STATUS: U
DISTRICT PROCESS: C SERVED: 061702 CK DIG#: LID#: 9743200
CHG: M SIMPLE ASSAULT C&F: FTA: OFA:
CONV: M SIMPLE ASSAULT CLASS:2 P:GU V:GU M:JU DISP:080502
FINE: COST: 0065 REST: M PAID: Y TO BE PAID: NMFTC
SPEC COND: NO FURTHER CONTACT W/GINA M
COMP: ADAMS,L, AGY: CPD ORI:
STATE AOC CIS CR/IF CASE PROCESSING **** CAUTION ****
780 ROCKINGHAM STATEWIDE NAME INQUIRY INDEXED SOLELY BY NAME
NO GUARANTEE TO IDENTITY
REDD,CLAIR SSN#: 780 02CR 005729
DL#:
STONEVILLE NC 27048 CIT#:
TRIAL DT: 022802 SID#: STATUS:
DISTRICT PROCESS: S SERVED: 021902 CK DIG#: LID#:
CHG: M SIMPLE WORTHLESS CHECK C&F: FTA: OFA:
CONV: CLASS: P: V: M:VD DISP:022802
SPEC COND: DISMISSED BY DA BECAUSE CHECK PD AND WITNESS WHO TOOK CHECK COMP:
CUTCHFIELD,DALE AGY: CPD ORI
STATE AOC CIS CR/IF CASE PROCESSING **** CAUTION ****
780 ROCKINGHAM STATEWIDE NAME INQUIRY INDEXED SOLELY BY NAME
NO GUARANTEE TO IDENTITY
REDD,CLARISSA,ANN BFO1311978 SSN#: 780 00CR 121758
DL#: NC 553638
EDEN NC CIT#: C1700823
TRIAL DT: 121400 SID#: STATUS:
DISTRICT PROCESS: C SERVED: 111100 CK DIG#: LID#:

Criminal Records for Clarissa Redd, Cont'd.

CHG: M DISORDERLY CONDUCT C&F:
CONV: M DISORDERLY CONDUCT CLASS: P:GU V:GU M:JU DISP:121400
FINE:00050 COST: 0051 REST: M PAID: Y TO BE PAID: NMFTC
SPEC COND: J. TINDAL, -SUSO 9ON COND PAY FINE & COSTS
COMP: FRAZIER,M AGY: CPD ORI:
STATE AOC CIS CR/IF CASE PROCESSING **** CAUTION ****
640 NEW HANOVER STATEWIDE NAME INQUIRY INDEXED SOLELY BY NAME
NO GUARANTEE TO IDENTITY
REDD,CLARICE BFO1311978 SSN#:24519XXXX 640 00CR 000648
DL#:
WILMINGTON, NC 28403 CIT#: 209472
TRIAL DT: 080502 SID#: STATUS: U
DISTRICT PROCESS: C SERVED: 122999 CK DIG#: LID#: CHG: M
CHG: M MISDEMEANOR LARCENY C&F: FTA: OFA:
CONV: M MISDEMEANOR LARCENY CLASS: P:GU V:GU M:JU DISP:012500
FINE: 00100 COST: 0050 REST: M PAID: Y TO BE PAID: NMFTC
SPEC COND: 24 HRS COMM SERV,EGT
COMP: PAIT,R,H AGY: CPD ORI:

Criminal Records for Charles Jones

STATE AOC CIS CR/IF CASE PROCESSING *** CAUTION ***
000 ALAMANCE STATEWIDE N E INQUIRY INDEXED SOLELY BY NAME
NO GUARANTEE TO IDENTITY
JONES,C BM06211950 SSN: 237981323 000 80CR 055328
709 AVON AVE DL#: NC 3904029
NC 27217 0000 CIT#:
TRIAL DT: 081503 SID#: NC0389764A STATUS:
DISTRICT PROCESS: W SERVED: 062603 DIG#: S66327V LID#: CJBM1323-000
CHG: M ASSAULT ON A FEMALE C&F: FTA: OFA:
CONV: M ASSAULT ON A FEMALE CLASS:A1 P:GU V:GU M:JU DISP:081503
FINE: COST: 0100 REST: 588.25 PAID: Y TO BE PD: NMFTC:
SPEC COND: PAY REST TO ARMC (BY 092603), COURT COSTS TO BE PAID TODAY,
COMP: CONYERS,PATRICIA AGY: ORI: NCO010100
STATE AOC CIS CR/IF CASE PROCESSING *** CAUTION ***
000 ALAMANCE STATEWIDE N E INQUIRY INDEXED SOLELY BY NAME
NO GUARANTEE TO IDENTITY
JONES,C BM05211950 SSN: 000 79CRS018076 510 LAKEVIEW DR DL#:
NC 27217 0000 CIT#:
TRIAL DT: 080796 SID#: NC0389764A STATUS:
SUPERIOR PROCESS: W SERVED:080696 CK DIG#: P87573K LID#:
CHG: F PWIMSD MARIJUANA C&F: FTA: OFA:
CONV: F PWIMSD MARIJUANA CLASS:I P:GU V:GU M:JU DISP:080796
DISTRIC
CHG: F PWIMSD MARIJUANA C&F: FTA: OFA:
CONV: CLASS: P: V: M:SI DISP:080796
SPEC COND: JUDGE W. STEVEN ALLEN COMP: COBB, JT
STATE AOC CIS CR/IF CASE PROCESSING *** CAUTION ***
250 CUMBERLAND STATEWIDE N E INQUIRY INDEXED SOLELY BY NAME
NO GUARANTEE TO IDENTITY:

Criminal Records for Charles Jones, Cont'd.

JONES,CHARLES BM SSN: 250 78CR 033945
137 BUCKINGHAM AVE DL#:
NC CIT#:
TRIAL DT: 091784 SID#: STATUS:
DISTRICT PROCESS: S SERVED:081084 CK DIG#: LID#:
CHG: M ASSAULT BY POINTING A GUN C&F: FTA: OFA:
CONV: M ASSAULT BY POINTING A GUN CLASS: P:NG V:NG M:JU DISP:080796
SPEC COND: JUDGE KEEVER
COMP: GILLIAN,JARRETT,D AGY: SHP ORI:
STATE AOC CIS CR/IF CASE PROCESSING *** CAUTION ***
000 ALAMANCE STATEWIDE N E INQUIRY INDEXED SOLELY BY NAME
NO GUARANTEE TO IDENTITY
JONES,CHARLES BM05211950 SSN: 000 75CRS006977
510 LAKEVIEW DR DL#:
NC CIT#:
TRIAL DT: 060396 SID#: NC0389764A STATUS:
SUPERIOR PROCESS: I SERVED:040296 CK DIG#: P92555X LID#:
CHG: M POSSESS DRUG PARAPHERNALIA C&F: FTA: OFA:
CONV: M POSSESS DRUG PARAPHERNALIA CLASS:I P:GU V:GU M:JU DISP:080796 DISTRIC
SPEC COND: JUDE JAMES C SPENCER JR
COMP: COBB,J & PUTNAM,R AGY: SFF ORI: NC0010000

Criminal Records for Charles Jones, Cont'd.

STATE AOC CIS CR/IF CASE PROCESSING *** CAUTION ***
000 ALAMANCE STATEWIDE N E INQUIRY INDEXED SOLELY BY NAME
NO GUARANTEE TO IDENTITY
JONES,CHARLES BM05211950 SSN: 000 73CRS012016
417 CRATER STREET DL#:
NC CIT#: TRIAL DT: 020791 SID#: NC0389764A STATUS:
SUPERIOR PROCESS: W SERVED:090990 CK DIG#: E15417P LID#:
CHG: M ILLEGITIMATE CHILD/NON-SUPPORT C&F: FTA: OFA:
CONV: M ILLEGITIMATE CHILD/NON-SUPPORT CLASS:I P:GU V:GU M:JU DISP:092890
SPEC COND: SIGN WAGE WITHHOLDING. SUPPORT COREY MILES - $70 PER WEEK—
COMP: JOANNE GUNTER

Substance Abuse Assessment

Family Name: Clarissa Redd Case No.: 123.456

Name: Clarissa Redd SIS ID 3/28

1. Presenting Problem/Reason for Assessment

   This case was referred to me by Kim Ellis, the foster care worker for Ms. Redd's PCP-positive female infant, Mariah Redd, born 2/1. Ms. Redd was PCP positive and tested at elevated levels of THC at the time of delivery. S/A assessment was requested to determine feasibility of reunification. Ms. Redd has a 10-year-old son in her mother's custody and a 7-year-old son living with his father. Ms. Redd is a single African American female, mother of three, and she is 25 years old.

2. Family of Origin History in Relation to:

   A. Chemical Dependency

   She said on her mother's side of the family her grandfather was an alcoholic but her mother doesn't drink. She said her stepfather is a drinker. She doesn't know about the rest of his family. She doesn't know about her natural father's family.

   B. Mental Illness

   She said there was no mental illness on either side of the family.

   C. Marital Status

   She said her mother and natural father were divorced when she was 4 years old. Her mother married her stepfather when she was 7. She has one sister.

   D. Past Abuse

   She said her mother never beat her but her stepfather did. He has not hit her since she grew up (age 18). She said he was really hard on her sister, who ran away to join the army when she was 18. She said her sister accused the stepfather of attempting to have sex with her but she doesn't believe it. Her mother said it wasn't true, "And besides, he never tried to touch me."

Substance Abuse Assessment, Cont'd.

3. Education

   Graduated high school

4. Employment

   Not currently employed. Past employment includes fast food preparation and working at a car wash. She said she had never lost a job due to alcohol or drug use.

5. Legal Status—Past/Present

   She has been arrested for assault, worthless checks, larceny, and in 2008, possession of marijuana and possession of drug paraphernalia. She has never had a DWI.

6. Marital Status/Functioning

   She has never been married.

7. Mental Illness History

   She said she has never had counseling for life issues, been suicidal, homicidal, or had hallucinations.

8. Chemical Dependency History

   She started smoking cigarettes and drinking on weekends at the age of 14. After her first child was born when she was 15 years old, she began to smoke marijuana occasionally. When she was 18, she experimented with cigarettes dipped in PCP ("sherm"). She liked it immediately and started using it whenever she had the money, almost every weekend, even during her pregnancy. Her second child was born PCP positive the summer after she graduated H.S. At age 20 she "got busted with some weed" and states she was dealing marijuana at the time to get money for cocaine. She experimented with inhalants, mushrooms, and speed in her early twenties but didn't use them often. She claims that she has not used PCP since her baby was born and that she has only smoked marijuana about five times. She said she hasn't been drunk in years and only rarely has a beer if friends are drinking. She denied having shakes,

Substance Abuse Assessment, Cont'd.

achy bones, blackouts, night sweats, or hallucinations through the use of alcohol or drugs.

9. Treatment/Intervention

She attended NA weekly for 4 months in early 2010, as ordered by the court, subsequent to her drug charges. She did not continue to attend and never worked with a sponsor.

10. Prognosis—Strengths/Needs

Ms. Redd identified her mother and her boyfriend as her main support system. She does not see CPS as a support but stated that after court last week she understands she will have to work with them to get her baby back. She seems highly motivated to be reunited with her child. This may provide her with motivation to seek and complete treatment.

11. Recommendations

It is my recommendation that Ms. Redd enter Fresh Start or another mother/baby in-patient program where she can be reunited with her child immediately. She said she didn't want to leave town or be away from her boyfriend that long. Ms. Redd is in denial about the level of her addiction. She should at least enter our agency's pre-treatment program for women. I administered a drug screen today and recommend random tests for the next three months. If she uses PCP again, either in-patient or intensive outpatient (IOP) treatment is recommended.

12. Provisional Diagnosis

PCP Dependency. R/O: Dependent Personality Disorder

Signature: Grace Hanker, MS, CCAS

GH:ds/TH 107SA

Residential Substance Abuse Treatment Center: Fresh Start

Release form has been signed by patient; records are accessible to social worker and other necessary parties.

Fresh Start therapist explained to SW that Clarissa attended group sessions and individual therapy but she "never seemed wholeheartedly committed to the program." She seemed somewhat immature and self-centered. Her care for Mariah was only minimally sufficient, and she required a lot of coaching to parent even that well.

Clarissa was only in the program for 2 months before leaving AMA (against medical advice). Per clinicians, the usual stay is 6 months, minimum. Clarissa got into "petty disputes" with several other clients. Clarissa reported to this SW that an especially nasty and protracted "feud" between her and another client led to her leaving the program. Fresh Start staff stated that although they tried to mediate, Clarissa would not stop arguing with the other woman. Staff observed that Clarissa seemed to enjoy the excitement of it.

Fresh Start therapist noted to this SW: "She was very guarded and defensive in group, but we spoke a couple times in private. When Johnny's paternity test came up negative, Clarissa was terrified he would leave her. She was sure he would abandon her and just devastated when he did. That's the real reason she blew out of here. Plus I think things were getting a little too real for her in group. You know almost every addicted woman we treat here has experienced some kind of sexual abuse in the past. Clarissa said that never happened to her, but she would get very uncomfortable when other women started processing around that topic. Her reaction had that too-close-for-comfort feeling to it."

The therapist stated to this SW that Fresh Start would be willing to take Clarissa back into the program if she was willing to try again. They would have to interview her first, to make sure she's really committed to her own sobriety this time.

Redd Case Interviews (for Activity 8A)

Read the interviews in the following order:

- Foster Mother: Julia Budd (First Contact)
- Maternal Grandmother: Lela Jones (First Contact)
- Mother: Clarissa Redd
- Parents of Half-Brother Tyrone: Willy and Pearl Monroe
- Maternal Aunt: Sierra Redd Thomas (First Contact)
- Half-Brother: Buddy Redd
- Step-Grandfather: Charles Jones
- Social Worker: Kim Ellis (First Contact)
- Maternal Grandmother: Lela Jones (Second Contact)
- Maternal Aunt: Sierra Redd Thomas (Second Contact)
- Foster Mother: Julia Budd (Second Contact)
- Social Worker: Kim Ellis (Second Contact)

Redd Case Interviews (for Activity 8A), Cont'd.

Foster Mother: Julia Budd (First Contact)

Julia Budd is a Caucasian single mom who runs an in-home daycare. When I arrived, it was naptime and there were several little kids sleeping in playpens in the living room. Ms. Budd has three biological children, ages 15, 13, and 10, who were at school.

Ms. Budd showed me around the house, which was messy with kid stuff but clean. I peeked in on Mariah, who was napping on Julia's bed with pillows arranged to keep her from rolling off. She was appropriately dressed and appeared to be clean.

As I sat in the kitchen and chatted quietly with Ms. Budd, I heard a repeated occasional beep from the living room, a low-battery warning for a smoke alarm.

Ms. Budd described how small Mariah was when she first got her at 5 days old. "I asked the social worker, 'Where's the baby?' She was buried by the blanket and I couldn't even tell she was there! She only weighed 5 pounds."

Ms. Budd told me that Mariah had qualified for early childhood services because of her exposure to PCP in utero but that she had been given a clean bill of health and released from that program. She has caught up in her size and now falls within normal parameters for her age.

Ms. Budd said she never planned to adopt, she just wanted to be a foster mother. But Mariah has stolen her heart and she now wants to keep her.

Maternal Grandmother: Lela Jones (First Contact)

Lela agreed to meet during her lunch hour at work. She confirmed that her household consists of her and her husband, Charles, her daughter Clarissa, and Clarissa's son Buddy, for whom Lela has legal custody.

She told me that Clarissa was only 15 when she had Buddy, "Way too young to concentrate on a baby." She said that Clarissa was always out playing around and also busy going to school—she did graduate from high school. Lela ended up raising Buddy. Sometimes Clarissa would try to "pull rank on her and mess things up for him" so finally Lela went to social services and got legal custody of Buddy.

Redd Case Interviews (for Activity 8A), Cont'd.

I asked about Clarissa's use of drugs when Buddy was born. She didn't think Clarissa was using then, but started later after Buddy's father left her. She doesn't know where Buddy's father is now—she thinks he left the state.

Lela seemed to minimize her daughter's drug problem, and talked like she doesn't know what Clarissa is doing. She said that Clarissa will have to get it together for Mariah now because Lela can't stay home with another baby.

Lela didn't say much about Charles, except that he's a hard worker and a good provider. "He's the reason we have a good life." Lela married Charles when Clarissa was 7 and Sierra was 10. Sierra is her other daughter. She and her husband live in Texas and have a son, Antoine, who is 3. Sierra's husband is in the army. Lela told me that Sierra's a good girl. "She never messed with drugs and boys like Clarissa."

I asked Lela about Buddy. She said that he is a good boy and gets good grades in school. He goes to church with Lela and sings in the children's choir. Lela said that he knows Clarissa is his mom, not his sister, but that he also knows that Lela is in charge.

I asked about Buddy and Charles and was told that Charles leaves the children mostly up to her. He takes Buddy to a ball game sometimes but he's not that involved.

When I mentioned that I would like to interview Charles too, she said she would rather I not bother him. "He stays out of things where the kids are concerned. I don't know if he'll talk to you, really, and I don't think he'd have much to tell you that I can't tell you."

Mother: Clarissa Redd

Clarissa left her substance abuse treatment facility, Fresh Start, AMA (against medical advice).

Although she has continued to have positive drug screens, she insisted that she doesn't have a drug problem. "I don't do it that often anyway." She said that she is going to the NA (Narcotics Anonymous) meetings down at the armory, but doesn't have a sponsor yet. She also had the substance abuse evaluation done.

In reference to her substance abuse evaluation, she said, "Those doctors don't know everything. They can't say what kind of a person I am after only a couple hours."

Redd Case Interviews (for Activity 8A), Cont'd.

She stated that she loves Mariah and wants her back. However, she doesn't have a plan for fulfilling court-ordered requirements to do so. She said, "Give Mariah away? What! Are you crazy? They can't give away my child!"

She attended a parenting class. She has visitation with Mariah every other week. She said, "That's not enough and it's not fair. She's *my* baby."

She told me that she is no longer seeing Johnny anymore and that they broke up. She continues to be unemployed and to live in her mother's home.

Parents of Half-Brother Tyrone: Willy and Pearl Monroe

Willy, Pearl, and Tyrone are home when I visit. I chatted with Tyrone briefly before he was sent next door to play with a neighbor.

Pearl told me that she and Willy come from "nice" families but that Clarissa's people are "no good—except for Sierra, who was a good girl."

She does not trust Clarissa and has seen her all over town with lots of different men over the years, "doing the Lord knows what!" She believes that Clarissa's boyfriend Johnny deals drugs. She stated that she does not want Mariah to suffer and hopes that a safe home for her can be found. "Clarissa won't ever be a good mother."

She and Willy were going together when he started to see Clarissa. The affair was short lived and Willy was quickly back with Pearl, although Clarissa was pregnant. "But then we wouldn't have Tyrone if she hadn't been, so I guess that's for the best after all. I can't have children myself."

Willy added that Clarissa was too young and wild to take care of Tyrone and he is glad she was willing to sign him over without a fight. He said that he does not want "to mess in anybody else's business." He only sees Clarissa a couple times a year when she visits Tyrone. Other than that, he has no idea what she does. He doesn't really know Johnny Smith but commented that Johnny is "slick" looking.

Maternal Aunt: Sierra Redd Thomas (First Contact)

Sierra was polite and easy to speak with. She has been married for 5 years and has a 3-year-old son, Antoine.

Redd Case Interviews (for Activity 8A), Cont'd.

She got out of the army when she was pregnant to be a stay-at-home mom. Her husband is making a career of the army.

She left home at age 18 and doesn't call home often. She said that she left because her mother's husband, Charles, made sexual advances on her more than once, when he was drinking. She was scared he might rape her, and her mom took his side and didn't believe Sierra.

She doesn't understand why Clarissa keeps living there and she's been worried about her for years, ever since she had Buddy. But Sierra doesn't see what she can do to help her sister. She is not prepared to invite Clarissa to come live with her in Texas.

She is interested in being a possible placement for Mariah and would consider keeping her if it came to that, but she must speak with her husband about it first.

I followed up with her a week later and was told that her husband was open to having Mariah live with them. She asked that I not say anything to her mother or sister for now.

I told her to contact the social worker and express her interest.

Half-Brother: Buddy Redd

I went to the Jones house and found Buddy shooting baskets in the driveway. I spoke with him for a few minutes. He already knew who I was and was not afraid of me. He told me that he likes to play basketball and he's in the 5th grade at Hardy Elementary. He gets good grades and goes to church with his "mom" (Lela, not Clarissa).

I asked him where Charles was and he told me that he was out back mowing the lawn. He said that Charles just wants him "to be good."

I noticed that Buddy seemed to have some darkness in his complexion under one eye. Thinking it might be a black eye, I asked where he got the shiner. He didn't understand the question, so I asked if someone had hit him. He said no, that he fell down on the playground at school. His teacher did not see it happen. He seemed a little uncomfortable at this point so I thanked him for the visit and went to find Charles.

Redd Case Interviews (for Activity 8A), Cont'd.

Step-Grandfather: Charles Jones

I was not able to get Charles on the phone so I dropped by the house hoping to catch him home. Indeed, he was mowing their large lawn on a riding mower. He stopped the mower only when I practically stood in front of it. When I introduced myself and my role, he said he's not in charge of the kids. I asked to speak with him for a few minutes anyway. He said he's really got nothing to say and he's got a lot of work to do. He said, "Excuse me," in a tone that expressed controlled hostility, then restarted the lawn mower and rode off.

Social Worker: Kim Ellis (First Contact)

I finally met social worker Kim Ellis several months into the case. She seemed nice, but overworked.

She told me the following:

- Clarissa has not been in treatment since she left Fresh Start against medical advice.
- Clarissa dropped out of sight for a couple months. Lately she's been calling to request a visit with Mariah. Kim plans to let her visit only if she returns to Imaginary County Mental Health for S/A treatment.
- Kim will ask Clarissa to agree to have a psychological evaluation.
- There is no viable service agreement right now because Clarissa is out of compliance.
- Mariah is doing well in her foster placement. Her health is good. The plan will be adoption by Julia Budd if Clarissa doesn't get it together.
- Kim is not in touch with any biological family members about placement. She believes the foster family—the only family Mariah's ever known—will be best for this baby.
- She has no direct knowledge of a problem between Clarissa's stepfather and Buddy, but she'll keep an eye out if she visits the home again. She told me that if I have a concern about a child I should report it.

Redd Case Interviews (for Activity 8A), Cont'd.

Maternal Grandmother: Lela Jones (Second Contact)

Lela Jones told me that her daughter Sierra definitely lied about Charles. She just never liked him and she was trying to get Lela to divorce him, but "her little plan didn't work. I was so mad at her for accusing Charles like that, but I forgave her."

She admitted that Charles drinks sometimes but considers him to be a good man. She is aware of Charles's criminal record but says that was all from a long time ago. He hasn't been in trouble since they've been together—about 15 years. "How long do you have to wait until it doesn't count against you anymore?!"

She said that Clarissa is not in treatment and hasn't done much about getting treatment. She believes that Clarissa does go to meetings sometimes. "I tell Clarissa to get help but she doesn't listen to me."

She refuses to "throw out" Clarissa from her home. "I still love her and we still talk. Besides, Clarissa helps me with Buddy."

She said that Buddy had a black eye from being hit in the face with a football playing with some friends. She is adamant that Charles did not hit him.

Maternal Aunt: Sierra Redd Thomas (Second Contact)

I spoke with Sierra again. She said that if she takes Mariah, it will be a total commitment. She's only interested in adoption, not guardianship or custody, because she doesn't trust her family and doesn't want any future problems with them. She called Kim Ellis to express her interest in Mariah and said that the social worker was less than excited to hear from her. She is willing to come visit and meet Mariah whenever that can be arranged.

On the topic of Charles, she told me that he used to beat her and Clarissa "pretty bad as discipline."

She said that Charles really did make sexual advances on her. On two different occasions when he was drunk, he pressed her against the wall and kissed her. She was a 17-year-old high school senior at the time and said it was gross and terrifying. "I wouldn't lie about something like this even though they say I lied."

Redd Case Interviews (for Activity 8A), Cont'd.

Foster Mother: Julia Budd (Second Contact)

On this visit Julia Budd's three biological children were present and the daycare children were awake so there was a lot of activity. Ms. Budd seemed to take everything in stride, "No one is crying so it's good." Mariah was being carried around the house by her big "siblings" and appeared happy. I spoke with each of Julia's children and they all seem like typical kids.

I asked Ms. Budd why she wants to adopt Mariah and she said, "We love her! We're all so attached to her." She mentioned that the social worker said a family member called. "I hate that they're coming out of the woodwork now. It's not fair!" She expressed concern that the family would take Mariah away from them.

I asked her how she plans to deal with Mariah's different racial background. How will she honor the child's racial and ethnic heritage and deal with the obvious differences? She said, "Kids are kids. We're all humans and Mariah will be a member of our family equal to everyone else." She told me that she cares for kids from all races in her daycare and they get along just fine.

Social Worker: Kim Ellis (Second Contact)

I talked on the phone with Kim in November.

She was unhappy that I had contacted Mariah's maternal aunt. "It's too bad you can't leave well enough alone!"

She said that she would do a home study on Sierra if the court says she has to but she thinks it would be a waste of time. "This baby already has a family that loves her and she needs to stay there."

She told me that she believes that Clarissa is pretty much a lost cause. She's had plenty of chances and been offered a lot of services but she just doesn't follow through.

Writing Program Report Activity

Using the Program's Court Report Template found in Local/Program Pre-Work Handouts, write a court report based on the Redd Case. This is an opportunity for you to apply what you have learned from the training and to demonstrate your readiness to work on a case independently. You will have one week to complete the activity.

CASA/GAL Volunteer Competencies Review Activity

Take out the Developing Competencies checklist that you filled out prior to the beginning of training. Review the competencies and assess how you've grown over the course of training. Which competency categories do you still need to strengthen? Below, write down a plan for how you will address these areas.

Competency Category: _____

What I need to strengthen: _____

Steps I will take to increase my competency: _____

_____

_____

_____

Competency Category: _____

What I need to strengthen: _____

Steps I will take to increase my competency: _____

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Competency Category: _____

What I need to strengthen: _____

Steps I will take to increase my competency: _____

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CASA/GAL Volunteer Competencies Review Activity, Cont'd.

Competency Category: _____

What I need to strengthen: _____

Steps I will take to increase my competency: _____

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Competency Category: _____

What I need to strengthen: _____

Steps I will take to increase my competency: _____

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