



Texas CASA Pre-Service Training Curriculum
Volunteer Manual



TEXASCASA
Court Appointed Special Advocates
FOR CHILDREN

WELCOME

Dear Volunteer,

First and foremost, thank you for choosing to invest your time and effort to become an advocate and speak up for a child who needs you. Welcome to the CASA family.

We're happy you are here. Children in foster care have the odds stacked against them in many ways. In addition to grappling with the trauma of abuse or neglect, they are uprooted from everything they've ever known. By providing a reliable adult presence and advocacy, volunteers make a world of difference. You will listen deeply, work to improve the child's daily life, and be their voice in court.



CASA volunteers advocate in every way possible for the right services and individualized attention that will help a child stay on track to be successful. Their end goal is for the child to be moved out of foster care and into a safe, loving and permanent home where they can heal and grow.

This pre-service training will equip you with the solid base of knowledge you need to powerfully and compassionately advocate for a child that has been abused or neglected. In addition to gaining an understanding of child protection system and the CASA volunteer role, you will also learn about trauma and resilience, efforts at improving our systems, cultural competence and much more.

We have an uncompromising belief in The CASA Way: We will achieve what others think is impossible, and each of us is an essential part of the solution. By joining our movement and speaking up for a child in foster care, you have the opportunity to make a lasting, positive difference in our world and collective future. Thank you for stepping up to the challenge! Thank you for stepping up to transform the lives of Texas' most vulnerable children.

A handwritten signature in black ink that reads "Vicki Spriggs". The signature is fluid and cursive.

Vicki Spriggs, CEO

Every child has a chance – it's you. ®

OUR VISION

We envision a safe and positive future for all Texas children.

OUR MISSION

The mission of Texas CASA is to support local volunteer advocacy programs and to advocate for effective public policy for children in the child protective system.

ACKNOWLEDGMENTS

This Texas CASA Volunteer Manual is the work of many hands. The core content is adapted from the 2017 Pre-Service Volunteer Manual manual created by National CASA. The leadership and staff of CASA of Travis County contextualized and honed the content to meet the specific needs of our region.

We are grateful for their collaboration as the Training Team at Texas CASA developed a manual universal to Texas programs, and customizable for each individual agency. We acknowledge all who offered insights so that this work can best benefit children across Texas.

Design by Tablo Consulting

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STRENGTHENING THE VOICES OF CASA STATEWIDE

HEARST *foundations*



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Chapter 1

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TEXASCASA
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**Every child deserves a champion:
an adult who will never give up on them,
who understands the power of connection
and insists they become the best they can
possibly be.”**

– Rita Pierson

Chapter 1: The CASA/GAL Volunteer Role

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PRE-WORK INSTRUCTIONS

Please complete the following pre-work before you attend your first volunteer training session. This pre-work can also be completed online at Texas CASA’s Learning Center at www.learn.texascasa.org.

1. Read pages 7–46, “The CASA Role” through the end of the “Bleux Case File.”
2. Review and think about the Developing Competencies for CASA/GAL Volunteers assessment.
3. Write down any questions you have about the “Child Welfare History” material.
4. Using the Bleux Case File, write a case history in one or two paragraphs.
5. Write down any questions you have about the case.

The CASA Role

A CASA volunteer is a court-appointed, trained and committed adult who ensures that each child's individual needs remain a priority in an overburdened child welfare system. They get to know the child while also gathering information from the child's family, teachers, doctors, therapists, caregivers, and anyone else involved in the child's life in order to make independent and informed recommendations to help the judge decide what's best for the child.

WHO SUPPORTS THE ADVOCATE?

CASA volunteers are paired with a staff professional who supports and guides them every step of the way. This includes preparing for and attending case-related hearings and meetings, and guiding the volunteer to pertinent resources specific to each case. The different CASA programs call this professional by a variety of titles, such as advocate supervisor, advocate coordinator, case supervisor and coach supervisor. When the staff professional who is there to guide them is not available for a meeting or hearing, another CASA staff member might attend to support the volunteer.

Please read your program's Advocate Job Description, provided by your trainer. Below is a general list of duties, but your program's exact requirements take precedence.

VOLUNTEERS' PRIMARY DUTIES

CASA volunteers are expected to perform the tasks listed below. These tasks constitute what is minimally required to effectively fulfill the role as an advocate for a child in the child welfare system:

- Review/research case information.
- Participate in case staffings, family team meetings, court hearings, school related meetings, etc.

- Establish rapport and relationships with the child and all other parties in the case.
- Meet with the child regularly (at least once per month, or per your program's requirements) and monitor their placement.
- Assess the child's physical, mental, behavioral and educational needs.
- Observe parent-child interactions.
- Monitor adherence to court orders to ensure compliance.
- Identify needs and advocate for services (make referrals as needed).
- Stay abreast of the most up-to-date case information.
- Check for accountability in service planning and delivery to ensure for quality.
- Document all activities, accurately taking note of any concerns, progress or lack thereof.
- Identify resources within the child's family and help build/maintain connections.
- Facilitate communication among parties while maintaining confidentiality.
- Submit required reports and case updates on or before the specified due date.
- Monitor compliance with court timelines to expedite permanency.
- Maintain consistent contact with the supervisor (at least monthly).
- Complete a minimum of 12 hours of in-service training each year.
- Comply with CASA/GAL policies, procedures and ethical guidelines that promote and protect the CASA/GAL program.
- Remain appointed until the case is closed.
- Maintain monthly contact with caregiver.
- Maintain monthly contact with service providers.
- Maintain documentation required by local CASA/GAL staff.

Developing Competencies for CASA/GAL Volunteers

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:

CATEGORY	KNOWLEDGE, SKILLS AND ATTRIBUTES	CURRENT	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 their role from that of others involved in the case		
	Knows how to find support and resources to assist their advocacy		
	Understands how to obtain relevant confidential information		
	Understands the importance of partnering with their supervisor to develop goals, discuss issues and assess progress		
	Understands the importance of participating in ongoing professional development to strengthen advocacy skills		
COMMUNICATION	Knows how to effectively articulate a point of view while advocating for the needs of the child(ren)		
	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		

Developing Competencies for CASA/GAL Volunteers

CATEGORY	KNOWLEDGE, SKILLS AND ATTRIBUTES	CURRENT	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 the 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 cultural differences		
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		
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 lifestyle		
	Understands the importance of knowing when to ask for and accept help		
	Understands the importance of maintaining a sense of hope and optimism		

Developing Competencies for CASA/GAL Volunteers

CATEGORY	KNOWLEDGE, SKILLS AND ATTRIBUTES	CURRENT	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(ren)		
	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 a thorough review of the information		
	Understands evaluating alternative decisions		
	Understands the confidentiality requirements of being a CASA/ GAL volunteer		
	Understands that personal values and biases about mental illness, domestic violence and substance abuse can affect objectivity		
	Knows how to evaluate what is in the child(ren)'s best interest		
FOUNDATIONS OF KNOWLEDGE	Understands the importance of using a strength-based approach		
	Understands concurrent planning		
	Understands advocacy differs depending on the age of the child		
	Understands the options for permanency for a child		
	Understands how to identify a child's basic needs		
	Understands the cycle of attachment		
	Understands possible reactions to separation and 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		

Developing Competencies for CASA/GAL Volunteers

CATEGORY	KNOWLEDGE, SKILLS AND ATTRIBUTES	CURRENT	DEVELOP
FOUNDATIONS OF KNOWLEDGE	Understands strategies to advocate for children and adolescents with mental health disorders		
	Understands the ways that substance abuse can affect children and families		
	Knows the importance of being aware of resources in the community that assist with substance abuse		
	Understands how domestic violence affects children and 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		
	Understands possible reactions to separation and loss		
	Recognizes the importance of understanding a child's journey through the child welfare system		
	Understands Minimum Sufficient Level (MSL) of Care and its importance in best interest		
	Understands the nature and scope of the roles of others in court system (e.g., caseworkers, attorneys, therapists, etc.)		
	Knows the importance of the federal laws that impact their advocacy		
Understands what constitutes abuse and neglect			

Child Welfare History

MARY ELLEN'S 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 children who have been abused or neglected.

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 American Society for the Prevention of Cruelty to Animals (ASPCA). 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 rawhide. [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."

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: The country’s first juvenile court, in 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. This allowed for better identification of cases of child abuse.
- 1938: The Fair Labor Standards Act (FLSA), which detailed children’s first legal rights, 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 children who’ve been abused or neglected. We are also new to developing appropriate systems, methods, and programs to cope with the problems these families and children face.
- The list 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 and Neglect Laws

1974: Child Abuse Prevention and Treatment Act (CAPTA), Public Law 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.

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 child who has been abused or neglected whose case results in a judicial proceeding.
- Maintain the confidentiality of child protective services records.

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

Responded to congressional hearings in the 1970s that revealed pattern of public and private removal of Indian children from their homes, undermining families and threatening tribal survival and Native American cultures. ICWA 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.

Requires that states:

- Recognize that Indian children have special rights as members of sovereign nations within the United States.
- Set up placement preference schemes for foster care placements and adoptions of children who have been determined to be Indian children.
- Establish the right of certain entities, including the tribe and the Indian custodian, if one exists, to appear as parties to child welfare cases.

- Determine when and if a case should be transferred to tribal court.
- Describe rights of the Indian child and the child's tribe.

CASA/GAL volunteers should:

- 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 and be culturally responsive.
- Remember that Adoption and Safe Families Act (ASFA) timelines do not apply to Indian children sovereign nations within the United States.
- Keep in mind that ICWA takes precedence over other federal and state laws.
- Visit the National Indian Child Welfare Association website; it has several excellent packets of ICWA information available for a small charge.

1980: Adoption Assistance and Child Welfare Act, Public Law 96-272

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

Federal Child Abuse and Neglect Laws

CASA/GAL volunteers should:

- Consider possible placements that respect a child's cultural heritage but do not limit their options.
- Become familiar with IMPACT, the data collection system used by DFPS to document all stages of service of a case, including when someone reports abuse, neglect, or exploitation and when those cases are investigated.

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)

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

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 a permanency plan within 12 months.
- Requires a 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.
- 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 on the next page).
- Allows states to provide Medicaid to young people between the ages of 18 and 21 who were in foster care on their 18th birthday.

Federal Child Abuse and Neglect Laws

- 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 percent) of their independent living program funds to provide room and board for youth 18 to 21 who have left foster care.

The John H. Chafee 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.
- 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 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".

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 for out of state general revenues. These expenses include foster care and therapy.
- 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.

Texas Family Code: Foster Children’s Bill of Rights

Title 5. The Parent-Child Relationship and the Suit Affecting the Parent-Child Relationship

Subtitle E. Protection of the Child

Chapter 263. Review of Placement of Children Under Care of Department of Family and Protective Services

Subchapter A. General Provisions

Sec. 263.008. Foster Children’s Bill of Rights

(a) In this section:

- (1) “Agency foster home” and “facility” have the meanings assigned by Section 42.002, Human Resources Code.
- (2) Repealed by Acts 2015, 84th Leg., R.S., Ch. 944, Sec. 86, eff. September 1, 2015.
- (3) “Foster children’s bill of rights” means the rights described by Subsection (b).

(b) It is the policy of this state that each child in foster care be informed of the child’s rights provided by state or federal law or policy that relate to:

- (1) abuse, neglect, exploitation, discrimination, and harassment;
- (2) food, clothing, shelter, and education;
- (3) medical, dental, vision, and mental health services, including the right of the child to consent to treatment;
- (4) emergency behavioral intervention, including what methods are permitted, the conditions under which it may be used, and the precautions that must be taken when administering it;
- (5) placement with the child’s siblings and contact with members of the child’s family;
- (6) privacy and searches, including the use of storage space, mail, and the telephone;

- (7) participation in school-related extracurricular or community activities;
 - (8) interaction with persons outside the foster care system, including teachers, church members, mentors, and friends;
 - (9) contact and communication with caseworkers, attorneys ad litem, guardians ad litem, and court-appointed special advocates;
 - (10) religious services and activities;
 - (11) confidentiality of the child's records;
 - (12) job skills, personal finances, and preparation for adulthood;
 - (13) participation in a court hearing that involves the child;
 - (14) participation in the development of service and treatment plans;
 - (15) if the child has a disability, the advocacy and protection of the rights of a person with that disability; and
 - (16) any other matter affecting the child's ability to receive care and treatment in the least restrictive environment that is most like a family setting, consistent with the best interests and needs of the child.
- (c) The department shall provide a written copy of the foster children's bill of rights to each child placed in foster care in the child's primary language, if possible, and shall inform the child of the rights described by the foster children's bill of rights:
- (1) orally in the child's primary language, if possible, and in simple, nontechnical terms; or
 - (2) for a child who has a disability, including an impairment of vision or hearing, through any means that can reasonably be expected to result in successful communication with the child.
- (d) A child placed in foster care may, at the child's option, sign a document acknowledging the child's understanding of the foster children's bill of rights after the department provides a written copy of the foster children's bill of rights to the child and informs the child of the rights described by the foster children's bill of

Texas Family Code: Foster Children's Bill of Rights

rights in accordance with Subsection (c). If a child signs a document acknowledging the child's understanding of the foster children's bill of rights, the document must be placed in the child's case file.

- (e) An agency foster home or other residential child-care facility in which a child is placed in foster care shall provide a copy of the foster children's bill of rights to a child on the child's request. The foster children's bill of rights must be printed in English and in a second language.
- (f) The department shall promote the participation of foster children and former foster children in educating other foster children about the foster children's bill of rights.
- (g) The department shall develop and implement a policy for receiving and handling reports that the rights of a child in foster care are not being observed. The department shall inform a child in foster care and, if appropriate, the child's parent, managing conservator, or guardian of the method for filing a report with the department under this subsection.
- (h) This section does not create a cause of action.

Texas Family Code: Powers and Duties of Guardian Ad Litem for Child

Title 5. The Parent-Child Relationship and the Suit Affecting the Parent-Child Relationship

Subtitle A. General Provisions

Chapter 107. Special Appointments, Child Custody Evaluations, and Adoption Evaluations

Subchapter A. Court-Ordered Representation in Suits Affecting the Parent-Child Relationship

Sec. 107.002. Powers and Duties of Guardian Ad Litem for Child.

- (a) A guardian ad litem appointed for a child under this chapter is not a party to the suit but may:
- (1) conduct an investigation to the extent that the guardian ad litem considers necessary to determine the best interests of the child; and
 - (2) obtain and review copies of the child's relevant medical, psychological, and school records as provided by Section 107.006.
- (b) A guardian ad litem appointed for the child under this chapter shall:
- (1) within a reasonable time after the appointment, interview:
 - (A) the child in a developmentally appropriate manner, if the child is four years of age or older;
 - (B) each person who has significant knowledge of the child's history and condition, including educators, child welfare service providers, and any foster parent of the child; and
 - (C) the parties to the suit;
 - (2) seek to elicit in a developmentally appropriate manner the child's expressed objectives;
 - (3) consider the child's expressed objectives without being bound by those objectives;

Texas Family Code: Powers and Duties of Guardian Ad Litem for Child

(4) encourage settlement and the use of alternative forms of dispute resolution; and

(5) perform any specific task directed by the court.

(b-1) In addition to the duties required by Subsection (b), a guardian ad litem appointed for a child in a proceeding under Chapter 262 or 263 shall:

(1) review the medical care provided to the child;

(2) in a developmentally appropriate manner, seek to elicit the child's opinion on the medical care provided; and

(3) for a child at least 16 years of age, ascertain whether the child has received the following documents:

(A) a certified copy of the child's birth certificate;

(B) a social security card or a replacement social security card;

(C) a driver's license or personal identification certificate under Chapter 521, Transportation Code; and

(D) any other personal document the Department of Family and Protective Services determines appropriate.

(c) A guardian ad litem appointed for the child under this chapter is entitled to:

(1) receive a copy of each pleading or other paper filed with the court in the case in which the guardian ad litem is appointed;

(2) receive notice of each hearing in the case;

(3) participate in case staffings by the Department of Family and Protective Services concerning the child;

(4) attend all legal proceedings in the case but may not call or question a witness or otherwise provide legal services unless the guardian ad litem is a licensed attorney who has been appointed in the dual role;

(5) review and sign, or decline to sign, an agreed order affecting the child;

Texas Family Code: Powers and Duties of Guardian Ad Litem for Child

- (6) explain the basis for the guardian ad litem's opposition to the agreed order if the guardian ad litem does not agree to the terms of a proposed order;
 - (7) have access to the child in the child's placement;
 - (8) be consulted and provide comments on decisions regarding placement, including kinship, foster care, and adoptive placements;
 - (9) evaluate whether the child welfare services providers are protecting the child's best interests regarding appropriate care, treatment, services, and all other foster children's rights listed in Section 263.008;
 - (10) receive notification regarding and an invitation to attend meetings related to the child's service plan and a copy of the plan; and
 - (11) attend court-ordered mediation regarding the child's case.
- (d) The court may compel the guardian ad litem to attend a trial or hearing and to testify as necessary for the proper disposition of the suit.
- (e) Unless the guardian ad litem is an attorney who has been appointed in the dual role and subject to the Texas Rules of Evidence, the court shall ensure in a hearing or in a trial on the merits that a guardian ad litem has an opportunity to testify regarding, and is permitted to submit a report regarding, the guardian ad litem's recommendations relating to:
- (1) the best interests of the child; and
 - (2) the bases for the guardian ad litem's recommendations.
- (f) In a nonjury trial, a party may call the guardian ad litem as a witness for the purpose of cross-examination regarding the guardian's report without the guardian ad litem being listed as a witness by a party. If the guardian ad litem is not called as a witness, the court shall permit the guardian ad litem to testify in the narrative.
- (g) In a contested case, the guardian ad litem shall provide copies of the guardian ad litem's report, if any, to the attorneys for the parties as directed by the court, but not later than the earlier of:

Texas Family Code: Powers and Duties of Guardian Ad Litem for Child

- (1) the date required by the scheduling order; or
 - (2) the 10th day before the date of the commencement of the trial.
- (h) Disclosure to the jury of the contents of a guardian ad litem's report to the court is subject to the Texas Rules of Evidence.
- (i) A guardian ad litem appointed to represent a child in the managing conservatorship of the Department of Family and Protective Services shall, before each scheduled hearing under Chapter 263, determine whether the child's educational needs and goals have been identified and addressed.

Acronyms and Definitions

AAL – Attorney ad litem, attorney for the child

Abuse – When an individual, whether through action or failing to act, causes injury, death, emotional harm or risk of serious harm to a child

ADA – Assistant District Attorney; the attorney representing CPS, often referred to as the DA

ADHD – Attention deficit/hyperactivity disorder

Adoption Staffing – A meeting where the case file is officially transferred from the Temporary Managing Conservatorship (TMC) caseworker to the new adoption caseworker. CASAs can attend this meeting and contribute valuable information to the new worker about the children, their needs and the adoption plan.

AG – Attorney General

APS – Adult Protective Services; the agency responsible for investigating abuse/neglect and exploitation of the elderly or individuals who have a disability

CAC – Forensic interview that is administered to children who have made an outcry of physical or sexual abuse. This interview is done at the Center for Child Protection (CAC - Child Advocacy Center was the original name)

CASA – Court Appointed Special Advocate

CCMS – Child Care Management Services

CCP – Center for Child Protection; an organization focused on reducing trauma to victims of child sexual abuse, physical abuse and neglect during the investigations of child abuse cases.

COS – Court-Ordered Services; cases where parents maintain rights of their children, but the court requires parents to do services to maintain these rights. In COS cases, the state does not take legal custody of the children. The children live either with the parents or in a placement that the parents have approved (like a relative or symbolic relative).

COS – Circle of Support; a meeting conducted for teens, to discover the teen’s goals and if they need extra support; the individuals attending the meeting are usually suggested by the teen. These meetings are held at least annually for all children in CPS custody (TMC or PMC – Permanent Managing Conservatorship) age 16 and over. The youth may invite anyone they wish to be there, and the goal is for trusted adults to assist the youth in developing plans as they approach adulthood. These meetings are run by a CPS facilitator and will include the youth’s Preparation for Adult Living (PAL) worker from CPS, who will also provide the youth with information on the benefits available to them as a teen in care.

CPA – Child Placing Agency; an agency that trains and licenses foster parents

CPS – Child Protective Services; a division of a state agency that investigates reports of abuse and neglect of children, places children in foster care, and places children in adoptive homes.

CPU – Child Placement Unit; the part of CPS that locates foster homes/RTCs for children in CPS care

CVS – Conservatorship; the work unit that handles cases where CPS is granted temporary or permanent conservatorship (custody) of children

DFPS – Department of Family and Protective Services; the state agency that includes

Acronyms and Definitions

Child Protective Services (CPS), as well as programs protecting people with disabilities, the elderly and overseeing childcare.

DSM – Diagnostic and Statistical Manual of Mental Disorders; published by the American Psychiatric Association and offers a common language and standard criteria for the classification of mental disorders.

ED – Emotional Disturbance

Emotional Abuse – The systematic diminishment of a child. It reduces a child’s self-concept to the point where the child feels unworthy of respect, friendship, love and protection.

FA – Father

FAS – Fetal Alcohol Syndrome

FBSS – Family-Based Safety Services; protective services provided to any family that needs CPS assistance to reduce the likelihood that a child in the family will be abused or neglected.

FGC – Family Group Conference; a meeting in which the child and family meet with relatives, friends, CPS supervisors and caseworkers, service providers, CASA, and support persons in the community to develop a plan to ensure that the child is cared for and protected from future harm. These meetings are generally two to three hours, but are sometimes longer. The idea is to bring together all of the parties and all important family members – grandparents, aunts, uncles, cousins and any symbolic relatives – to support the family and figure out how they can work toward the permanency goal. Like permanency conferences, a convener from CPS facilitates FGCs. These are typically positive meetings, focusing on the hopes, dreams, strengths, and support network of the family. The reasons for removal are discussed, and the family has a chance to explore and discuss solutions on their own.

FH – Foster Home

Final Orders – The court must enter a final order before the first Monday after the first anniversary of the order appointing CPS as temporary managing conservator, unless the court has granted an extension. A final order is one that:

- Requires the child be returned to the parents
- Names a relative or another person as the child’s managing conservator
- Without terminating the parent-child relationship, appoints CPS as the managing conservator of the child, or
- Terminates the parent-child relationship and appoints a relative, another suitable person, or CPS as the managing conservator.

FP – Foster Parents

FTT – Failure to Thrive; when a child under 2 years of age has a weight or rate of weight gain significantly below that of other children of similar age.

FTM – Family Team Meeting

GAL – Guardian Ad Litem. Some CASA programs are given the legal status of GAL by their court. Texas Family Code states that “the guardian ad litem conducts an investigation to the extent that the guardian ad litem considers necessary to determine the best interests of the child.”

Hair Strand – A hair strand test is used to detect drug use for roughly the past three months.

Hrg – Hearing

Hx – History

ICPC – Interstate Compact on the Placement of Children; established to ensure that when children are placed out of state, they receive protection and services that would be provided in their home state. An ICPC Home Study is required and done on the potential out-of-state placement.

ICWA – Indian Child Welfare Act (pronounced ick-wuh); a federal law that seeks to keep American Indian children with American Indian families

IOP – Intensive Outpatient Services; nonresidential services for drug or alcohol treatment.

Acronyms and Definitions

ISP – Individualized Service Plan; a treatment meeting usually held at the child’s placement to see how the child is progressing, if they are meeting their goals both at home and in school and a review of medications; the child will attend this meeting and have input. CASA should also attend this meeting.

JMC – Joint Managing Conservatorship; the sharing of the rights and duties of a parent by two parties, ordinarily the parents, even if the exclusive right to make certain decisions may be awarded to one party.

JPO – Juvenile Probation Officer

LD – Learning Disabled

LOC – Level of Care; the level of care is determined by the Youth for Tomorrow Organization, and once it has been established, the level of care determines the placement for each child. The levels are basic, moderate, specialized and intense.

Mediation – A meeting between the child’s parents, the parents’ attorneys, CPS, the child’s attorney, and CASA to reach an agreement regarding permanency instead of going to trial. These all-day meetings are designed to find a permanent legal solution to which all parties can agree. They take place toward the end of a case, usually when reunification is unlikely and an alternate legal outcome is needed. This may be a time when parents recognize that they are unlikely to have their children returned, but that they can avoid a trial by agreeing to some terms. For example, they may agree to relinquish parental rights if the children will be adopted by a specific relative. They are facilitated by licensed mediators, and all conversations during mediation are confidential. Unless pre-authorized, only legal parties to the case may attend.

Medical Neglect – The failure of the person responsible for the child’s welfare to meet their medical needs

MGF – Maternal Grandfather

MGM – Maternal Grandmother

MSL – Minimum Sufficient Level (of care)

MO – Mother

MSA – Mediated Settlement Agreement

MSP – Munchausen Syndrome by Proxy

Neglect – The failure of a person responsible for the child’s welfare to provide necessary basic needs, care or medical attention.

NOS – Not Otherwise Specified

NSUP – Neglectful Supervision; the failure of the person responsible for the child’s care to adequately supervise them

OSAR – Outreach Screening Assessment and Referral; the first point of contact for those seeking substance abuse services. These services are free for individuals who qualify.

PAL – Preparation for Adult Living; a program that provides youth in foster care age 16 or older with training in independent living skills, support services and benefits to prepare them for departure from CPS care.

PC – Permanency Conference; a meeting to go over the families’ service plan. These are generally one-hour meetings at CPS. PCs are meetings for all parties on the case to come together and discuss the history and permanency plans. The child’s placement may be present for this meeting, as well. A convener will run the meeting and make sure everything is covered. Everyone will receive a copy of what was discussed. This can be particularly helpful to make sure everyone knows where the parents are on their services and how they can move forward.

Permanency – The goal of the CPS program is to provide permanence (i.e., a permanent home) for a child who’s been removed from home and placed in substitute care by resolving family dysfunction and returning the child to the family. If this objective cannot be attained, CPS recommends termination of the parent-child relationship and permanent placement of the child with another family or caretaker.

PGF – Paternal Grandfather

PGM – Paternal Grandmother

Acronyms and Definitions

PHAB – Physical Abuse; intentionally harming a child, using excessive force or reckless endangerment.

Physical Neglect – The failure of the person responsible for a child’s care to meet the child’s physical needs for food, clothing, shelter, etc.

PMC – Permanent Managing Conservatorship; when a judge appoints a person to be legally responsible for a child without adopting the child. The court can give PMC to someone other than a parent, including CPS, a relative, a close family friend or a foster parent. This can happen with or without the termination of parental rights.

PO – Parole Officer

Possessory Conservator – A possessory conservator typically still has parental rights, but will not have the final say on most decisions.

Presentation Staffing – This meeting, part of the adoption process, is when CASA can talk directly with a family who has been selected to adopt a child to make sure that the family has a very clear idea of what to expect. Often, the current foster family participates and can share details of the child’s daily routine, behaviors, food preferences, etc. At this meeting, a visitation and transition plan is created. The adoptive family will be given 24 hours after this meeting to confirm that they want to move forward.

RAD – Reactive Attachment Disorder

RAPR – Refusal to Accept Parental Responsibility; pronounced “rapper”

RTB – Reason to Believe; when an incident is reported during an investigation and there is enough proof to believe the incident did occur

RTC – Residential Treatment Center; provides specialized inpatient psychotherapy and education services for youth.

R/O – Ruled Out; when an incident is reported during an investigation and there is not enough proof to believe the incident did occur

SAPCR – Suit Affecting the Parent-Child Relationship, aka Original Petition

SBS – Shaken Baby Syndrome, aka Abusive Head Trauma

SIDS – Sudden Infant Death Syndrome

Selection Staffing – This meeting, part of the adoption process, is to assess home studies on potential adoptive families. CASA and CPS have generally selected top choices of families and are given a chance during this meeting to ask follow-up questions and express concerns. By the end of the meeting, there is often a plan on how to move forward.

Service Plan – Developed initially 30–45 days after a child’s removal from home and reviewed in preparation for hearings, the service plan is developed by everyone involved in the case, including CASA. The goal of the service plan is to secure permanency for the child through one of these ways:

- Reunification with parent(s)
- Termination of parents’ rights to the child
- Placement of child with relatives
- Placement of child in foster care, or
- Adoptive placement

Show Cause (262 Hearing) – This hearing will happen about two weeks after the ex parte hearing. The name refers to the chapter of the Texas Family Code that requires a hearing in which the parents are present and can answer the allegations of abuse and neglect. CPS can start the service plan at this time to show the parents what they can complete for the case to move toward reunification. If CASA was appointed ex parte, CASA will be present at this hearing.

SSI – Supplemental Security Income; a federal program providing income for basic needs for the elderly and people with disabilities

SXAB – Sexual Abuse; engaging a child in any activity for an adult’s own sexual gratification.

Acronyms and Definitions

TANF – Temporary Aid for Needy Families; a federally funded state program that provides financial help for children and their parents or relatives who are living with them.

TBRI – Trust-Based Relational Intervention; an attachment-based, trauma-informed intervention that is designed to meet the complex needs of vulnerable children.

TMC – Temporary Managing Conservatorship; when CPS temporarily becomes the parent of the child

TPR – Treatment Plan Review

TPR – Termination of Parental Rights

Trial – The trial is the final hearing at which a final order is made by the judge after considering testimony and evidence offered by all parties involved, including CASA, regarding the child’s best interest.

Tx – Treatment

UTD – Unable to Determine; when an incident is reported but the investigation is unable to determine whether or not the incident did occur

Additional Acronyms and Definitions for specific topics can be found at:

- Hearings - Chapter 1, Page 52
- Cultural Competence - Chapter 5, Page 185
- Educational Advocacy - Chapter 7, Page 245
- LGBTQ - Chapter 7, Page 249

Bleux Case File

CPS Case File					
Last Name of Case: Bleux			Legal Number(s): D-1-FM-18-097542		
Child(ren)'s Name	DOB	Age	Ethnicity	Sex	Current Location
Deshawn Bleux	March 12	4 months	AA	Male	Foster Care

Current Caretaker(s)	Address	Phone
Emily Padron and Lawrence Cary	8904 Cleveland Ave NW	512-555-2272

Attorneys for:		
Mother	Samuel Bluestein	512-555-7622
Father	Jacob Bell	512-555-6704
CPS	Meghan Fowler	512-555-9300 ext. 38
Child	Elaine Moore	707-555-6659

Case History
<p>May 19: 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.</p> <p>May 21: 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, Antoinette Bleux; father, Miles Bleux), but they refused to be interviewed on the advice of counsel.</p>

Case History continued
<p>May 23: 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.”</p> <p>May 24: 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.</p>

CASA/GAL History	Person(s)	Date Assigned	Date Terminated
Case Initially Assigned to:	You and your team	Today	N/A
Current CASA/GAL Volunteer:	You and your team	Today	
Initial CPS Caseworker:	Jane Morgan		
Current CPS Caseworker:	Jane Morgan		

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

June 6 Family Team Meeting

Case No. D-1-FM-18-097542

Allegation(s): Child sustained serious injuries requiring hospitalization.

In the matter of: Deshawn Lee Bleux

Age: 2 months

The PURPOSE of the Family Team Meeting 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 team meeting coordinator; Jane Morgan, county Child Protective Services (CPS) caseworker; 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 supervisor; Elaine Moore, attorney for the child; 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 appointed to represent the parents in this matter. At the first court hearing, the court has determined the child and parents qualify for court-appointed lawyers.
- IV. PARENTS: Inquiries have been made as to the identity and location of any missing parent.

Bleux Case File

- 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 correct.
 - The mother can be reached at 512-555-1790, cell number.
 - 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 512-555-3865, 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 was 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 was in the hospital for one week.
 - CASA volunteer for the child will be [Your Name]; they can be reached at XXX-XXXX.
 - According to the caseworker, the county medical examiner stated that the injuries could have occurred on the evening he was admitted and were determined to be non-accidental in origin.

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 a foster home.
- CPS stated that the child is doing well.
- The agency is considering other family members for placement of the child.

VII. SERVICES FOR THE PARENTS

Services for the mother of the child:

- At the 262 the mother was ordered to attend parenting education and anger management, to undergo a mental health assessment and follow all recommendations, to attend medical education concerning shaken baby syndrome, and to 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:

- At the 262 the father was ordered to attend parenting education and anger management, to undergo a mental health assessment and follow all recommendations, to attend medical education concerning shaken baby syndrome, and to 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.

Bleux Case File

- 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.

IX. VISITATION

- All visits are to be supervised at this time.
- Visitation would be twice weekly, at the agency for two hours. The parents may visit together if they choose. If they choose not to attend together or it is deemed unsafe for visits together, Mrs. Bleux’s visits will be Tuesdays, 3:30–5:30 p.m. and Mr. Bleux’s visits will be Thursdays, 3:30–5:30 p.m. 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 CPS 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 CPS 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 a status hearing currently scheduled for August 7, 2018, at 2 p.m.

FAMILY TEAM PLANNING CONFERENCE SIGN-IN

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.

Date:		Juvenile(s) Name(s): Deshawn Lee Bleux	
Name	Agency	Address	Phone #
Kerry Rowan	FC	3rd Flr CCH	512-555-4567
Sandi Freeman	CHCC	200 Brookdale	512-555-6789
[Your Name]	CASA	5th floor CCH	415-555-3770
Ramona Haskins	CASA	5th floor CCH	618-555-3770
Sabine Lee		330 Hawkins	512-555-9752
Antoinette Bleux		330 Hawkins	512-555-1790
Sam Bluestein		1260 Main St., Ste 200	403-555-7622
Jane Morgan	CPS	200 Brookdale	917-555-7262
Miles Bleux		740 Center, Apt 204	512-555-3865
Jacob Bell	OPR	7525 Broad	512-555-6704
Adrienne Nikos	CPS	200 Brookdale	512-555-7579
Kim Rytter	CPS	200 Brookdale	713-555-7260
Elaine Moore	OCR	202 Eclipse	512-555-6659

FAMILY TEAM PLANNING CONFIDENTIALITY AGREEMENT

Through their signatures, the undersigned acknowledge that this Memorandum of Understanding has been read to them, accurately reflects what occurred during the Family Team Meeting, and they have received a copy of the Memorandum of Understanding.

Date:	File Number/Name: D-1-FM-18-097542	
Role	Name	Signature
Mother	Antoinette Bleux	
Mother's Attorney	Samuel Bluestein	
Father	Miles Bleux	
Father's Attorney	Jacob Bell	
CASA Volunteer	[Your Name]	
CASA Supervisor	Ramona Haskins	
Family Team Mtg. Coord.	Kerry Rowan	
CPS Caseworker	Jane Morgan	
CPS Supervisor	Kim Rytter	
CHCC Coordinator	Sandi Freeman	
WCPSS Representative		
Friends & Relatives	Sabine Lee (maternal aunt)	
Child's Attorney	Elaine Moore	
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 expected to be hospitalized for one or two 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.

Incident Report continued

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.

END OF PRE-WORK FOR CHAPTER 1

The Four Key Components of the CASA/GAL Volunteer Role

INVESTIGATION

Gather information to carry out an objective examination of the situation including getting to know the child(ren) and their families. This includes developing an understanding of the needs of the child(ren), the relationships that the child(ren) have with family members and fictive kin, the history of the child(ren) and their family, the family environment and cultural norms, and the existing or potential support system.

This information is gathered through regular visits in the placement (and elsewhere), plus conversations, research, and observations with the child(ren), their parents, relatives, fictive kin, teachers, doctors, therapists, caregivers, service providers, daycare workers, CPS caseworkers, the attorney ad litem, and anyone else who has knowledge of the child(ren) or the family. This is not an investigation of the abuse or neglect that started the case. Investigators with CPS have already completed that.

FACILITATION

Identify resources and services for the child(ren) and their family, and facilitate a collaborative relationship between all parties involved in the case, helping to create a situation in which the child(ren)'s needs can be met. Ensure that any information that you obtain during your investigation reaches the parties that need that information. For example, if you are told that your child is failing math during a conversation with the child's teacher, do not assume that the CPS caseworker has that information. Make sure to give that information to anyone who needs it.

ADVOCACY

Speak up for the child(ren) by making fact-based recommendations regarding the child(ren)'s best interest in a written court report and verbally during hearings. Understand that, although court is a very important part of CASA's advocacy, it is not the only place advocacy occurs.

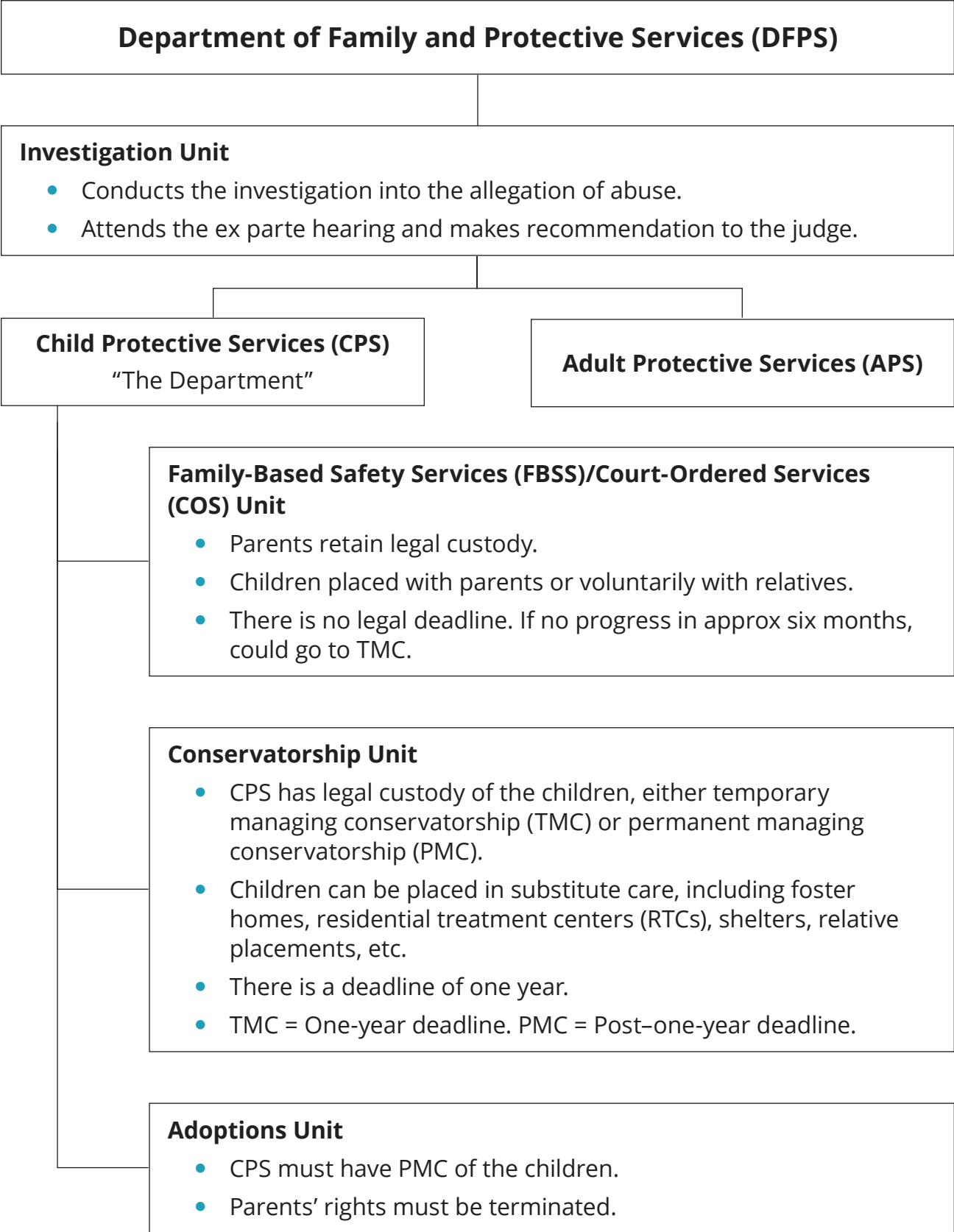
The Four Key Components of the CASA/GAL Volunteer Role

The majority of our advocacy actually occurs outside of the courtroom during meetings and conversations with the parties on the case. If you see a need that is not being met for your child(ren), you should discuss it with your supervisor and bring it up to the parties immediately. Do not wait for court to be the child(ren)'s advocate.

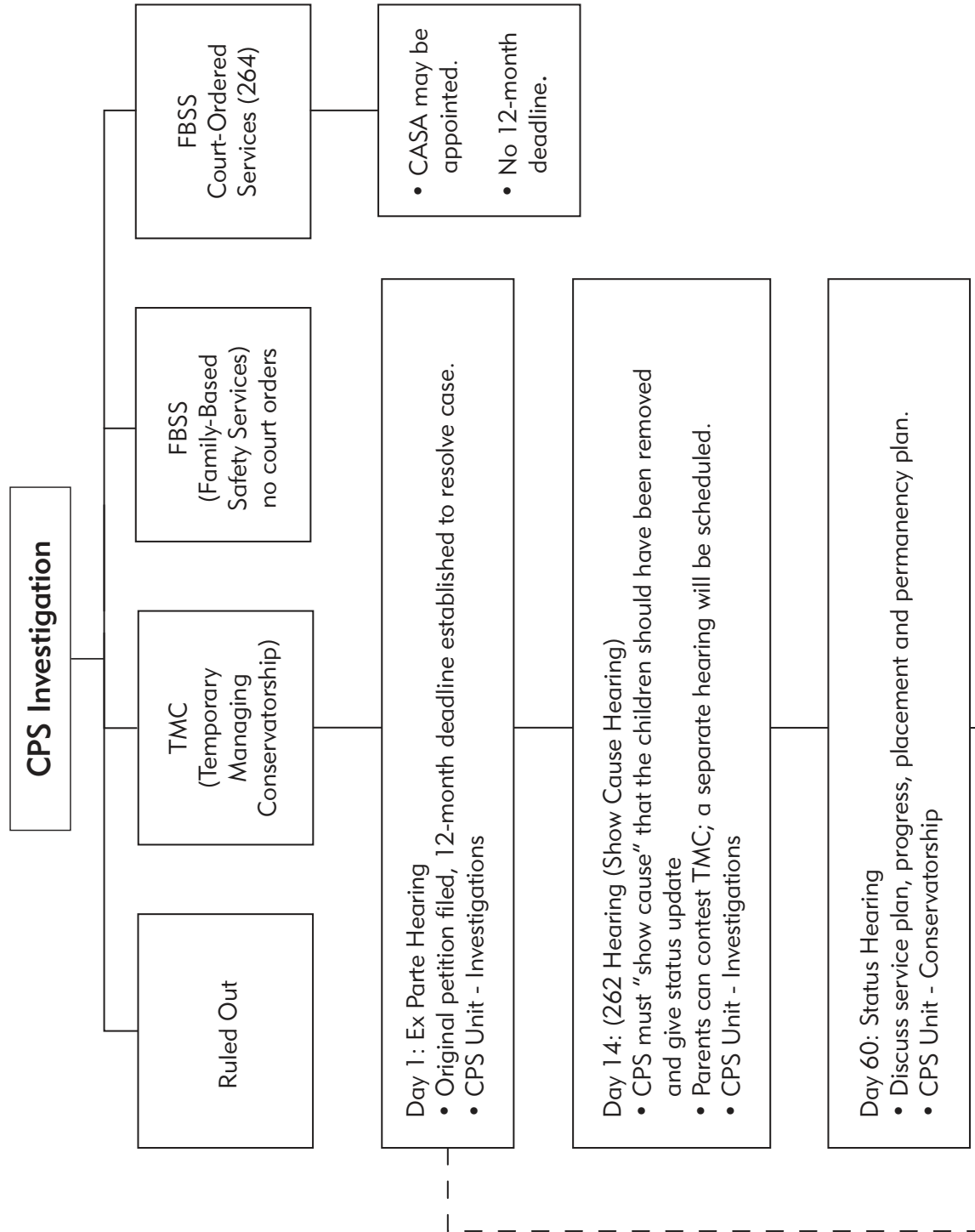
MONITORING

Visit the child(ren) in their placements regularly to ensure their safety and assess their needs. Keep track of whether the orders of the court and the plans of the CPS services agency are carried out, and report to the court or the CPS caseworkers when any of these parties do not follow those orders and plans.

Department of Family and Protective Services Units



Child Protective Services Process Flowchart



CASA may be appointed at any time.

Day 180: First Permanency Hearing (halfway to deadline)

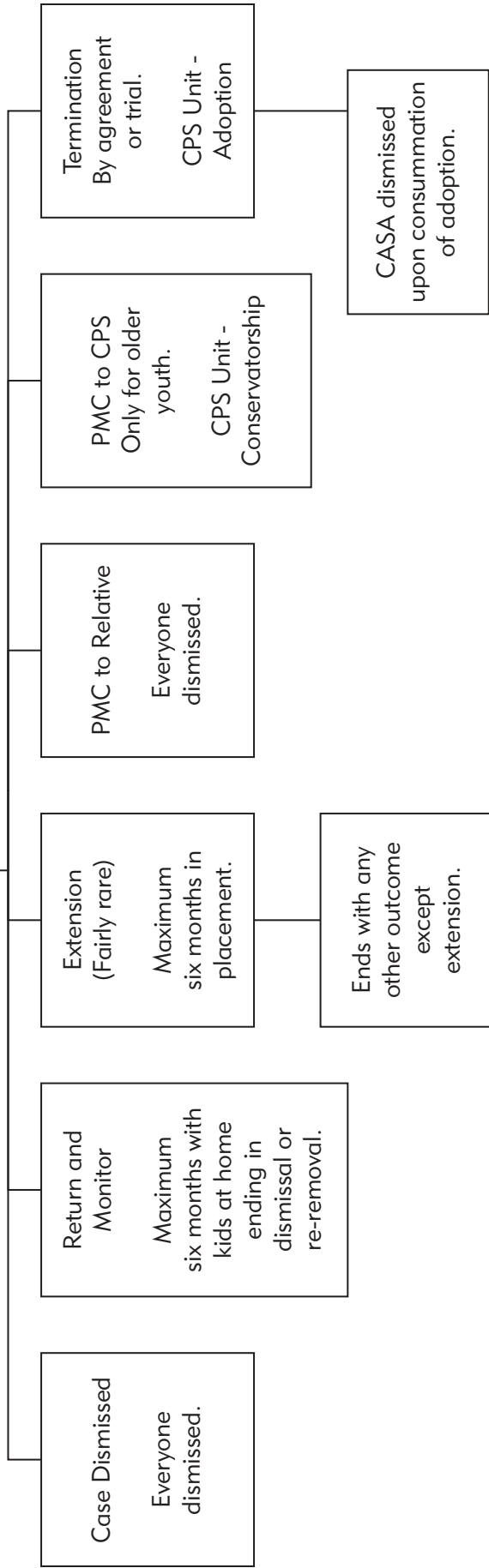
- Discuss service plan, progress, placement.
- Focus on permanency goals and barriers.
- CPS Unit - Conservatorship

Day 300: Second Permanency Hearing

- Discuss service plan, progress, placement.
- Focus on permanency goals and barriers.
- Possibly discuss transition plans and options.
- CPS Unit - Conservatorship

Outcomes

- Prior to 365 day dismissal date, must achieve one of the six following outcomes:



Child Protective Services Hearings

FBSS/COURT-ORDERED SERVICES HEARINGS

Chapter 264 or COS Review

Court-ordered services cases have review hearings around every three to four months. There is not a legal deadline for these cases. The focus is on both the children and the parents. CASA is expected to have a report and be present at the hearing to provide recommendations.

TEMPORARY MANAGING CONSERVATORSHIP HEARINGS

Ex Parte Hearing

Once a child is removed from a home, the case will need to be before a judge within 72 hours. Usually, only CPS is present at that point, so the hearing is called ex parte, meaning all parties are not present. This is when the attorney ad litem is generally appointed and often when CASA is appointed. CASA is not normally involved in a case at this point.

262 Hearing (Show Cause)

This hearing will happen about two weeks after the ex parte hearing. The name refers to the chapter of the Texas Family Code that requires a hearing in which the parents are present and can answer the allegations of abuse and neglect. CPS can start the service plan at this time to show the parents what they can complete for the case to move toward reunification. If CASA was appointed ex parte, CASA will be present at this hearing.

Status Hearing

This hearing takes place two months after the 262. This hearing will solidify the service plan and clarify what the parents need to be doing and address the services the children may need. CASA is expected to have a report and be present at the hearing to make recommendations.

First Permanency Hearing

This hearing takes place at six months from the beginning of the case. This is the approximate halfway point, and the judge wants to know where the case is going and how to get there. It is important to make sure all original concerns are addressed and there is a strong permanency plan and a strong concurrent plan. CASA is expected to have a report and be present at the hearing to make recommendations.

Second Permanency Hearing

Generally, four months after first permanency, there is another hearing to make sure everything is still on the right track. At this hearing, the judge wants to see the permanency plan being put into action. If the parents aren't working toward reunification, mediation and merits are generally requested. If the parents are doing well, discussion begins about the reunification plan and the possibility of return and monitoring. CASA is expected to have a report and be present at the hearing to make recommendations.

Third Permanency Hearing

Each case is different, and some do achieve legal permanency before this stage and therefore do not require a Third Permanency Hearing. At this point, the one-year time frame is nearly over and the court is moving toward permanency. In rare cases, a six-month extension can be requested. CASA is expected to have a report and be present at the hearing to make recommendations.

PERMANENT MANAGING CONSERVATORSHIP HEARINGS

Permanency Hearings After Final Orders

If the child stays in the Permanent Managing Conservatorship of CPS, there will be regular hearings approximately every four months. These hearings focus on the well-being of the child, school and medical needs, and the adoption process, if applicable. CASA is expected to have a report and be present at the hearing to make recommendations.

OTHER HEARINGS

Contested Placement Hearing

This hearing will be called if there is disagreement about a child's placement. CASA will be expected to have an opinion about the best interest, and a court report may be needed if applicable and appropriate.

Special Hearing or Motion for Further Orders

All parties, including CASA, have the ability to set a hearing. This can be done for any reason, and CASA is expected to attend any hearing that is set. CASA will be given notice of at least three business days. CASA will often receive a motion from the attorney setting the hearing explaining the nature of the hearing. A court report may be needed if applicable and appropriate.

The Roles in a Child Welfare Court Case

CHILD

Why is the child's case in court?

- A petition has been filed alleging abuse or neglect.

What does the child need during court intervention?

- The child needs the court to order an appropriate intervention and treatment plan so they can live in a safe, stable home without ongoing need for intervention from the child protection agency.
- The child needs the court to address the areas of safety and protection, placement if the child is out of the home, family contact, belonging to a family, financial support, a support system, education, and mental and physical health.
- The child needs the court intervention to be focused and timely.
- The child needs services provided that will meet their needs.

CASA VOLUNTEER/GUARDIAN AD LITEM

What does the CASA volunteer do in the case?

- Independently investigate the child's case (not the original allegations of abuse, but the child's ongoing situation).
- Determine the child's needs.
- Explore family and community resources to meet the child's needs.
- Make recommendations to the court.
- Advocate for the child.
- Monitor the case.
- Be the voice of what is in the child's best interest.
- Try to ensure the child's expressed wishes are represented as well, when they are in the child's best interest.

What does the CASA volunteer bring to the case?

- An interest in improving the life of the child through the court process.
- Time, energy and focus.
- Longevity and consistency.
- An "outside the system" point of view and an independent perspective.
- The community's standard for the care and protection of its children.

When is the CASA volunteer involved in the case?

- CASA as an agency can be appointed as early as the ex parte hearing. A volunteer then becomes involved as soon as one is available. This can be as early as a couple of weeks.

ATTORNEY FOR THE CHILD/ATTORNEY AD LITEM

What does the attorney for the child do in the case?

- Represent the child's wishes.
- Protect the child's legal rights in court.
- Advise the child on legal matters (if the child is old enough).
- File legal documents relevant to the child's case.

What does the attorney for the child bring to the case?

- Legal expertise, facilitation and negotiation skills, and courtroom experience.

When is the attorney for the child involved in the case?

- From the petition filing through the end of the court case.

What is the difference between the attorney ad litem and the CASA volunteer's role as the guardian ad litem?

- The attorney ad litem represents the child's wants, while the CASA volunteer/guardian ad litem represents what is in the child's best interest or what they need. For example, if a child tells their attorney they want to eat ice cream for every meal every day, the attorney has to represent that to the court. The CASA volunteer can then tell the court that the child needs to have a well-rounded diet, not entirely featuring ice cream, because they are representing the child's best interest. So keep that in mind: what the child wants may not always be in their best interest, and that is the CASA volunteer's job to represent.

PARENTS

Why are the parents involved in the case?

- They have been forced into this court action because a child protection agency asked the court to intervene to protect the child from maltreatment and/or to have their basic needs met.

- They need to comply with the child protection agency's intervention plan and correct the conditions that led to the child's removal, thereby effectively protecting their child and/or enabling their child to return home.
- They need to follow the orders of the court or risk having their parental rights terminated.

What do the parents bring to the case?

- Love for the child.
- Family ties and network of connections.
- Their history of parenting the child.
- Their knowledge of the child.
- Their own culture(s).
- Their level of ability and skill as parents.
- Their mental, emotional, and physical health or illness.
- Their support systems.
- Their housing and income, or lack of it.
- Their own issues and problems.
- Their own strengths and resources.

ATTORNEY FOR THE PARENT

What does the attorney for the parent do in the case?

- Represent the wishes of the parent or caretaker they represent.
- Protect the legal rights of the parent or caretaker in court.
- Advise the parent or caretaker on legal matters.
- File legal documents relevant to the case.

What does the attorney for the parent bring to the case?

- Legal expertise, facilitation and negotiation skills, and courtroom experience.

When is the attorney for the parent involved in the case?

- From the petition filing through the end of the court case or whenever the court appoints them.

CHILD PROTECTIVE SERVICES (CPS) CASEWORKER

What is the role of the CPS caseworker in the case?

- The caseworker initiates the case by completing a risk assessment process and, based on risk and/or substantiated allegations of abuse and/or neglect, determining the need for court intervention. The caseworker petitions the court to intervene on the child's behalf because:
 - They have developed an intervention plan with the family, which has not resulted in eliminating the risk that child maltreatment will recur, or
 - Due to risk of imminent danger, they have removed the child from their home to ensure the child's safety.
- The caseworker petitions the court to order that the agency's intervention and treatment plan be followed by the parents and other service providers, thereby ensuring the child receives proper care and protection without requiring continuous agency intervention.
- The caseworker is responsible for managing the case and arranging for court-ordered services to be provided to the child and the child's family.

What does the CPS caseworker bring to the case?

- Training in analyzing risk, assessing service needs and providing guidance to families.

- Direct services for families to provide them with the knowledge, skills, and resources necessary for change.
- Links to other service providers so that the family can access resources outside the child protective services system.

When is the CPS caseworker involved in the case?

- From the initial contact with the family and/or child until the case closes (CPS caseworkers will change throughout the case as it transfers to different departments).

ASSISTANT DISTRICT ATTORNEY FOR CHILD PROTECTIVE SERVICES

What does this attorney do in the case?

- Represent the position of Child Protective Services in court.
- Protect Child Protective Services from liability.
- Advise Child Protective Services regarding its responsibilities as outlined in the law.
- File legal documents relevant to the case.

What does this attorney bring to the case?

- Legal expertise, facilitation and negotiation skills, and courtroom experience.

When is this attorney involved in the case?

- From the petition filing through the end of the case.

JUDGE

What does the judge do in the case?

- Determines if there is a continued safety issue for the child that necessitates continued out-of-home placement if the child has been removed from home.
- Decides if the child meets the legal definition of abused or neglected, and, if so, orders services that will address the needs of the child.
- Orders appropriate reviews.
- Hears testimony, motions, etc., regarding the case.
- Approves the permanent plan for the child.
- Orders termination of parental rights when appropriate.
- Settles disputed adoption cases.
- Closes the court case when there is no longer a need for court intervention or when the permanent plan has been achieved.
- Files legal documents when it is necessary.

When is the judge involved in the case?

- From the request for emergency custody at the petition filing until the court case is closed (or, if the child is not removed from home, from the arraignment or adjudication hearing, depending on jurisdiction, until the court case is closed).

INDIAN CHILD'S TRIBE

What does the Indian child's tribe do in the case?

- Represent to the court the "best interest of the child" as defined by the Indian Child Welfare Act (ICWA).
- Ensure that the parents, the child, and the tribe have all the rights they are afforded pursuant to ICWA.

- Bring to the attention of the court culturally relevant service options and dispositional recommendations.
- Protect the tribe's interest in the child and ensure the preservation of the child's ties to the tribe and its resources.
- Where appropriate, offer or require that the tribe take jurisdiction of the matter
- File legal documents when it is necessary.

What does the tribe bring to the case?

- A special perspective on preservation of the child's ties to the tribe.
- Knowledge of relevant cultural practices and culturally relevant services that can be considered as potential resources for the child.



Chapter 2

2



TEXASCASA
Court Appointed Special Advocates
FOR CHILDREN

“If children feel safe, they can take risks, ask questions, make mistakes, learn to trust, share their feelings, and grow.”

– Alfie Kohn

Chapter 2: The Well-Being of the Child

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PRE-WORK INSTRUCTIONS

Please complete the following pre-work before attending your second volunteer training session. This Pre-Work can also be completed online at Texas CASA’s Learning Center at www.learn.texascasa.org.

1. Read pages 66-98, “How Children Grow and Develop” through “The Importance of Family Engagement.”
2. Read the “Bleux Case Court Report” provided by your facilitator.
3. Read your program’s policies provided by your facilitator.

How Children Grow and Develop

No two children are alike. Each child is a growing, changing person. Children cannot be made to grow. On the other hand, they cannot be stopped from growing.

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 consistent figures in their lives.

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 move 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.

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.

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. 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. As a CASA/GAL volunteer, be aware of your values, attitudes and perceptions about what is typical so that you can be objective and culturally sensitive when assessing a child's needs.

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 facilitate healthy growth.

When observing a child's development, keep in mind that there is a wide range of typical behavior. At any particular age, 25 percent of children will not exhibit a behavior or skill, 50 percent will show it, and 25 percent 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.

Above all, children need to feel that they are loved, that they belong, and that they are wanted.

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

Child Development Chart

Child Development Chart

	BIRTH TO 6 MONTHS	6 TO 12 MONTHS	12 TO 18 MONTHS
COGNITIVE	Recognition of primary caregiver; no concept of past or future; reaches for familiar people or toys	Objects can be held in memory; learns through routines and rewards; recognizes name; says 2 to 3 words besides "mama" and "dada"; imitates familiar words	Experiments with physical environment; understands the word "no"; comes when called; recognizes words as symbols for objects (cat—meows); uses 10 to 20 words, including names; combines two words, such as "daddy bye- bye"; waves good-bye and plays pat-a-cake; makes the sounds of familiar animals; gives a toy when asked; uses words such as "more" to make wants known; points to their toes, eyes and nose; brings objects from another room when asked
PSYCHOLOGICAL	Attachment to primary caregiver; totally dependent; totally trusting; learns intimacy	Separation from primary caregiver; begins to develop a sense of self; learns to get needs met; trusts adults; stretches arms to be picked up; likes to look at self in mirror	Early social development; egocentric; accepts limits; develops self-esteem (love from family); plays by self
MORAL	None	None	Fear of authority figures

Child Development Chart

	BIRTH TO 6 MONTHS	6 TO 12 MONTHS	12 TO 18 MONTHS
SEXUAL	Erections possible; both sexes can be stimulated	Generalized genital play	Continued generalized genital play
MOTOR	Sucking; hands clenched/grip; neck muscles develop; pulls at clothing; laughs/coos	Rolls over; stands with support; creeps/ crawls; walks with help; rolls a ball in imitation of adult; pulls self to standing position and stands unaided; transfers object from one hand to the other; drops and picks up toy; feeds self cracker; holds cup with two hands; drinks with assistance; holds out arms and legs while being dressed	Creeps up stairs; gets to standing position alone; walks alone; walks backward; picks up toys from floor without falling; pulls and pushes toys; seats self in child- size chair; moves to music; turns pages 2 or 3 at a time; scribbles; turns knobs; paints with whole arm movement; shifts hands; makes strokes; uses spoon with little spilling; drinks from cup with one hand unassisted; chews food; unzips large zipper; indicates toilet needs; removes, socks, pants and sweater

Child Development Chart

	18 TO 36 MONTHS	3 TO 5 YEARS	6 TO 9 YEARS
COGNITIVE	<p>Can conduct experiments inside head but limited to experience; rapid language growth; copies adult chores in play; carries on conversation with self and dolls; asks "What's that?" and "Where's my . . .?"; has 450-word vocabulary; gives first name; holds up fingers to tell age; combines nouns and verbs "mommy go"; refers to self as "me" rather than by name; tries to get adult attention, exclaiming "Watch me"; likes to hear same story repeated; may say "no" when means "yes"; talks to other children as well as adults; names common pictures and things</p>	<p>Can conduct experiments inside head; cannot sequence; capacity to use language expands; understands some abstract concepts: colors, numbers, shapes, time (hours, days, before/after); understands family relations (baby/ parent); can tell a story; has a sentence length of 4 to 5 words; has a vocabulary of nearly 1,000 words; can name at least one color; understands "tonight," "summer," "lunchtime," "yesterday"; begins to obey requests like "put the block under the chair"; knows their last name, name of street on which they live and several nursery rhymes; uses past tense correctly; can speak of imaginary conditions "I hope"; identifies shapes</p>	<p>Can think using symbols; can recognize differences; makes comparisons; can take another's perspective; defines objects by their use; knows spatial relationships like "on top," "behind," "far" and "near"; knows address; identifies pennies, nickels and dimes; knows common opposites like "big/little"; asks questions for information; distinguishes left from right</p>
PSYCHOLOGICAL	<p>Autonomy struggles; learns system of meeting needs; social development increases; points to things they want; joins in play with other children; shares toys; takes turns with assistance</p>	<p>Can cooperate; self-perceptions develop; cannot separate fantasy from reality; has nightmares; models on same-sexed parent; experiences and copes with feelings (sad, jealous, embarrassed); plays and interacts with other children; dramatic play is closer to reality, with attention paid to detail, time and space; plays dress-up</p>	<p>Early close peer relationships; presence of well-developed defenses; develops identity outside family (school, friends); has likes and dislikes (food, friends, games); chooses own friends; plays simple table games; plays competitive games; engages in cooperative play with other children involving group decisions, role assignments, fair play</p>

Child Development Chart

	18 TO 36 MONTHS	3 TO 5 YEARS	6 TO 9 YEARS
MORAL	Knowledge of and preferences for authority figures	Self-esteem dependent on authority figures; follows peers' fads; negotiates to get needs met	Has a conscience; refinements in moral development
SEXUAL	Continued generalized genital play; early sex-role development	Generalized genital play in males; masturbation to orgasm in females is possible; early experimentation; gender identity established	Defenses reduce experimentation, but some continues
MOTOR	Can run, throw ball, kick ball, jump; goes up stairs with one hand held by adult; turns single pages; snips with scissors; holds crayon with thumb and fingers (not fist); uses one hand consistently in most activities; rolls, pounds, squeezes, and pulls clay; uses spoon with little spilling; gets drink from fountain or faucet independently; opens door by turning handle; takes off and puts on coat with assistance; washes and dries hands with assistance	Swings/climbs; uses small scissors; jumps in place; walks on tiptoes; balances on one foot; rides a tricycle; begins to skip; runs well; bathes and dresses; runs around obstacles; walks on a line; pushes, pulls, steers wheeled toys; uses slide independently; throws ball overhead; catches a bounced ball; drives nails and pegs; skates; jumps rope; pastes and glues appropriately; skips on alternating feet; pours well from small pitcher; spreads soft butter with knife; buttons and unbuttons large buttons; washes hands independently; blows nose when reminded; uses toilet independently	Is increasing small muscle motor skills; cuts foods with a knife; laces shoes; dresses self completely; ties bow; brushes independently; crosses streets safely

Child Development Chart

	10 TO 15 YEARS	16 TO 21 YEARS
COGNITIVE	Can engage in inductive and deductive logic; neurons are present; understands hypothetical situations; conflicts with parents increase	Uses formal logic (e.g., opposes racism); debates and can change sides of debate; understands probabilities; uses more flexible abstract thinking; examination of inner experiences; conflicts with parents begin to decrease
PSYCHOLOGICAL	Increased autonomy struggles; increased focus on identity; focus on peer relationships; rebellious; often moody; romantic feelings; struggle with sense of identity; feels awkward or strange about their body; worries about being normal; frequently changing relationships	Interest in relationships; solidifies personal identity; becomes goal directed; sometimes rebellious; increased concern for others; increased concern for future; places more importance on their role in life
MORAL	Moral development is legalistic; recognition of principles (e.g., justice); selection of role models	Identifies with moral principles, rules, and limit testing; experimentation with sex and drugs; examination of inner experiences
SEXUAL	Puberty; sex organs mature; males ejaculate and have wet dreams; all genders able to masturbate to orgasm with fantasies; girls develop physically sooner than boys	Feelings of love and passion; development of more serious relationships; sense of sexual identity established; increased capacity for tender and sensual love
MOTOR	Greater body competence (physical coordination); manual dexterity; growth patterns vary	Heightened physical power, strength, coordination

Chart compiled by Katie Thompson, Elon College student intern, North Carolina Guardian ad Litem Program. Modified for Fourth Edition. Sources include: "Infant and Toddler Development," Dr. Maureen Vandermaas-Peeler, Elon College; "Child Development," Ray Newnam, PhD; "LD In Depth," LD OnLine, www.ldonline.org; "Growing Up," Pasternak and Kroth; "Your Child's Growth: Developmental Milestones," American Academy of Pediatrics, www.aap.org; and "Normal Adolescent Development," American Academy of Child and Adolescent Psychiatry, www.aacap.org.



Maslow's hierarchy of needs

Understanding Children's Needs

Children served by CASA/GAL programs come to the court's attention because their parents or caretakers are not meeting their most basic needs for food, clothing, shelter, safety 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 caretakers.

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 everyday challenges with success and growth. Unlike Maslow's theory, these three needs are not sequential, but they 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: <http://bit.ly/maslowpyr>.

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 interests. Understanding these theories can provide a framework for you to refer to when working with the child and family.

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 vary depending 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, clothing, safety and security—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.

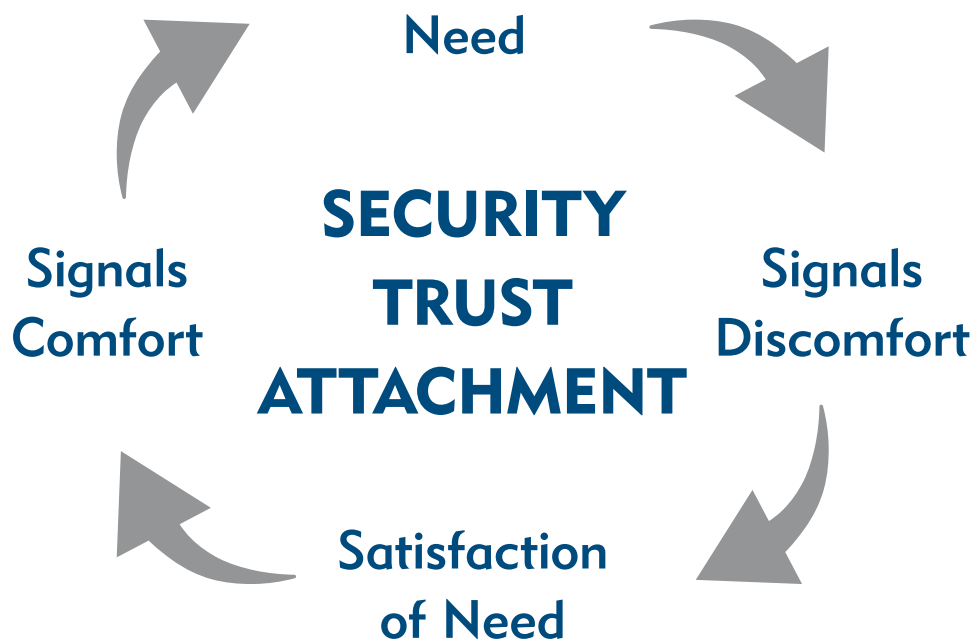
Importance of Attachment in Child Development

WHAT IS ATTACHMENT?

In child development, attachment refers to a strong, enduring bond of trust that develops between a child and the caregiver(s) they interact with most frequently. Our capacity to form an emotional and physical “attachment” to another person is what gives us the sense of stability and security necessary to take risks, grow and develop. A deep emotional and physical attachment to at least one primary caregiver is a necessity for infants’ and childrens’ healthy development. Those formative relationships set the stage for life: If the child’s physical, emotional and mental needs aren’t met in a consistent way, then attachment is disrupted.

Attachment develops intensely throughout the first three years. When a baby cries, the caretaker responds by picking up the child. The caretaker continues to stroke, talk to, and hold the baby during feeding or diaper changing. The child learns that to get their needs met, all they have to do is cry. The caretaker 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 caretaker. It is referred to as the “attachment cycle” or the “trust cycle.”

THE ATTACHMENT CYCLE



After age three, children can still learn how to attach; however, this learning is more difficult. A child's positive or negative experiences with bonding will strongly influence their response to caregivers and other loved ones, as well as how they respond to stressors.

When an infant experiences consistent care where his/her needs are met, he/she internalizes three things:

- I am safe.
- I am heard.
- I am valuable.

With this as the foundation, a child can then develop other healthy relationships. Psychoanalyst John Bowlby, considered the originator of modern attachment theory, stated, "The initial relationship between self and others serves as a blueprint for all future relationships."

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

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, they may not seek out a caregiver for soothing or comfort, or they 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
- Constant requests for reassurance or approval of worth
- Reduced ability to recognize the emotions of others
- Poor or reduced emotional self-regulation
- Low self-esteem or feelings of inadequacy
- 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 and Middle 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
- May appear immoral
- Lying and stealing

Adolescence

- May exhibit aggressive, antisocial, delinquent or risk-taking behaviors
- May use alcohol or substances
- At risk for related depression and anxiety
- Shows higher levels of disengagement
- May become involved in abusive or harmful relationships

Adapted from Students First Project: Quick Facts on Disrupted Attachment

Recognizing Child Abuse and Neglect

WHAT CONSTITUTES 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. However, CASA/GAL volunteers need 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.

Child abuse can be seen as part of a continuum of behaviors. At the low end of the continuum are behaviors one 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.

TYPE	DESCRIPTION	INDICATORS
PHYSICAL ABUSE	Intentionally harming a child, use of excessive force, reckless endangerment	<ul style="list-style-type: none"> • 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
SEXUAL ABUSE	Child sexual abuse is a form of child abuse that includes any kind of sexual activity with a minor. A child cannot consent to any form of sexual activity, period. Child sexual abuse does not need to include physical contact between a perpetrator and a child. Often an abuser might tell the child that the activity is normal or that they enjoyed it or may make threats if the child refuses to participate or plans to tell another adult. Child sexual abuse is not only a physical violation, it is a violation of trust and/or authority.	<ul style="list-style-type: none"> • Age-inappropriate sexual knowledge • Sexual acting out • Child’s 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.	<ul style="list-style-type: none"> • Habit disorders (thumb sucking, biting, rocking, picking scabs or skin, 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
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.	<ul style="list-style-type: none"> • Consistent dirtiness • Constant tiredness or listlessness • Insufficient or improper clothing • Filthy living conditions • Inadequate shelter • Insufficient food or poor nutrition • Lack of medical or dental care • Lack of supervision

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/caretaker-related factors, social-situational factors, family factors and triggering situations. These factors frequently coexist.

CHILD-RELATED FACTORS

- Chronological age of child: 50 percent of abused children are younger than 3 years old; 90 percent 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/CARETAKER-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. Parents who are abusive or neglectful are often seen and considered by themselves and others to be depressed people.
- Impulsiveness: Parents who are abusive 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.

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 their own clothes.
- Isolation: Families who are abusive or neglectful 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 stressors of poverty, unemployment, restricted mobility and poor housing can be instrumental in a parent's ability to adequately care for a child. The child should never be separated from their family solely because of stressed economic conditions. This is not an acceptable form of advocacy, and it also operates as a common bias. This is important to look out for in oneself and others. Abuse is not limited to families in poverty, and poverty is not abuse.

Risk Factors for Child Abuse and Neglect

- 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.

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. This is a complex situation, and the parent being abused may need services.
- 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 them. 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 may be at higher risk of experiencing abuse and neglect.

TRIGGERING SITUATIONS

Any of the previously mentioned factors 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 parent is fired from a job.
- The child tries to intervene in domestic violence.
- A teenager demonstrates rebellion.
- A parent is served an eviction notice.
- A prescription drug used to control mental illness is stopped.
- A parent feels disrespected by another adult and takes it out on the child.

Texas Family Code: Definition of Abuse

Title 5. The Parent-Child Relationship and the Suit Affecting the Parent-Child Relationship

Subtitle E. Protection of the Child

Chapter 261. Investigation of Report of Child Abuse or Neglect

Subchapter A. General Provisions

- (1) "Abuse" includes the following acts or omissions by a person:
 - (A) mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning;
 - (B) causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning;
 - (C) physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident or reasonable discipline by a parent, guardian, or managing or possessory conservator that does not expose the child to a substantial risk of harm;
 - (D) failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child;
 - (E) sexual conduct harmful to a child's mental, emotional, or physical welfare, including conduct that constitutes the offense of continuous sexual abuse of young child or children under Section 21.02, Penal Code, indecency with a child under Section 21.11, Penal Code, sexual assault under Section 22.011, Penal Code, or aggravated sexual assault under Section 22.021, Penal Code;
 - (F) failure to make a reasonable effort to prevent sexual conduct harmful to a child;
 - (G) compelling or encouraging the child to engage in sexual conduct as defined

by Section 43.01, Penal Code, including compelling or encouraging the child in a manner that constitutes an offense of trafficking of persons under Section 20A.02(a)(7) or (8), Penal Code, prostitution under Section 43.02(b) 43.02(a)(2), Penal Code, or compelling prostitution under Section 43.05(a)(2), Penal Code;

- (H) causing, permitting, encouraging, engaging in, or allowing the photographing, filming, or depicting of the child if the person knew or should have known that the resulting photograph, film, or depiction of the child is obscene as defined by Section 43.21, Penal Code, or pornographic;
- (I) the current use by a person of a controlled substance as defined by Chapter 481, Health and Safety Code, in a manner or to the extent that the use results in physical, mental, or emotional injury to a child;
- (J) causing, expressly permitting, or encouraging a child to use a controlled substance as defined by Chapter 481, Health and Safety Code;
- (K) causing, permitting, encouraging, engaging in, or allowing a sexual performance by a child as defined by Section 43.25, Penal Code; or
- (L) knowingly causing, permitting, encouraging, engaging in, or allowing a child to be trafficked in a manner punishable as an offense under Section 20A.02(a)(5), (6), (7), or (8), Penal Code, or the failure to make a reasonable effort to prevent a child from being trafficked in a manner punishable as an offense under any of those sections.

(2) "Department" means the Department of Family and Protective Services.

(3) Repealed by Acts 2015, 84th Leg., ch. 1 (S.B. 219), § 1.203(4).

(4) "Neglect":

(A) includes:

- (i) the leaving of a child in a situation where the child would be exposed to a substantial risk of physical or mental harm, without arranging for necessary care for the child, and the demonstration of an intent not to return by a parent, guardian, or managing or possessory conservator of the child;

Texas Family Code: Definition of Abuse

(ii) the following acts or omissions by a person:

- (a) placing a child in or failing to remove a child from a situation that a reasonable person would realize requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that results in bodily injury or a substantial risk of immediate harm to the child;
- (b) failing to seek, obtain, or follow through with medical care for a child, with the failure resulting in or presenting a substantial risk of death, disfigurement, or bodily injury or with the failure resulting in an observable and material impairment to the growth, development, or functioning of the child;
- (c) the failure to provide a child with food, clothing, or shelter necessary to sustain the life or health of the child, excluding failure caused primarily by financial inability unless relief services had been offered and refused;
- (d) placing a child in or failing to remove the child from a situation in which the child would be exposed to a substantial risk of sexual conduct harmful to the child; or
- (e) placing a child in or failing to remove the child from a situation in which the child would be exposed to acts or omissions that constitute abuse under Subdivision (1)(E), (F), (G), (H), or

(iii) committed against another child; or

- (a) the failure by the person responsible for a child's care, custody, or welfare to permit the child to return to the child's home without arranging for the necessary care for the child after the child has been absent from the home for any reason, including having been in residential placement or having run away; and

(B) does not include the refusal by a person responsible for a child's care, custody, or welfare to permit the child to remain in or return to the child's

home resulting in the placement of the child in the conservatorship of the department if:

- (i) the child has a severe emotional disturbance
 - (ii) the person's refusal is based solely on the person's inability to obtain mental health services necessary to protect the safety and well-being of the child; and
 - (iii) the person has exhausted all reasonable means available to the person to obtain the mental health services described by Subparagraph (ii).
- (5) "Person responsible for a child's care, custody, or welfare" means a person who traditionally is responsible for a child's care, custody, or welfare, including:
- (A) a parent, guardian, managing or possessory conservator, or foster parent of the child;
 - (B) a member of the child's family or household as defined by Chapter 71;
 - (C) a person with whom the child's parent cohabits;
 - (D) school personnel or a volunteer at the child's school; or
 - (E) personnel or a volunteer at a public or private child-care facility that provides services for the child or at a public or private residential institution or facility where the child resides.
- (6) "Report" means a report that alleged or suspected abuse or neglect of a child has occurred or may occur.
- (7) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.
- (8) Repealed by Acts 2015, 84th Leg., ch. 1 (S.B. 219), § 1.203(4).
- (9) "Severe emotional disturbance" means a mental, behavioral, or emotional disorder of sufficient duration to result in functional impairment that substantially interferes with or limits a person's role or ability to function in family, school, or community activities.

Texas Family Code: Mandatory Reporting

Title 5. The Parent-Child Relationship and the Suit

Affecting the Parent-Child Relationship

Subtitle E. Protection of The Child

Chapter 261. Investigation of Report of Child Abuse or Neglect

Subchapter B. Report of Abuse or Neglect; Immunities

Sec. 261.101. Persons Required to Report; Time to Report.

CASA volunteers and staff members are mandatory reporters.

- (a) A person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report as provided by this subchapter.
- (b) If a professional has cause to believe that a child has been abused or neglected or may be abused or neglected, or that a child is a victim of an offense under Section 21.11, Penal Code, and the professional has cause to believe that the child has been abused as defined by Section 261.001, the professional shall make a report not later than the 48th hour after the hour the professional first suspects that the child has been or may be abused or neglected or is a victim of an offense under Section 21.11, Penal Code. A professional may not delegate to or rely on another person to make the report. In this subsection, "professional" means an individual who is licensed or certified by the state or who is an employee of a facility licensed, certified, or operated by the state and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children. The term includes teachers, nurses, doctors, day-care employees, employees of a clinic or health care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers.
- (b-1) In addition to the duty to make a report under Subsection (a) or (b), a person or professional shall make a report in the manner required by Subsection (a) or (b), as applicable, if the person or professional has cause to believe that an adult was a victim of abuse or neglect as a child and the person or professional determines in good faith that disclosure of the information is necessary to protect the health and safety of:

- (1) another child; or
 - (2) an elderly person or person with a disability as defined by Section 48.002, Human Resources Code.
- (c) The requirement to report under this section applies without exception to an individual whose personal communications may otherwise be privileged, including an attorney, a member of the clergy, a medical practitioner, a social worker, a mental health professional, an employee or member of a board that licenses or certifies a professional, and an employee of a clinic or health care facility that provides reproductive services.
- (d) Unless waived in writing by the person making the report, the identity of an individual making a report under this chapter is confidential and may be disclosed only:
- (1) as provided by Section 261.201; or
 - (2) to a law enforcement officer for the purposes of conducting a criminal investigation of the report.

The Importance of Family Engagement

Laws require that family members be notified when a child is removed from parents' care. However, extended family members are often unaware a child is in foster care. This locating and engagement of extended family is of crucial importance, and taking the time to do that work is one way that an advocate can have a profound impact on a case. The overarching goals of family engagement are to avoid removing children from their biological family whenever possible and to help children achieve strong connectivity and permanency faster, preferably with relatives.

According to the Child Welfare Information Gateway, "Family engagement is a family-centered, strength-based approach to establishing and maintaining relationships with families and accomplishing change together. At the practice level, this includes setting goals, developing case plans, making joint decisions, and working with families to ensure their children's safety, permanency, and well-being. It encompasses the inclusion of children and youth (when age-appropriate), as well as adult family members, in case-planning and case activities, and also involves supporting the development of relationships between resource families and biological families. On an organizational or system level, family engagement means including families as key stakeholders and advisors in policy development, service design, and program and service evaluation.

"Effective family empowerment is the act of engaging, involving, and lifting up the voice of families throughout the child welfare continuum—at the practice and system level. It promotes family buy-in; enhances the helping relationship; and promotes the safety, permanency, and well-being of children and families. When families feel they are a part of the process, they are more motivated to make needed changes. Family empowerment allows them to be the drivers of the decision-making process rather than being told what to do. When family buy-in is achieved, reunification rates are improved and overall family outcomes are better."

THE COLLABORATIVE FAMILY ENGAGEMENT INITIATIVE IN TEXAS

In 2016, Texas CASA and DFPS created a partnership called Collaborative Family Engagement (CFE) that trains child advocates to find relatives, engage family members in the decision-making process, and help create lifetime support networks for children and families. Although this initiative may not have reached your program or regional area, there are a number of helpful basic tools and strategies below that all CASA advocates can practice (with their supervisor's support and guidance). You can learn more by searching Collaborative Family Engagement at Texas CASA's Learning Center.

FAMILY ENGAGEMENT TOOLS

CASA advocates identify and locate relatives and fictive kin that may have become disconnected from children in care, by searching with online tools, carefully mining case records and researching family connections in a variety of ways. Although we characterize these efforts as "family" engagement, we recognize the importance of bonds outside of biological relatives, and we work to include others with whom the children and parents have close relationships, such as teachers, caregivers, safe family friends and close neighbors, positive role models, faith leaders or faith community members, and those who may have been in a supportive role in the child's life. This is "family" in the larger human sense; those who care about the child.

By working to re-engage these family members and fictive kin, volunteers can position them as resources, building healthy connections where youth may have otherwise been isolated. Creating a family support network that continues past case closure can help to prevent a young person's re-entry into child protective services. The support system can be the grounds for their healing and growth.

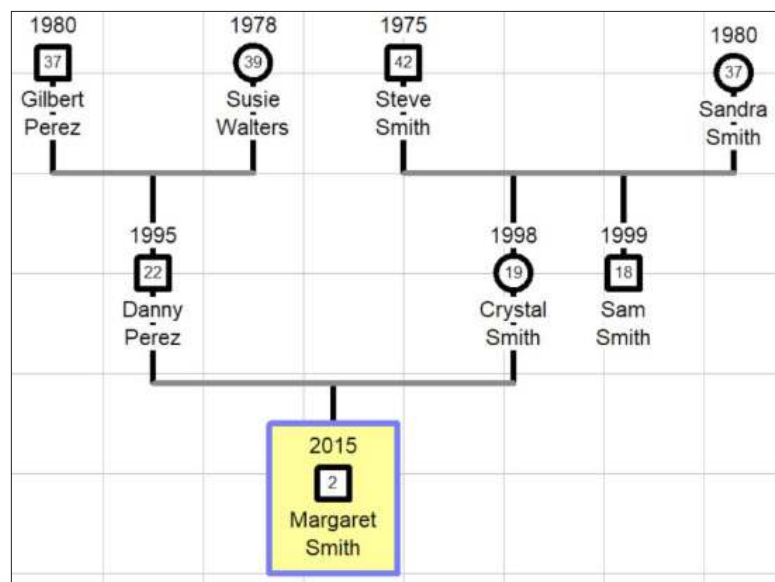
During your initial review of the case file, carefully document the names and contact information for any family or community members noted in the file. As you review the file, consider these questions:

The Importance of Family Engagement

- Have relatives on both the maternal and paternal sides been identified, including fathers?
- What involvement has there been with extended family?
- How much contact have investigators and workers had with fathers, family members and others close to the child?
- Is there a focus on family strengths?

Family Trees

Creating a family tree or genogram is an excellent way to capture information about family connections as you learn more about a child's family. One easy way to do this is by using GenoPro, a user-friendly software application compatible with PC computers that creates family trees. Advocates can gather information about family connections from youth, parents and other family members and then transfer this information into GenoPro to build out the family tree. Search for GenoPro in the Learning Center on Texas CASA's website to instantly download GenoPro for free and start creating a genogram.



Texas CASA also has accounts with Ancestry.com and WhitePages.com, which can be used to search for family information. These accounts are available to any advocate in Texas to use. These sites can help uncover names and contact information of relatives,

as well as information about family heritage. For log in information, contact training@texascasa.org.

Talk with your supervisor about your program's policies regarding use of social media sites to locate and contact relatives.

The Importance of Contacting Fathers

Although all children have a biological father, it's not uncommon for fathers to be "out of the picture." Establishing contact with fathers in order to assess their ability and willingness to care for their children is critical to our family engagement work, and can lead to further connections with members of the child's paternal family. It's important to remember that fathers, whether or not they have been actively involved in their children's lives, have legal rights that must be addressed, and they may be willing to provide for their children if they knew that their children needed them.

Out-of-State Relatives: the Interstate Compact on the Placement of Children

When relatives, fictive kin or other potential placements live out of state, an approved ICPC home study must be completed on the potential placement before the child(ren) can be placed in their care. ICPC stands for the Interstate Compact on the Placement of Children, a law established to ensure that when children are placed out of state, they receive the same protection and services that would be provided in their home state.

An ICPC home study can take six months or longer to be completed and approved before a child can be placed out of state. Because this can create delays in placing children with out-of-state family members, it's important that the process is started as early as possible for any potential out-of-state placements. When appropriate, CASA volunteers can advocate that the judge order the ICPC home study be expedited, which will shorten the timeline states have to complete the required paperwork. It's important to establish and maintain communication with the ICPC coordinator for your region to stay updated on the status of the home study. Once the ICPC packet has been submitted to the receiving state, establish contact with the ICPC coordinator in the receiving region to continue to track the progress of the home study.

Locating Relatives in Mexico

When working with Mexican minors or children of Mexican origin who are in the custody of Texas Child Protective Services, there are special pathways to help with family finding. Texas CASA and the Consulates of Mexico in Texas engage in mutual collaboration in these cases, based on a Memorandum of Understanding. The joint aim of the collaboration is to help every child benefit from the connections and support that family provides, regardless of whether the family resides in Mexico or the United States.

For support with locating and contacting family members residing in Mexico, talk with your supervisor about submitting a Mexican Consulate Referral Form to your local consulate office.

Contacting Relatives

Before making initial contact with family members, always talk with your supervisor for guidance. Keep in mind that family members can offer different types of support, connection and insights, whether or not they are appropriate relative placements. The overarching goals of establishing communication are to assess if this person wants to connect or reconnect with the child, find out whether there are other people that this person can connect us with who would want to be involved, and to learn more about child's family.

When contacting family members, be careful to follow these parameters around confidentiality:

What you CAN share:

- Information about your role
- The child's age and gender
- The parents' names
- That the family is involved with CPS
- The name and contact info for CPS caseworker

What you CAN'T share:

- Location of the child
- Information about why the case began or the parents' challenges
- Information about parents' engagement in services
- Child's diagnoses or other personal information

Keep in mind that your goal is to gather information rather than to disseminate information. If a family member asks you a question and you are uncertain whether the answer is confidential, let them know you need to check with your supervisor before sharing that information.

Carefully preparing with your supervisor before attempting to contact family members can help you gain confidence in your family engagement efforts. Below is a sample script for a phone call with a family member:

“Hello, may I please speak with [name of relative]? My name is [your name] I am with an organization called CASA, and we help children involved in the child welfare system. I am calling because I believe you are a relative of a child/children that CASA is helping. The parents of the child/children are [name of parents]. Do you know these parents and their child/children?”

If they are able to confirm that they know the child(ren), explain your goal in reaching out to them:

“This child is currently not living with family, and I’m hoping to connect with some family support for the child. I’m calling you today to find out if you would be interested in learning more about connecting with this child, and if you would be open to talking with CASA again in the future. I’d also like to ask if there are there other people you know of who you believe care about this child and that you think would be good for me to contact. If so, could you provide me with their contact information? I’m putting together a family tree for the child, so I would appreciate any information you can share about who is related to this child.”

At end of call, make sure the relative has your name and contact information, and let them know that they are welcome to call you back with any questions or to share additional information. Also, let the relative know that you’ll provide their contact info to the child’s caseworker, and let them know that they are welcome to contact the caseworker directly.

Adapted from the CASA of Travis County Family Engagement Program

CULTURAL CONSIDERATIONS

It's important to keep in mind that we are often working with families who have different cultural backgrounds than our own, and that the ability to communicate and work effectively across cultural lines is central to the success of our family engagement work. Regardless of whether or not we identify as the same race, socio-economic class, religion, gender or sexual orientation as the families and youth we're working with, our life experience and stories will almost always be different. Learning to approach these connections with an open mind is key to building trust and working together to advocate for the best interests of the children we serve.

In many Texas family courts, our judges keep a list of questions at their bench designed to help them "protect against implicit bias." It reminds them to pause and ask themselves:

- What assumptions have I made about people based on their cultural identity, profession or background?
- How might my assumptions influence my decision-making?
- How have I challenged any assumptions I might have made based on cultural identity, profession or background?

As advocates, we have a powerful voice in the experiences and outcomes for the families and youth we work with, and this comes with a great responsibility to ensure we're continually working to practice and expand our cultural awareness skills and ensure that our efforts to engage families are inclusive, respectful, and welcoming to all.

END OF PRE-WORK FOR CHAPTER 2

What Is “Minimum Sufficient Level of Care” (MSL)?

Removing a child from their home because of abuse and/or neglect is a drastic remedy. Because removal is so traumatic for the child, both the law and good practice require that agencies keep the child in the home when it is possible to do so and still keep the child safe. Children should be removed only when parents cannot provide the minimum sufficient level of care required by that child.

The concept of the minimum sufficient level of care is based in the idea that we focus our attention on the child’s basic needs and whether or not they are being met. This is true even when the family’s lifestyle, beliefs, resources and actions are very different from our own or from what we are used to. We are not deciding if the child is in a home with access to extracurricular activities and enrichments, or a home that looks like the homes we grew up in. We each come to this advocacy work with our own unique experiences, worldviews and personal standards, so it is important that we have a reference point to mitigate personal biases and personal value judgments in determining what constitutes a safe home for each child we serve.

The MSL is a baseline that is determined by a number of factors, each of which must be looked at specifically in relation to each unique child. It is an assessment that describes what must be in place for this child to remain in the home, and the same standard is also used to determine whether or not parents have made sufficient progress so that a child can be safely returned to the family home. It is also important that we take into consideration social, cultural and community norms.

FACTORS TO CONSIDER INCLUDE:

The Child’s Needs

Is the parent providing for the following needs at a basic level?

- Physical (food, clothing, shelter, medical care, safety, protection, freedom from abuse)
- Emotional (attachment between parent and child)
- Developmental (education, special help for children with disabilities)

Social Standards

Does the parent's behavior inside or outside of the home reflect commonly accepted child-rearing practices in our society?

There are many lenses through which to look at commonly accepted practices. Our society has norms, broadly, that help us determine how to raise kids. In terms of discipline, whipping a child with a belt was generally thought to be appropriate during the first half of the 20th century. This practice is now widely considered abusive in Western societies. Contemporary families frequently use a verbal reprimand, withholding of an extra privilege, or a short "time-out" as a punishment for children. A parent who whips their child with a belt is falling outside of social standards.

Community Standards

Does the parent's behavior fall within reasonable limits, given the specific community in which the family resides?

Here are some examples: The age at which it is deemed safe for a child to be left alone varies significantly from urban to suburban to rural communities. The age at which a child is considered old enough to care for other children is largely determined by cultural and community norms. Even something as simple as sending a 9-year-old child to the store might fall within or outside those standards, depending on neighborhood safety, the distance and traffic patterns, the weather, the child's clothing, the time of day or night, the ability of the child and the necessity of the purchase.

Communities can be geographical or cultural. An example of a non-geographical, cultural community is a Native American tribe in which members live in a variety of locales but still share common child-rearing standards.

According to the Indian Child Welfare Act, the minimum sufficient level of care standard must reflect the community standards of the child's tribe.

WHY THE THE MSL STANDARD IS USED

- It maintains the child's right to safety and permanence while not ignoring the parents' right to raise their children.
- It is required by law (as a practical way to interpret the "reasonable efforts" provision of the Adoption Assistance and Child Welfare Act).
- It is a reasonable expectation for parents to reach.
- It provides a reference point for decision makers.
- It protects (to some degree) from individual biases and value judgments.
- It discourages unnecessary removal from the family home.
- It discourages unnecessarily long placements in foster care.
- It keeps decision makers focused on what is the least detrimental alternative for the child.
- It is sensitive across cultures.

KEY PARAMETERS OF THE MSL STANDARD

- The standard takes into consideration the particular circumstances and needs of each child.
- It is a set of minimum conditions, not an ideal situation.
- It is a relative standard, depending on the child's needs, social standards and community standards. It will not be the same for every family or every child in a particular family.
- It remains the same when considering removal and when considering reunification.

CULTURAL CONSIDERATIONS

An understanding of a child’s cultural practices is important when considering the MSL standard. For children who are Alaska Native or American Indian, sources for information about cultural practices may include the parents, the tribal child welfare worker, relatives of the child or other tribal members. For children who are immigrants from other continents, or whose parents are, consult with service providers who work specifically with those communities. For other ideas for making sure MSL is applied consistently, you may consider:

- Discussing the MSL standard with your case coordinator or supervisor.
- Learning about the various cultural groups in your community (more on this in Chapter 6).
- Systematically comparing the standard for removal and the standard for reunifying a child in the home of origin.

The “Best Interest Principle”

WHAT IS THE BEST INTEREST PRINCIPLE?

- A safe home
- A permanent home
- As quickly as possible

Parents typically decide what is best for their children and then provide it for them to the extent that they can. They are their children’s best advocates. The child protection system intervenes in families’ lives when parents cannot or will not protect, promote and provide for their children’s basic needs. A CASA/GAL volunteer becomes the advocate when the parents cannot—or will not—fulfill this role.

Judges use the “best interest of the child” standard when making their decisions in child abuse and neglect cases. Child welfare and juvenile court practitioners and

scholars have debated the meaning of “best interest of the child” for years. Books have been written on the subject; however, there is still no concise legal definition for this standard.

In cases where the Indian Child Welfare Act (ICWA) applies, the law presumes that it is always in the best interest of an Indian child to have the tribe determine what is best for the child’s future.

THE BEST INTEREST PRINCIPLE: WHAT THE NATIONAL CASA ASSOCIATION SAYS

The CASA/GAL volunteer is guided by the “best interest principle” when advocating for a child. This means that the volunteer knows the child well enough to identify the child’s needs. The volunteer makes fact-based recommendations to the court about appropriate resources to meet those needs and informs the court of the child’s wishes, whether or not those wishes are, in the opinion of the CASA/GAL volunteer, in the child’s best interest.

In order to use the “best interest principle” to determine the best interest of the children we serve, we must understand the true meaning of the word “home.” In the “best interest principle,” “home” does not just refer to the physical dwelling. “Home” refers to all the things that make up a home or home life for the child. This not only includes the elements of safety and permanency as stated in the “best interest principle” but also includes all the elements of minimum sufficient level of care (MSL).

MSL requires that a child’s basic physical needs (food, clothing, shelter, medical care, safety, protection and security) be met but also includes the requirement that a child’s developmental (education, special needs) and emotional (attachment, identity, belonging) needs be met as well. Because all the aspects of MSL are an integral part of determining the best interest of the children, it is imperative that we consider family when determining best interest.

We know that it’s best for children when they are placed with family, be it parents, biological relatives or fictive kin (symbolic family) who can meet the MSL. This is due to the child’s emotional needs for connection and a feeling of belonging.

CHECKLIST FOR APPLYING THE “BEST INTEREST PRINCIPLE”

As a CASA/GAL volunteer, you can use the following categories and questions to evaluate and advocate for the best interest of children:

Safety: Child safety is paramount and best achieved by supporting parents within their community. Ask yourself, “Is the child emotionally and physically safe?” and “What is required to maintain the safety of this child?”

Permanence: Children and youth need and have the right to lifelong nurturing and secure relationships that are provided by families who have the skills and resources to meet their specific needs. Efforts to identify and secure permanence for children are continuous and integrated into all stages of involvement with children and families. Ask yourself, “Who are the child’s main attachment figures?”, “Is the child receiving the emotional nurturance necessary for healthy brain development?” and “Is the child’s unique sense of time being honored?”

Well-Being: Children’s well-being is dependent upon strong families and communities meeting their physical, mental, behavioral health, educational and cultural needs. Ask yourself, “What are the special needs of this child, and are they being met?” and “Is the child receiving the educational support they require?”

Fostering Connections for Youth: As youth transition to adulthood, they benefit from services that promote healthy development, academic success, and safe living conditions, as well as establish connections to caring adults who will commit to lasting, supportive relationships.

Family Focus: Families are the primary providers for children’s needs. The safety and well-being of children is dependent upon the safety and well-being of all family members. Ask yourself, “What are the needs of the family?”

Partnership: Families, communities and the child welfare system are primary and essential partners in creating and supporting meaningful connections in a safe and nurturing environment for children and youth.

Respectful Engagement: Children, youth, and families are best served when advocates actively listen to them and invite participation in decision making. Respectful

engagement includes understanding and honoring of the family's history, culture and traditions, as well as empowering them to meet their unique and individual needs through utilization of family strengths, and educating them regarding the child welfare process. Ask yourself, "What are this child's/family's strengths, and how can we address areas for growth?"

Professional Competence: Children are best served by advocates who respond to the evolving needs of communities, are knowledgeable of the historical context within which the child welfare system operates, provide respectful treatment to families and continually strive for professional excellence through critical self-examination.

Cultural Competence: Cultural competence is achieved through understanding and serving children, youth, and families within a context of each unique family and community to help them achieve equitable outcomes. This includes but is not limited to the families' beliefs, values, race, ethnicity, history, tribe, culture, religion and language. Ask yourself, "Is the child's/family's unique culture being respected?"

Holley Factors

Holley v. Adams, 544 S.W.2d 367, 371-72 (Tex 1976) is a Texas Supreme Court case that is most often used to provide a “non-exhaustive” list of factors to be considered in determining best interest. All the “Holley factors” listed below are considerations that every CASA volunteer must investigate for every child they serve.

The nine factors identified in Holley include:

1. The desires of the child
2. The emotional and physical needs of the child now and in the future
3. The emotional and physical danger to the child now and in the future
4. The plans for the child by the party seeking the change
5. The stability of the home or the proposed placement
6. The parental abilities of the individuals seeking custody
7. The programs available to assist these individuals and to promote the best interest of the child
8. The acts or omissions of the parent that may indicate that the existing parent-child relationship is not a proper one
9. Any excuse for the acts or omissions of the parent

Resources vs. Deficits: Choosing Our Lens

It is equally important to identify the strengths and the resources in a family as it is to evaluate problems. Your ability to identify strengths in families depends partially on which lens—the resource lens or the deficit lens—you use in your work with families. The lens you choose will also influence your work with others involved in the case.

RESOURCES VS. DEFICITS	
If I look through a RESOURCES lens, I am likely to . . .	If I look through a DEFICITS lens, I am likely to . . .
Look for positive aspects	Look for negative aspects
Empower families	Take control or rescue
Create options	Give ultimatums or advice
Listen	Tell
Focus on strengths	Focus on problems
Put the responsibility on the family	See the family as incapable
Acknowledge progress	Wait for the finished product
See the family as experts	See service providers as experts
See the family invested in change	Impose change or limits
Help identify resources	Expect inaction or failure
Avoid labeling	Label
Inspire with hope	Deflate the family's hope

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

How Can You See the Strengths and Resources in Families?

Using a strengths-based approach means acknowledging the resources that exist within a family (including extended family) and tapping into them. For instance, you may identify a relative who can provide a temporary or permanent home for a child, you may help a parent reconnect with a past support system, or you may identify healthy adults who in the past were important to a child or family. Using a resource lens creates more options for resolution, and it empowers and supports children and families.

Here are a few questions you can ask when using the resource lens to assess a family:

- How has this family solved problems in the past?
- What has the family or parent done or overcome to get where they are now?
- What network of community, such as religious groups, does the family have?
- What do the family members see as their strengths and positive qualities?
- What are the family members or parent(s) proud of?
- What court-ordered activities have family members completed?
- Does the family have extended family or non-relative kin who could be a resource?
- How are family members coping with their present circumstances?

CULTURAL CONSIDERATIONS

Strengths don't look the same in every family. Family structures, rules, roles, customs, boundaries, communication styles, problem-solving approaches, parenting techniques and values may be based on cultural norms and accepted community standards.

For instance, in a deficit model, a family with a sole female head of household may be viewed as dysfunctional or lacking. But using a resources lens, the female-head-of-household structure is appreciated for the strength and survival skills of the mother,

How Can You See the Strengths and Resources in Families?

and there is a deeper examination of historical and institutional factors that have contributed to the prevalence of matriarchal families.

In another example, many Western cultures believe that children should have a bed to themselves, if not an entire room. In contrast, many other cultures believe that such a practice is detrimental to a child's development and potentially dangerous.

Additionally, in the United States, the ideal of the nuclear family dominates. However, in many communities, extended family have a greater role in child-rearing, and family may include members of a faith community or others who are not blood relatives.

People in different cultures and socioeconomic classes may use different skills and resources to deal with stress and problems. Material goods are one kind of resource, but some individuals and cultures prize other resources above material wealth. For example:

- Emotional resources provide support and strength in difficult times.
- Spiritual resources give purpose and meaning to people's lives.
- Musical traditions, crafts, art and performance add depth and connection.
- Good health and physical mobility allow for self-sufficiency.
- Cultural heritage provides context, values and morals for living in the world.
- Informal support systems provide a safety net (e.g., money in tight times, care for a sick child, job advice).
- Healthy relationships nurture and support everyone.
- Role models provide examples and practical advice on achieving success.

Asking Strengths-Based Questions

Parents may feel more comfortable voicing concerns or needs and exploring solutions when we:

- Focus on the parents' own hopes and goals for their children
- Help parents identify and build on their strengths in parenting
- Model nurturing behavior by acknowledging frustrations and recognizing the parents' efforts.

Here are some questions to help explore strengths, challenges and resources as you talk with the parents on your case. Remember to use the child(ren)'s names when speaking with their parents.

IN ORDER TO EXPLORE...	ASK THE PARENT...
<ul style="list-style-type: none"> • How the parent observes and attends to the child • Specific play or stimulation behaviors 	<ul style="list-style-type: none"> • How much time are you able to spend with your child or teen? • When you spend time with your child or teen, what do you like to do together? • How do you engage your child or teen during everyday activities (diapering, meals, driving in the car)? • What games or activities does your child or teen like?
<ul style="list-style-type: none"> • How the parent responds to the child's behavior 	<ul style="list-style-type: none"> • What does your child or teen do when they are (sad, angry, tired)? • What happens when your child (cries for a long time, has a tantrum, wets the bed, skips school)?
<ul style="list-style-type: none"> • How the parent demonstrates affection • How the parent models caring behavior 	<ul style="list-style-type: none"> • How do you show affection in your family? • How do you let your child know that you love them?

IN ORDER TO EXPLORE...	ASK THE PARENT...
<ul style="list-style-type: none"> • How the parent recognizes accomplishments 	<ul style="list-style-type: none"> • What are your child’s greatest gifts and talents? • How do you encourage these talents? • What do you do when your child does something great?
<ul style="list-style-type: none"> • The parent’s view of their child’s strengths 	<ul style="list-style-type: none"> • What does your child do best? • What do you like about your child?
<ul style="list-style-type: none"> • How the parent views their own role 	<ul style="list-style-type: none"> • What do you like about being a parent of an infant (preschooler, teenager)? • What are some of the things that you find challenging as a parent?
<ul style="list-style-type: none"> • How the parent observes and interprets the child’s behavior 	<ul style="list-style-type: none"> • What kinds of things make your child happy (frustrated, sad, angry)? • Why do you think your child (cries, eats slowly, says “no,” breaks rules)?
<ul style="list-style-type: none"> • How the parent encourages positive behavior through praise and modeling 	<ul style="list-style-type: none"> • How have you let your child know what you expect? • What happens when they do what you ask?
<ul style="list-style-type: none"> • Whether the parent can identify alternative solutions for addressing difficult behaviors • Community, cultural, and ethnic expectations and practices about parenting 	<ul style="list-style-type: none"> • How have you seen other parents handle this? What would your parents have done in this situation? • How do you learn about parenting skills? • What teaching (discipline) methods work best for you? • How does your child respond?

Asking Strengths-Based Questions

IN ORDER TO EXPLORE...	ASK THE PARENT...
<ul style="list-style-type: none"> • How the parent understands the child's development • Any parental concern that the child's behavior appears to be outside the normal range 	<ul style="list-style-type: none"> • How do you learn about your child's development? • How do you think your child compares to other children their age? • Are there things that worry you about your child? • Have others expressed concern about your child's behavior?
<ul style="list-style-type: none"> • How the parent encourages healthy development 	<ul style="list-style-type: none"> • How do you encourage your child to explore their surroundings, try new things, and do things on their own?
<ul style="list-style-type: none"> • What the parent identifies as their coping strengths and resilience • The parent's strengths in parenting 	<ul style="list-style-type: none"> • What helps you cope with everyday life? • Where do you draw your strength? • How does this help you in parenting?
<ul style="list-style-type: none"> • What the parent identifies as everyday stressors • Problem-solving skills • Stressors precipitated by crises 	<ul style="list-style-type: none"> • What kinds of frustrations or worries do you deal with during the day? • How do you solve these everyday problems as they come up? • Has something happened recently that has made life more difficult?
<ul style="list-style-type: none"> • Impact of stress on parenting 	<ul style="list-style-type: none"> • How are you able to meet your children's needs when you are dealing with stress? • How are your children reacting to crisis?
<ul style="list-style-type: none"> • How the parent communicates with their spouse or partner • Whether there is marital stress or conflict 	<ul style="list-style-type: none"> • How do you and your spouse or partner communicate and support each other in times of stress? • What happens when you and your spouse or partner disagree?

IN ORDER TO EXPLORE...	ASK THE PARENT...
<ul style="list-style-type: none"> Needs that might be identified by a different family member (not all family members may identify the same needs) Actions that a parent may need to take when additional needs are identified 	<ul style="list-style-type: none"> Are other family members experiencing stress or concern? Has anyone in your family expressed concern about drug and alcohol abuse, domestic violence or mental health issues? What steps have you taken to address those concerns?
<ul style="list-style-type: none"> Short-term supports (respite care, help with a new baby, help during an illness) Long-term strategies (job training, marital counseling, religious or spiritual practices) 	<ul style="list-style-type: none"> What do you do to take care of yourself when you are stressed? Do you have family or friends who help out from time to time? Where in the community can you find help?
<ul style="list-style-type: none"> The parent's ability to set and work toward personal goals 	<ul style="list-style-type: none"> What are your dreams (long-term goals) for yourself and your family? What are your goals for your family or children in the next week (or month)? What steps might you take toward those goals in the next week (or month)?
<ul style="list-style-type: none"> The parent's current social support system, including family, friends, and membership in any formal groups 	<ul style="list-style-type: none"> Do you have family members or friends nearby who help you out once in a while? Do you belong to a church, temple, mosque, women's group or men's group? Do you have a child in the local school or Head Start program?


Adapted from U.S. Department of Health and Human Services Administration for Children and Families, Making Meaningful Connections: 2015 Prevention Resource Guide www.childwelfare.gov/pubPDFs/2015guide.pdf

Supplemental Materials

ASKING THE RIGHT QUESTIONS & PLANNING YOUR NEXT STEPS


When working with younger children, one way to engage them in sharing information about their family relationships is to invite them to draw their family with you, if they're comfortable. This can provide insights into who they see as important figures within their family and fictive kin network, and help inform your family engagement efforts.

Another engagement tool for youth is called My Three Houses. See the visual below and visit www.mythreehouses.com for further information:



My Three Houses™

This connection tool helps identify the aspects of a child's life that are worries, good things and dreams, and locates them in three houses to make the issues more accessible.





House of
Worries

House of
Good Things

House of
Dreams

Helpful Tips

- The child can draw three houses or the advocate can bring a printout
- There is an app on Android devices that can be downloaded at www.mythreehouses.com and used with youth
- Revisit this activity during later visits to identify any changes
- The image can be adapted and updated depending on the interests of the youth (i.e. cars, horses, etc.)



INITIAL INVESTIGATION PLAN

This worksheet is a helpful tool for creating your investigation plan. Remember, the plan for your investigation will be different in each case because each child's situation is unique.

Date of Next Court Hearing:		
Type/Purpose of Hearing:		
Court Report Is Due:		
Questions I Would Like to Address	Possible Sources of Information	Priority #
A		
B		
C		
D		
E		
F		
G		
H		
I		
J		

SOURCES OF INFORMATION

CHILD	
<p>Child Interviews</p> <p><i>Please note that it is not your role as a CASA/GAL volunteer to interview a child about the allegations; many of the children have been interviewed many times, and additional interviews may be harmful to the child and to any potential criminal prosecution.</i></p> <p>Type of Information/Assistance:</p> <p>If the child is verbal:</p> <ul style="list-style-type: none"> • History of the family situation • Information about relationships (parents, families, foster families) • Wishes and desires for the future • Challenges or areas in need of help • Likes/dislikes • Information regarding visits with parents, siblings, other family • Other _____ <p>Best way to contact source:</p>	<p>Child Observations</p> <p><i>Visits with parents, visits with siblings, child in current setting, child at school or daycare, etc.</i></p> <p>Type of Information/Assistance:</p> <ul style="list-style-type: none"> • Affect • Moods, mood changes • Developmental stages • Verbal ability • Relationships, interactions with others • Intellectual ability • Other _____ <p>Best way to arrange observation:</p>

FOSTER PARENTS AND INDEPENDENT LIVING COORDINATORS

Type of Information/Assistance

- Specific information about the child's daily life and about the child's behavior related to:
 - Visits with parents and siblings
 - Adjustments in school
 - Behavior problems and strengths
 - Medical concerns
 - Contact made by parents through letters, phone calls, etc.
 - Child's daily functioning
 - Adjustment to separation/loss
 - Other _____

Best way to contact source:

PARENTS AND FAMILY	
<p style="text-align: center;">Parents</p> <p><i>When parents are represented by an attorney, follow program protocol before speaking with the parents.</i></p> <p>Type of Information/Assistance:</p> <ul style="list-style-type: none"> • Their version of the events stated on the petition • Omissions or extenuating circumstances they feel are important • Their child's developmental milestones, joys, fears, etc. • Specific information about the child's behavior related to: <ul style="list-style-type: none"> • Visitations with parents and siblings • Adjustments in school • Behavior problems and strengths • Medical concerns • Adjustment to separation/loss • Their background • Other _____ <p>Best way to contact source:</p>	<p style="text-align: center;">Family</p> <p>Type of Information/Assistance:</p> <ul style="list-style-type: none"> • What they've seen happening as it relates to the life of the child • Potential resources for the child and family • Other _____ <p>Best way to contact source:</p>

TRIBE
<p><i>Applies only if you are working with an Indian child as defined by the Indian Child Welfare Act.</i></p> <p>Type of Information/Assistance</p> <ul style="list-style-type: none"> • Potential service resources • Tribal enrollment issues • Potential transfer of jurisdiction • Information regarding whether anyone is going to appear in court for the tribe and whether the tribe is going to formally intervene, send a representative, or make a written recommendation; information regarding recommendations • Potential cultural responses to the current family problem • Extended family or members of the tribe who may be a potential placement alternative for the Indian child • Other _____ <p>Best way to contact source:</p>

PROFESSIONALS	
<p style="text-align: center;">Child Protection Agency Caseworkers</p> <p>Type of Information/Assistance</p> <ul style="list-style-type: none"> • Where the child is placed • Documentation, case record • Case plan within 30 days of placement • Names, addresses, and phone numbers of other principals in the case • Contact information (e.g., for foster parents, parents, etc.) • Response to your observations • Community or educational resources • Progress of case plan • Safety issues, if any • Medical status of child • Educational status of child • Anything else the CASA/GAL volunteer should know • Other <p>Best way to contact source:</p>	<p style="text-align: center;">Child's Teacher or Childcare Provider</p> <p>Type of Information/Assistance</p> <ul style="list-style-type: none"> • Child's behavior at school • Educational problems or delays, strengths • Changes in behavior • Child's appearance • Peer relationships • Grades • Parental involvement • Likes/dislikes • Attendance prior to/post removal • School nurse reports • School counselor reports • Other _____ <p>Best way to contact source:</p>

PROFESSIONALS	
<p style="text-align: center;">CASA Advocate Supervisor</p> <p>Type of Information/Assistance</p> <ul style="list-style-type: none"> • Coaches and supports volunteer throughout case assignment • Reviews all documentation written by volunteer • Reviews case recommendations and legal complexities throughout case • Attends hearings and meetings alongside CASA volunteer • Other <p>Best way to contact source:</p>	<p style="text-align: center;">Attorney ad Litem</p> <p>Type of Information/Assistance</p> <ul style="list-style-type: none"> • Represents child's expressed wishes and/or desired case outcomes in and out of court if child is verbal • Assists in negotiating settlements in preparation for trial • Files legal documents • Other <p>Best way to contact source:</p>
<p style="text-align: center;">District Attorney</p> <p>Type of Information/Assistance</p> <ul style="list-style-type: none"> • Criminal records, other court records • Preparation for trial • Other <p>Best way to contact source:</p>	<p style="text-align: center;">Attorneys for the Parents</p> <p>Type of Information/Assistance</p> <ul style="list-style-type: none"> • Arrangements to talk to their clients • Anything the volunteer should know about the client • Other _____ <p>Best way to contact source:</p>

PROFESSIONALS	
<p style="text-align: center;">Medical Personnel</p> <p>Type of Information/Assistance</p> <ul style="list-style-type: none"> • Child's medical condition as related to the abuse and/or neglect • Past medical history, medical records • Follow-up services that may be required to address medical conditions resulting from abuse and/or neglect • A particular medical condition that should come to the attention of the caseworker, foster parents, courts, etc. • Contact with parent(s), if any • Other <p>Best way to contact source:</p>	<p style="text-align: center;">Psychological/Psychiatric Professionals</p> <p>Type of Information/Assistance</p> <ul style="list-style-type: none"> • Nature of referral information they received • How they came to a particular conclusion • What the diagnosis means in practical terms and how progress is measured • Discrepancies in opinion • Possible counseling or therapeutic models being recommended for the child, parents, family, etc. • Other <p>Best way to contact source:</p>

Chapter 3

3





We do not believe in ourselves until someone reveals that deep inside us something is valuable, worth listening to, worthy of our trust, sacred to our touch. Once we believe in ourselves we can risk curiosity, wonder, spontaneous delight or any experience that reveals the human spirit.”

– e. e. cummings

Chapter 3: Trauma, Resilience and Communication Skills

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PRE-WORK INSTRUCTIONS

1. Read pages 126-141, “Understanding Child Trauma” through “Initial Case Notes for the Black-Smith Case.”
2. Watch “Shane’s Digital Story” video at www.learn.texascasa.org.
3. Watch “CASA/GAL Sample Interview: 4-Year-Old Child Part 1” video at www.learn.texascasa.org and take notes as instructed.
4. Watch “First Impressions: Exposure to Violence and a Child’s Developing Brain” video at www.learn.texascasa.org.
5. Complete the assignment “Preparation for Interviewing a 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
- Experiencing physical or sexual abuse
- The death or loss of a loved one
- Being in an automobile accident
- Being present for a life-threatening natural disaster or a war
- The experience of being removed from your family by CPS

The traumatic event often causes feelings of fear, helplessness or horror that the child may express 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 long-standing 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., racial trauma such as slavery or forced placement in boarding schools; transgenerational trauma such as sexual abuse that happens in several generations of a family).

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 and/or availability of adults who can offer help and protection

NCTSN, Child Welfare Trauma Toolkit, January 2013

Understanding Child Trauma

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 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 and participate in trauma-informed therapy. 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 their 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 and make sure you do not try to provide or direct therapy. Because some therapeutic providers that contract with CPS do not specialize in trauma, it is important to advocate for your child to work with a **trauma-informed therapist** in order to ensure that the child is receiving appropriate support.

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.

QUESTIONS TO ASK

The following questions can help you determine whether to recommend an assessment for a child or a 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 showing persistent difficulties in relationships with others?
- Does the child have difficulty regulating his/her physical states and feelings, such as sleep, eating, sensory processing or expressing emotions?
- Is the child having difficulty controlling his/her behavior, sometimes appearing hyperactive, engaging in risky behaviors or not following rules?
- Is the child having difficulty with sustaining attention, concentration or learning?
- Does the child have multiple mental health diagnoses without one diagnosis explaining all of their symptoms?

Secondary Trauma, Self-Care and the CASA/GAL Advocate

It's not just children in foster care who need support and healing time to process their trauma. Everyone involved in the child welfare system is exposed to trauma in some way, as the nature of the work is deeply affecting and difficult. Secondary trauma, also known as vicarious trauma, secondary PTSD and, in milder cases, compassion fatigue, can affect anyone, and it is not ever a sign of personal weakness. Secondary trauma can show up in the form of nightmares, excessive anxiety and preoccupation, dissociation, depression, a feeling that you can never do enough, intrusive thoughts or triggers from your own history being activated and causing distress.

Pay close attention to your own emotional well-being as you work your CASA case. Prioritize self-care and community. Make sure that you are getting enough sleep, nourishing food, connection with others, and support. Reach out to your supervisor if you feel overwhelmed. It is perfectly acceptable to ask for a break or to volunteer in another capacity if emotional distress is heightened too greatly for you to do the best job. There is nothing wrong with admitting this; it can be a natural response to the work for some people. Above all, take care of yourself.

Clear 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.

COMMUNICATION BASICS

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.

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 be confused and 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 various cultures:

- Pointing with one finger is considered to be rude.
- Patting a child's head is inappropriate.
- Direct eye contact is thought to be disrespectful.
- Handshakes between men and women are questioned.

If a case involves a family with a culture distinct from an advocate's, the advocate should read and study about that culture's communication dynamics.

Asking the Right 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 other 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

More Examples

Closed-Ended Question for a Child:

- Do you want to live with your mother or your father?

Open-Ended Question for a Child:

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

Asking the Right Questions

Closed-Ended Question for a Parent:

- Do you feel happy?

Open-Ended Question for a Parent:

- 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 for a Child:

- 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 for a Parent:

- 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?

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 guided 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 them while still presenting yourself as a professional.

Keep the interview focused. 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. Focus on communicating an empathetic, accepting and 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.
5. Do not ask leading questions. A leading question assumes a point of view on your part.
6. Listen to understand. Be careful not to interrupt.
7. Do not expect to gather all the information needed in one conversation.
8. Communicate that you are actively listening with phrases such as "Okay," "Go on," or "Please continue" or by allowing five seconds of silence.

Asking the Right Questions

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. As always, remember to check any assumptions you may have made based on this person’s cultural background, socioeconomic class, immigration status, religion, sexual orientation or other identity characteristic. Approaching every interaction with an open mind and a respectful attitude is critical to unbiased advocacy.

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, upset and re-traumatize the child.

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 now. Some children can talk about their situations and their wishes, but other children do not have sufficient verbal and developmental skills to express themselves. For that reason, fact-based observations about a child are important to your role in gathering information about a case.

The Center for Problem-Oriented Policing (POP) website states that common errors in interviewing children include reinforcing certain answers, relaying what others believe about the allegation, and asking complicated questions. They advise the following:

- Make the interview setting child-friendly
- Recognize the developmental capabilities of children of different ages
- Always remain patient
- Avoid “why” questions and focus instead on clear, open-ended questions
- Make efforts to offset any guilt the victim may experience for “causing trouble”

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), caregivers, 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.

Ideas 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 their story. Listen.

Adapted from Lucas County, Ohio CASA/GAL.

Assignment: Preparation for Interviewing a Child

In order to enhance your interviewing skills as a CASA/GAL volunteer, think about how you will go about conducting interviews. Mentally choose a child between the ages of 5 and 17 and prepare interview questions. Review the child development information for the age of the child you choose to make sure your questions are age-appropriate. Please bring the following interview preparation worksheet to class with you.

You do not need to actually interview a child for this assignment.

INTERVIEW PREPARATION WORKSHEET

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?

Initial Case Notes for the Black-Smith Case

CPS Case File					
Last Name of Case: Black/Smith			Legal Number(s): 3AN-15-154/155		
Child(ren)'s Name	DOB	Age	Ethnicity	Sex	Current Location
Tammy Black	9/1	6	White	F	Foster Care
Grace Smith	8/19	4 months	White	F	Foster Care

Current Caretaker(s)	Address	Phone
Foster Parents: Linda and Dave Gilbert	4206 Front Street	682-555-4413

Attorneys for:		
Mother	Megan Miller	682-555-9894
Father	Ben Bryant	817-555-1337
CPS	Heather Stafford	682-555-7344
Child	Amelia Reynolds	682-555-0201

Case History
<p>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, Alan Smith, was arrested on DV charges. CPS was notified, and the children were placed together in emergency foster care.</p> <p>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.</p>

Case History continued
<p>Sept 25: Due to where the new foster home is located, Tammy was moved to a new school. Linda reported this change has been very difficult for Tammy.</p> <p>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, Frances Smith, was ordered to attend domestic violence survivors' program.</p> <p>Nov 29: Parents stipulated to adjudication, thereby acknowledging the issues are substance abuse, physical abuse and anger management.</p>

CASA History	Person(s)	Date Assigned	Date Terminated
Case Initially Assigned to:	You and your team	Today	N/A
Current CASA Volunteer:	You and your team	Today	
CASA Supervisor:	Jessica Clarkson	9/17	
CPS Social Worker:	Becky Howard	9/15	

Court-Ordered Services
<p>For the Child:</p> <ul style="list-style-type: none"> Educational needs met as appropriate
<p>For the Father:</p> <ul style="list-style-type: none"> Drug/alcohol screening and substance abuse treatment Domestic violence program
<p>For the Mother:</p> <ul style="list-style-type: none"> Domestic violence survivors' program

END OF PRE-WORK FOR CHAPTER 3

Self-Care and the Feelings Thermometer

As you begin to explore the topic of trauma, be aware that your feelings about any personal trauma you or someone you are close to has experienced may be heightened. It is good and appropriate to pay attention to your feelings. Make taking care of yourself emotionally a priority. We can only do good advocacy by being in touch with ourselves and caring for our wellbeing. Being a CASA/GAL advocate is a job that evokes many emotions. Share them with others in the training room, or with your supervisor—don't carry them alone.

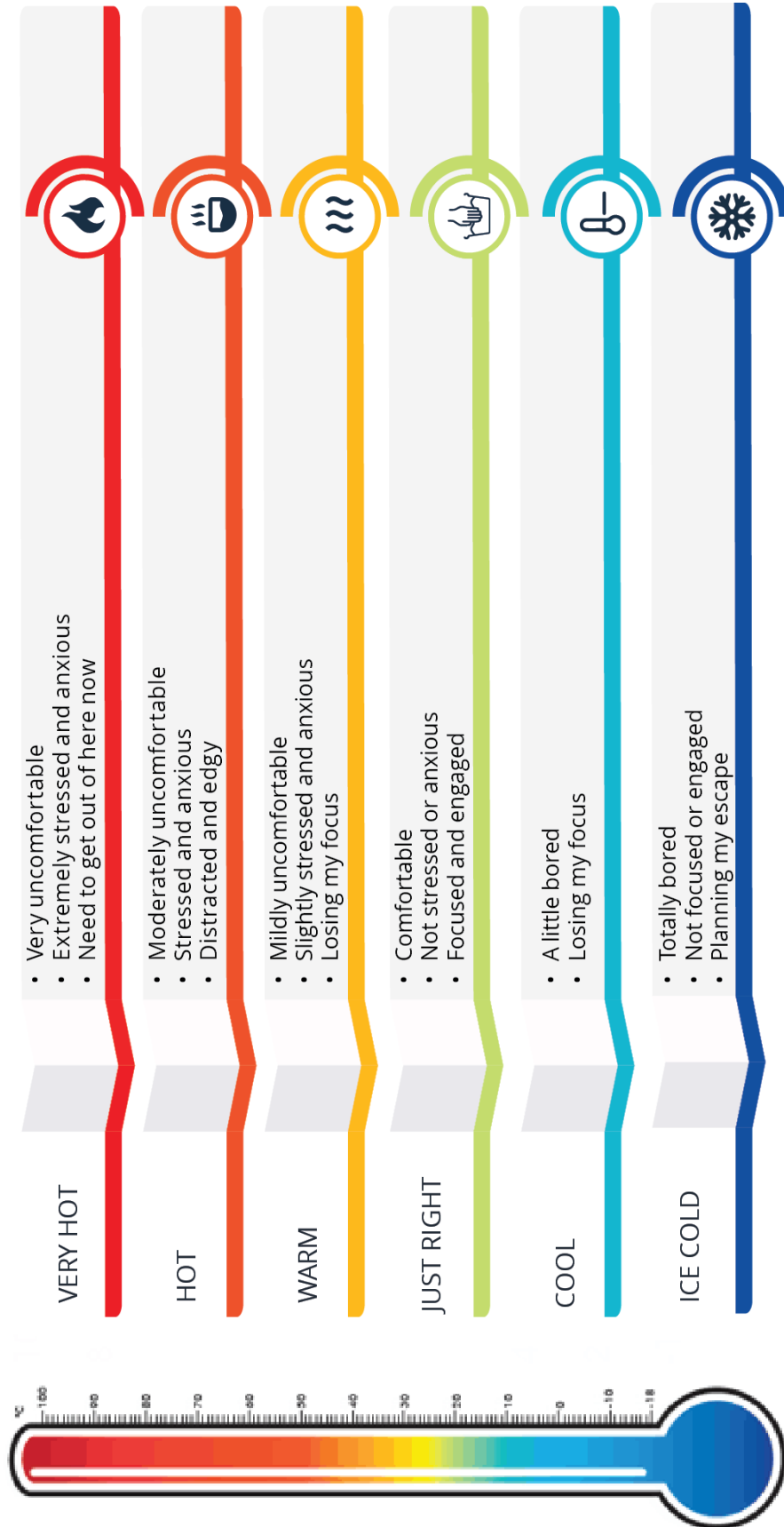
THE FEELINGS THERMOMETER

The National Child Traumatic Stress Network (NCTSN) has developed the concept of a “feelings thermometer” to gauge your “emotional temperature” or response to what you're learning about. In their training for parents caring for children who have experienced trauma, NCTSN writes:

“The Feelings Thermometer . . . [can] make you more aware of the topics or situations that push your buttons, and how you react when your buttons are pushed. With this awareness, you may be able to anticipate situations that are going to raise your emotional temperature, and come up with a game plan for coping with them. When your Feelings Thermometer goes way up, that means you're feeling stressed, anxious, and feel the need to escape. You also may find that when you become very uncomfortable, you “space out” and withdraw from the discussion. . . . [S]pacing out or withdrawing is something that traumatized kids do sometimes as well. What looks like boredom, or just not caring, or withdrawal can sometimes be a reaction to trauma.”

NCTSN, Caring for Children Who Have Experienced Trauma, February 2010.

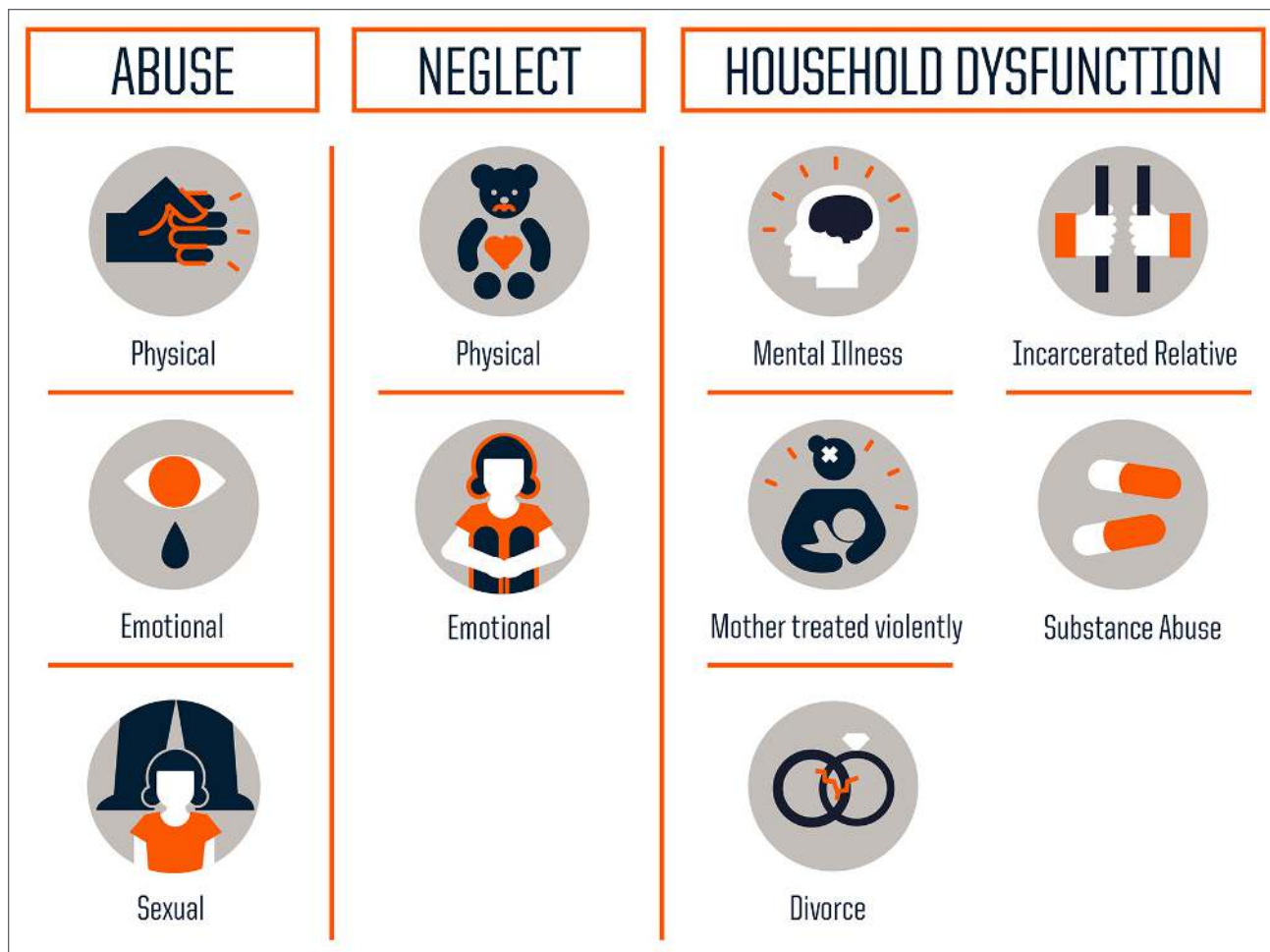
If you find that your “feelings thermometer” is running high and may be affecting your role as an advocate, please reach out for support from your CASA/GAL program staff.



The Long-Term Effects of Childhood Trauma

Childhood traumatic experiences affect us for life. We call these “Adverse Childhood Experiences,” or ACEs.

THREE TYPES OF ACEs



Source: Centers for Disease Control and Prevention
Credit: Robert Wood Johnson Foundation

FINDING YOUR ADVERSE CHILDHOOD EXPERIENCE (ACE) SCORE

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often** swear at you, insult you, put you down, **or** humiliate you or act in a way that made you afraid that you might be physically hurt?

No Yes If yes, enter 1: _____

2. Did a parent or other adult in the household **often or very often** push, grab, slap, or throw something at you? Or **ever** hit you so hard that you had marks or were injured?

No Yes If yes, enter 1: _____

3. Did an adult or person at least 5 years older than you **ever** touch or fondle you or have you touch their body in a sexual way? Or attempt or actually have oral, anal, or vaginal intercourse with you?

No Yes If yes, enter 1: _____

4. Did you **often or very often** feel that no one in your family loved you or thought you were important or special **or** your family didn't look out for each other, feel close to each other, or support each other?

No Yes If yes, enter 1: _____

5. Did you **often or very often** feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you **or** your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

No Yes If yes, enter 1: _____

6. Were your parents **ever** separated or divorced?

No Yes If yes, enter 1: _____

The Long-Term Effects of Childhood Trauma

7. Was your mother or stepmother **often or very often** pushed, grabbed, slapped, or had something thrown at her? Or **sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard? Or **ever** repeatedly hit at least a few minutes or threatened with a gun or knife?
No Yes If yes, enter 1: _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
No Yes If yes, enter 1: _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
No Yes If yes, enter 1: _____

10. Did a household member go to prison?
No Yes If yes, enter 1: _____

Now add up your “Yes” answers: _____ This is your ACE Score.

The ACE score doesn't determine your past or future; it's meant as guidance. When used in the context of CASA/GAL work, it helps advocates understand the situations the children and youth they care for are facing. ACE scores don't measure the inner resources of the individual, the nurturing and positive experiences that may have mitigated the traumatic ones, and the strong loving relationships that may have protected against some of trauma's effects.

To learn more, check the CDC's ACE Study website at:
www.cdc.gov/violenceprevention/acestudy/index.html

Helping Youth Build Resilience

Considerable research has shown that child abuse and neglect increase the likelihood of developing problems later, but not all children subjected to lives of severe adversity go on to become dysfunctional adults. Some don't experience problems or do so to only a minor degree. This is resilience: the ability to become strong, healthy or successful again after something bad happens. Resilient people overcome the ravages of poverty, abuse, unhappy homes, parental loss, disability or any of the other risk factors known to set people on a difficult course in life.

Resilient children achieve normal development despite their experience of past or present adversity. Studies of resilient people have repeatedly identified the presence of certain protective factors: personal qualities, family, relationships, outlooks and skills that assist them in overcoming hardships and finding success. Helping children and youth in the child welfare system discover and/or develop some of these characteristics can significantly improve their chances for positive life outcomes.

THE SEVEN C's: THE ESSENTIAL BUILDING BLOCKS OF RESILIENCE

When we encounter stress in our lives, we tend to develop ways to overcome that stress or prevent it in the future. Over time, overcoming stress can be refined, practiced and improved, making us more resilient to adverse situations. Healthy ways of dealing with stress include fostering one of the "seven C's":

- **Competence:** When we notice what young people are doing right and give them opportunities to develop important skills, they feel competent. We undermine competence when we don't allow young people to recover themselves after a fall.
- **Confidence:** Young people need confidence to be able to navigate the world, think outside the box and recover from challenges.
- **Connection:** Connections with other people, schools and communities offer young people the security that allows them to stand on their own and develop creative solutions.
- **Character:** Young people need a clear sense of right and wrong, and a commitment to integrity.

Helping Youth Build Resilience

- **Contribution:** Young people who contribute to the well-being of others will receive gratitude rather than condemnation. They will learn that contributing feels good and may therefore more easily turn to others and do so without shame.
- **Coping:** Young people who possess a variety of healthy coping strategies will be less likely to turn to dangerous quick-fixes when stressed.
- **Control:** Young people who understand that privileges and respect are earned through demonstrated responsibility will learn to make wise choices and feel a sense of control.

Bottom Line #1

Young people live up or down to expectations we set for them. They need adults who believe in them unconditionally and hold them to the high expectations of being compassionate, generous and creative.

Bottom Line #2

What we do to model healthy resilience strategies for our children is more important than anything we say to them.

The Seven Cs are an adaptation from the Positive Youth Development movement.

Because a strong sense of connection is critical for both healthy development and resilience, one thing CASA volunteers can do to support children in healing from trauma and building resilience is to advocate for them to have as many relationships with healthy adults as possible. Check in proactively with your CASA supervisor for support around continuing your family-finding and family engagement efforts as you work your case, and explore resources in your community for connecting youth with mentors who can provide added connection and support.

Chapter 4

4





We must protect families, we must protect children, who have inalienable rights and should be loved, should be taken care of physically and mentally, and should not be brought into the world only to suffer.”

– Indira Gandhi

Chapter 4: Mental Health, Poverty and Confidentiality

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PRE-WORK INSTRUCTIONS

1. Read pages 152-171, “Mental Illness in Families” through “Initial Case Notes for the Greene Case.”
2. Complete the “Examining Poverty vs. Neglect Scenarios” activity.
3. Play the online game Spent to learn more about the challenges of poverty. Find the link at www.playspent.org.

Mental Illness in Children and Families

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 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, the DSM serves as a universal authority for psychiatric diagnosis in the United States. The term “dual diagnosis” indicates that an individual has both a psychiatric disorder and a substance abuse problem.

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 predominantly 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. Mental illness is a condition and, at times, a disability, which we do not judge a person for having. A mental illness that is treated and managed is different from an untreated mental illness. Likewise, there are varying levels of severity, as with all other illnesses.

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
- 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 mean a life of problems. Approximately one in five adults in the U.S.—43.8 million, or 18.5 percent—experiences mental illness in a given year, according to the National Alliance on Mental Illness. 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. It may also result from a lack of access to treatment and affordable medical care. 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 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 their ability to provide a safe home for the child. The degree to which a parent’s ability to function 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.

“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. 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
- **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

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.

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 a 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 supervisor will be able to answer your questions about gaining access to this confidential information.
- 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.

Treatments for Mental Health and Children in Care

Medications can help children and teens in foster care, but they can also further impair them, derail them and sabotage them. Without a clear understanding of their mental health issues, misdiagnoses can be made, and incorrect medications can be prescribed. If there is no reliable caregiver who can describe the child's struggles, information collected can be biased and incomplete. If emotional trauma underlies the presenting symptoms and is not addressed, medications can have no effect or increase problems. If medications are prescribed but other therapies are not provided and supervision of the medication is inadequate, healing and stabilization supporting healthy growth will not occur.

Finally, if caregivers are not adequately trained and educated in caring for a child with significant emotional and psychological needs, medications can often be given to the child to "manage their behaviors" rather than to truly treat the child's illness.

To adequately and successfully represent and speak for a child or teen in foster care, the child's advocate must be able to communicate with the child and discuss the child's experiences. Does the child manage their acting-out behaviors and emotions, use positive social skills, think clearly and track the ongoing events in their lives?

Depression or suicidal thinking must be addressed. Self-abusive behaviors must be contained and risk-taking behaviors reduced. Medications can be part of a successful intervention and treatment plan when appropriate. Working with children and teens in foster care requires a solid understanding of the positive and negative aspects of medication use for the youth that we are serving.

Managing and treating mental health issues and the symptoms experienced by children and adolescents involves many modalities. A key aspect is that the child trust the provider.

- **Medication treatment, or psychopharmacology,** can alleviate or lessen the symptoms that accompany many mental health disorders. 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.

Treatments for Mental Health and Children in Care

- **Behavioral therapy** can help increase positive behaviors and decrease negative acting out.
- **Trauma-Focused Cognitive Behavioral Therapy** can help correct a pattern of negative thoughts that interfere with the ability to relate to others.
- **Eye Movement and Desensitization and Reprocessing (EMDR)** uses a structured eight-phase approach to address the past, present and future aspects of traumatic or distressing memories, and end their influence on the present.
- **Play therapy** and **art therapy** can help heal past trauma and facilitate a child's return to normal functioning.
- **Child-parent psychotherapy** involves working directly with the parent and child together and can help the child learn healthy ways of interacting and functioning. Parents can be coached to become more reflective and 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.

Questions Advocates Should Ask a Prescribing Doctor

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.

Questions Advocates Should Ask a Prescribing Doctor

- What therapies or counseling has the child received?
- Does the child already have a relationship with a certain counselor or therapist?
- What is the medication the child is on 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 vs. benefits of using this medication? What are the risks vs. 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.

Understanding the Higher Rate of Poverty in the System

WHY ARE CHILDREN WHO ARE IMPOVERISHED 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, children who are impoverished 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 people who are impoverished do. Even though family crisis, including abuse, happens at all income levels, it is people living in poverty 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 or housing. 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 families of color living in poverty 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 parents living in poverty 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

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 day care

RELATIONAL POVERTY

When we speak of poverty, we are generally thinking of economic poverty, the lack of funds and resources that is historically rooted and related to social imbalances of access and power. However, we can expand our thinking about this term to include relationships. A child may be in a home that is middle- or upper-class, and be in an emotional desert. They may be neglected or in isolation from important primary relationships. And, when a child is removed from their home, they may be stripped of all the relational sources and supports they did have. This is relational poverty.

Because a strong sense of belonging and connection are central to healthy development and resilience, it's key that we also advocate for a child's relational needs as well as their basic physical needs. When children are removed from their family due to concerns about abuse or neglect, they are at risk of experiencing relational poverty.

Understanding the Higher Rate of Poverty in the System

Instead of expressing these feelings of abandonment and isolation, however, youth often act out in ways that may jeopardize the sustainability of their placements and lead to further isolation through multiple disrupted placements. Family engagement efforts can help stabilize a placement by providing important relationships and empowering the youth to maintain a sense of connection and relational permanence.

Activity: Examining Poverty vs. Neglect

Consider the circumstances in which each of the following scenarios 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 . . . _____

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 status 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 case. The court order appointing you as the child’s advocate provides fairly wide latitude. Present photo identification and copies of your legal appointment when you visit an agency to seek information, or if any source from whom you seek information asks for them. Always remember that you have enormous responsibilities with handling and protecting confidential information.

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 region. You must regard as confidential any information that the source deems confidential. It is especially important that the name of any person who has made a report of suspected child abuse and neglect not be revealed.

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 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.

PROCESSES FOR OBTAINING INFORMATION FROM AGENCIES

The process for obtaining information from agencies and schools differs from program to program. For example, information may be obtained by lawyers through a process called “discovery,” or it may be up to the volunteer to obtain those records. Follow the direction of your program on how best to access child protective services documents, school records, and other information.

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. 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.

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 a third party (in this case, you) with access to the client’s confidential information. Many agencies require that you use their form, so look into downloading or getting it before you visit.

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. Your local program will advise you on how to access medical records. They may post hospital names and contact information on their website or provide a handout with that information. If you are denied access to records, contact your supervisor for support.

CONFIDENTIALITY AND YOUR RESPONSIBILITIES

The CASA/GAL volunteer may not release confidential information except to the child, CASA program staff, the attorney(s) on the case, the caseworker, the court, and others as instructed by law or local court rule.

Obtaining Confidential Case-Related Records

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 others. 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 ABOUT SHARING INFORMATION WITH THE CHILD?

You 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 their age and developmental level. This includes 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 for guidance.

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 and 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.

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. Your job is to focus on the child's needs and keep the child informed about the case in an age-appropriate manner, gather information for the court and make recommendations. Foster parents may seek information from you about the children in their care, but their contractual relationship is with the child protective services agency or a private licensing agency.

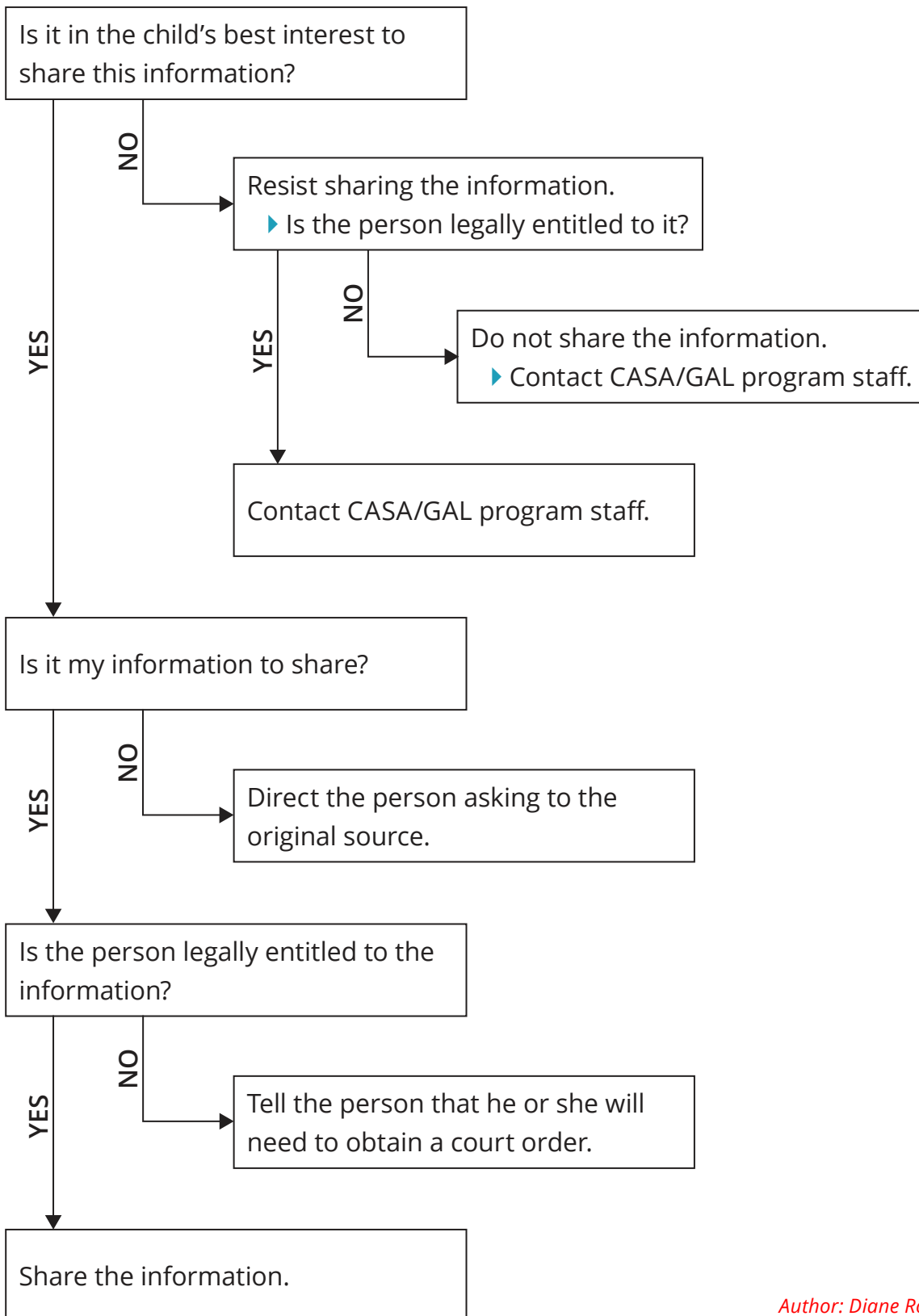
To provide adequate care, foster parents do need to know relevant information regarding the child. In fact, federal law requires that the child protective services agency provide the foster parent with the child's health and education records at the time of placement, updated periodically and each time 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 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 they have 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 by the caseworker with the current foster care provider. As a CASA/GAL volunteer, you should not share this information yourself.

SHOULD I SHARE INFORMATION WITH SOMEONE ELSE ABOUT THIS CHILD OR THIS CASE?



Author: Diane Robinson

Time Is of the Essence in Case Communication

There is no time to waste on anyone's part in a child welfare case. The juvenile court system functions on strict timelines, which are in place so children progress toward a safe, permanent home and do not languish in out-of-home care. As an advocate, you may have to function as the timekeeper to push things along and keep everyone aware of the urgency. Please take every opportunity to respond immediately to communication, to keep the process going.

Children and parents need services put in place as quickly as possible. Timelines and deadlines intended to protect children can make successful completion of a case plan difficult for parents, especially those with drug and mental health issues. Every person on a case needs to understand where the case stands—including roadblocks, setbacks and successes. This will give the parents the best chance at reunification and the child the best chance at finding a safe, permanent home. Time is of the essence!

You will need to speak with numerous people during the life of a case, many of whom 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. Be a facilitator of communication and avoid being part of a communication breakdown. Open, respectful communication among everyone involved is critical to serving the child's best interests.

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 Location
Marky Greene	2/15	6 years	White	M	Home of bio mother & father

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

Attorneys for:		
Mother	Darlene Wright	555-6000
Father	Walt Harris	555-8727
CPS	Robin Jackson	555-6552
Child	Chase Kelley	555-0311

Case History
<p>Two weeks ago:</p> <p>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.</p> <p>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.</p>

Case History continued

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 three-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	Person(s)	Date Assigned	Date Terminated
Case Initially Assigned to:	You and your team	Today	N/A
Current CASA Volunteer:	You and your team	Today	
CASA Supervisor:	Jessica Clarkson		
CPS Social Worker:	Becky Howard		

Court-Ordered Services

For the Child: <ul style="list-style-type: none"> • Educational needs met as appropriate
For the Father: <ul style="list-style-type: none"> • Psychological evaluation and treatment/counseling (if recommended)
For the Mother: <ul style="list-style-type: none"> • Psychological evaluation and treatment/counseling (if recommended)



Chapter 5



TEXASCASA
Court Appointed Special Advocates
FOR CHILDREN



What is addiction, really?

**It is a sign, a signal, a symptom of distress.
It is a language that tells us about a plight
that must be understood."**

– Alice Miller

Chapter 5: Substance Abuse, Diversity and Disproportionality

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PRE-WORK INSTRUCTIONS

1. Read pages 176–191, “What is Substance Abuse?” through “Initial Case Notes for the Bass Case.”

What Is Substance Abuse?

Substance abuse can simply be defined as a pattern of harmful use of any substance for mood-altering purposes. “Substances” can include alcohol and other drugs (illegal or not) as well as some substances that are not drugs at all.

Psychoactive substances, whether legal or illegal, impact and alter moods, emotions, thought processes and behavior. These substances are classified into different types (for example, stimulants, depressants and 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 a 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

To be clear, someone can use substances and not be addicted or even have a substance use disorder, as defined in the Diagnostic and Statistical Manual 5 (DSM 5).

CAUSES

There are different theories about how abuse/addiction starts and what causes substance abuse or 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. They can also develop as coping measures to traumatic stress, either acute or chronic.

It is important to remember that people suffering from abuse or 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 OPTIONS

The field of addiction treatment recognizes an individual’s entire life situation. Treatment should be tailored to the individual and guided by a treatment plan based on a comprehensive assessment of the affected person, as well as their family. Treatment can include a range of services depending on the severity of the addiction, from 12-step programs to outpatient counseling, intensive day-treatment programs and inpatient/residential programs.

Treatment programs use several methods, including assessment; individual, group, and family counseling; educational sessions; aftercare or 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 percent to 80 percent of families in the child welfare system are affected by addiction.”

It is helpful to remember that children of parents with substance abuse or addiction problems still love their parents, even though the parents may have abused or neglected them. While the volunteer must always consider the impact that substance abuse has on children, it is equally important to consider that prolonged removal from

What Is Substance Abuse?

a parent is traumatic for a child. When a parent is working to address their substance abuse, the focus should be on supporting these recovery efforts rather than advocating that visitation be withheld until the “destination” of recovery is reached.

Substance Abuse Statistics

QUICK FACTS ON DRUG ADDICTION

- According to the National Survey on Drug Use and Health (NSDUH), 21 million Americans (age 12 and older) experienced a substance use disorder in 2016.
- Almost 75 percent of individuals suffering from a substance use disorder in 2016 struggled with an alcohol use disorder per NSDUH.
- One out of every 9 people who experienced a drug use disorder in 2016, according to NSDUH, struggled with both alcohol and drug use disorders simultaneously.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) published that in 2016, 8.2 million American adults experienced both a mental health disorder and a substance use disorder, or co-occurring disorders.

STATISTICS ON SPECIFIC POPULATIONS

Adolescents (age 12–17)

- 488,000 American youths between ages 12 and 17 experienced an alcohol use disorder in 2016, according to NSDUH.
- An estimated 789,000 adolescents experienced an illicit drug use disorder in 2016, which was a decline from previous years, according to NSDUH.

Young Adults Age 18–25

- Approximately 3.7 million young adults age 18 to 25 had an alcohol use disorder in 2016, according to NSDUH.
- Approximately 2.4 million young adults age 18 to 25 had an illicit drug use disorder in 2016, which represents 7 percent of young adults per NSDUH.

Over Age 25

- In 2016, approximately 10.9 million adults age 26 or older had an alcohol use disorder, according to NSDUH.
- College graduates, age 26 or older, experienced 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.
- Two-thirds of the population over the age of 65 who struggle with alcohol addiction experienced an alcohol use disorder at a younger age and carried it with them as they aged.

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 the National Institute on Alcohol Abuse and Alcoholism (NIAAA).
- For boys and girls between the ages of 12 and 17, both genders experienced substance use disorders at similar rates, making it the only age bracket that men did not significantly outweigh women, according to the 2013 NSDUH.
- 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 the National Institute on Drug Abuse (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 experienced substance abuse and dependence in 2013, according to NSDUH.
- Hispanics and whites experienced substance abuse and dependence at similar rates in 2013, around 8.5 percent, while about 7.4 percent of African Americans struggled with it.
- Asian Americans were the least likely to suffer from substance abuse and dependency, with rates around 4.5 percent, per the 2013 NSDUH.

STATISTICS ON SPECIFIC SUBSTANCES

Alcohol

- According to the National Council on Alcoholism and Drug Dependence (NCADD), alcohol is the most abused addictive substance in America.
- In 2016, an estimated 15.1 million Americans aged 12 and older experienced an alcohol use disorder, according to NSDUH.
- Over half of all American adults have a family history of problem drinking or alcohol addiction, according to NCADD.

Cocaine

- 867,000 people over 12 (0.3 percent of population) struggled with a cocaine use disorder in 2016, per NSDUH.

Heroin

- 626,000 people over 12 (0.2 percent of population) struggled with a heroin use disorder in 2016, per NSDUH.

- Almost a quarter of people who use heroin will become addicted to it, according to the American Society of Addiction Medicine (ASAM).
- Individuals addicted to prescription drugs are 40 times more likely to become addicted to heroin, per the Centers for Disease Control (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.

Marijuana

- Approximately 4 million Americans 12 and over (1.5 percent of the population) experienced a marijuana use disorder in 2014, according to NSDUH.
- The majority of people struggling with marijuana addiction in 2016 were between the ages of 12 and 25, according to NSDUH.

Prescription drugs

- 11.5 million people age 12 or older (4.4 percent of the population) in 2016 misused prescription pain relievers, per NSDUH.
- Opioid misuse includes the misuse of prescription opioid pain relievers or the use of heroin. 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.

Honoring and Respecting Diversity

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, gender identity, age, 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 U.S. Census, approximately 36.3 percent of the population currently belongs to a racial or ethnic minority group. 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 percent of US residents in 2004 to 37.9 percent 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 section, 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. 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 children who’ve been abused or neglected. Building on our legacy of quality advocacy, we acknowledge the need to understand, respect, and celebrate diversity, including race, gender, gender identity, religion, national origin, ethnicity, sexual orientation, socioeconomic status and the presence of a sensory, mental, or physical 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 whom is culturally competent and whom 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 their behavior.
8. As a person learns about the characteristic traits of another cultural group, they 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 Statistics: Race

- Though African American children make up 14 percent of the child population, they constitute 28 percent of the children in foster care. American Indian children make up 1 percent of the child population and 2 percent of the foster care population. Children with more than one race make up 6 percent of the child population and 7 percent 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 5 out of 6 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 U.S.

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

- 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 the average length of stay 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 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

African American family dysfunction. Instead of being referred to foster care, 72 percent of Caucasian children receive services in their own homes. Just 40 percent of Hispanic children and 44 percent 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.

A Cultural Competence Vocabulary

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.

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

A Cultural Competence Vocabulary

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

Cultural Humility - The ability for an individual to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of the cultural identity or identities that are most important to the other person. To practice cultural humility is to recognize self-humility, rather than the belief that one can achieve a total state of knowledge or awareness. It is the recognition that there is always more that can be learned from another person's experience.

Cultural Group - A group of people whom 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.

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.” With specific regard to CASA, we prefer to use language like “children who’ve been abused or neglected” or “children in foster care” versus “abused children” or “foster children.”

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.

Homophobia - Personal biases against, and discriminatory practices toward, people who are lesbian, gay, bisexual, transgender or queer (LGBTQ).

Intersectionality - The idea that identities are influenced and shaped by race, class, ethnicity, sexuality/sexual orientation, gender/gender identity, physical disability, national origin, etc., and by the interconnection of all those characteristics.

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

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.

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."

Minority Stress - Chronic stress faced by members of stigmatized minority groups. Minority stress is caused by external, objective events and conditions, expectations of such events, the internalization of societal attitudes and/or concealment of one's sexual orientation.

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.

A Cultural Competence Vocabulary

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, particularly against women and girls.

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.

Transphobia - Bias against or prejudice toward transsexual or transgender people.

Values - What a person believes to be important and accepts as an integral part of who they are.

Xenophobia - A bias against or fear of all that is foreign, or a fear of/discrimination towards people believed to be foreigners.

Initial Case Notes for the Bass Case

CPS Case File					
Last Name of Case: 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 Caretaker(s)	Address	Phone
Foster Parents: Bonnie Matthews	52 Greylock Rd.	555-5874

Attorneys for:		
Mother	Sara Johnson	555-6498
Father	Fred Thompson	555-6644
CPS	Lisa Kelly	555-6298
Child	Kate Mackenzie	555-0513

Case History
<p>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.</p> <p>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 the mother was arrested for public drunkenness.</p> <p>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.</p> <p>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.</p>

Case History continued

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. 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 Bass 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 Report Case Summaries

John Bass (alleged father) is in the county jail approximately 100 miles from the foster placement. He was arrested for marijuana possession. 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 an active, present father to Lavender. Mr. Bass states that he and Lavender are Native American. 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."

Case History continued

Lavender Bass (6 years old) 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.

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 phone. CASA is able to reach mother via phone. 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 feels that drugs are being done at the home of the maternal aunt and grandmother. The children are also fearful of the aunt and grandmother.

END OF PRE-WORK FOR CHAPTER 5

The Effects of Substance Abuse on Parenting

It is important to remember that when a parent is involved with drugs or alcohol to a degree that interferes with the ability to parent effectively, a child may suffer in many ways:

- A parent may be emotionally and physically unavailable to the child.
- A parent's mental functioning, judgment, inhibitions and/or protective capacity may be seriously impaired by alcohol or drug use, placing the child at increased risk of all forms of abuse and neglect, including sexual abuse.
- A substance-abusing parent may "disappear" for hours or days, leaving the child alone or with someone unable to meet the child's basic needs.
- A parent may also spend the family's income on alcohol and/or other drugs, depriving the child of adequate food, clothing, housing and health care.
- The resulting lack of resources often leads to unstable housing, which results in frequent school changes, loss of friends and belongings, and an inability to maintain important support systems (religious communities, sports teams, neighbors).
- A child's health and safety may be seriously jeopardized by criminal activity associated with the use, manufacture and distribution of illicit drugs in the home.
- Eventually, a parent's substance abuse may lead to criminal behavior and periods of incarceration, depriving the child of parental care.
- Exposure to parental abuse of alcohol and other drugs, along with a lack of stability and appropriate role models, may contribute to the child's future substance abuse.
- Prenatal exposure to alcohol or other drugs may impact a child's development.

Shannon's Story

Shannon is the fourth child born to Caterina. Shannon's oldest half-siblings, two sisters who are each more than ten years older than Shannon, are in the custody of their father in another state. Caterina has not seen them in several years. The remaining half-sibling, a boy, lives locally with his father and spends weekends with Caterina.

Shannon was removed from Caterina's custody when she was approximately 1 year old because Caterina was arrested for driving while intoxicated with Shannon in the car. Shannon was placed in foster care with Natalia and Marie, a couple with no other children.

Shannon remained in foster care with Natalia and Marie for 16 months while Caterina engaged in treatment for her addiction to alcohol. During this time, Caterina, who initially fought treatment and was unable to complete her first stint in residential treatment, successfully completed treatment at a second facility and at a halfway house. Upon leaving the halfway house, she secured a centrally located three-bedroom apartment and reported consistent attendance at 12-step meetings. She engaged in therapy, secured a mentor through a women's mentoring program run by the United Way, and attended training in medical records management, though she struggled to find a job.

Communication with Natalia and Marie was frequent and supportive. The couple rallied their church to help furnish Caterina's apartment and, with the permission of Shannon's caseworker, often picked Caterina up on Sundays so that she could attend church with them and Shannon. Visits with Shannon, at first brief and supervised, increased to unsupervised overnight and weekend visits. When she was 28 months old, Shannon was returned to Caterina's custody.

In the months that followed, Caterina enrolled Shannon in preschool, continued her job-related training, and continued to report regular attendance at 12-step meetings. Caterina maintained a relationship with Natalia and Marie. Shannon often spent Sundays with them and even joined them on an out-of-state vacation to visit Marie's family.

After a little more than a year, Caterina relapsed in an episode for which Shannon was present, and Caterina was transported to the emergency room. Caterina called Natalia and Marie from the hospital. They picked up Shannon.

Shannon's Story

Her placement return to Natalia and Marie's home was formalized the next day. In the 15 months that followed, Caterina successfully completed day treatment for her addiction. She secured and retained employment. She continues to live in the same apartment. Visits with Shannon started almost immediately after her return to Natalia and Marie's home and have continued, though they continue to be supervised and more limited than during Shannon's previous time in foster care. Communication between Caterina and Natalia and Marie is more limited and guarded.

Shannon is now 4.5 years old. Natalia and Marie have recently hired an attorney to represent their interests in court. They are willing to adopt. The goal for Shannon remains to return to her parent, but all involved are unsure as to how to proceed and what is in Shannon's best interest. Should she return to Caterina, or should Caterina's parental rights be terminated so that Natalia and Marie can adopt? What do you think?

Can the Child Return Home? Key Points to Consider

In deciding whether a child can return home to a family where substance abuse occurs, many factors should be weighed. These include:

- The parent's ability to function in a caregiving role
- The child's health, development and age
- Parental history of alcohol or other drug abuse and substance abuse treatment
- Safety of the home
- Family supports
- Available treatment resources
- Treatment prognosis and/or length of sobriety

A dilemma that often arises is the conflict between the legal mandate (and the child's need) for permanence and the long-term treatment (including in-patient treatment) that parents who struggle with addiction may need. If a parent is in treatment, consideration should be given to placing the child with the parent rather than in foster

care. Although foster care is sometimes the only available option, the child may feel punished when placed away from the parent. The focus should be to support successful treatment, while simultaneously working at keeping the child with the parent.

What a CASA/GAL Volunteer Can Do

Educate yourself about the power of addiction and about resources such as Alcoholics Anonymous, Narcotics Anonymous, Rational Recovery, Al-Anon, Alateen and Nar-Anon. Support those family members who are willing to deal with the substance abuse problem, even if the person with the substance dependence is not.

Services for which you might advocate include:

- Thorough assessment with recommendations for treatment
- Substance abuse treatment services (especially programs where the child can be with the parent, if appropriate)
- Home-based services to build family skills
- Relocation out of an environment where drug or alcohol use is pervasive
- Financial assistance and child care while parents are in treatment
- Support services such as SSI (Supplemental Security Income), TANF (Temporary Assistance for Needy Families), food stamps, job training and child support
- When a child is in foster care, frequent visitation in a homelike atmosphere or an informal setting such as a park
- Assistance for a parent who abuses substances and is seeking to flee a domestic violence perpetrator, such as obtaining a protective order, finding alternative housing and performing other necessary steps (domestic violence victims are more likely to remain sober away from the abuser)

What Is Culture?

Culture is a learned pattern of customs, beliefs and behaviors, socially acquired and socially transmitted through symbols and widely shared meanings. Culture can be defined as an organized group of learned responses and ready-made solutions to problems people face and how to live day-to-day.

Culture is not only bound by race and ethnicity. Groups of people who work in certain fields may develop a unique culture. They have a unique language, practice model, etc. Culture defines how we do things, think about things and talk about things.

There are many analogies that help us understand culture. One is that culture is like an iceberg: There are parts we can see and parts we can't see but know are there. The part above the waterline makes up only about 10 percent of an iceberg's entirety. The visible parts of culture might include dress, music, food and games. Those that we can't see but know are there include unwritten rules guiding patterns of speech, concepts of time and the meanings of body language.

Chapter 6



TEXASCASA
Court Appointed Special Advocates
FOR CHILDREN



Safety and security don't just happen, they are the result of collective consensus and public investment. We owe our children, the most vulnerable citizens in our society, a life free of violence and fear."

– Nelson Mandela, former president of South Africa

Chapter 6: Domestic Violence, Bias and Cultural Competence

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PRE-WORK INSTRUCTIONS

1. Read pages 200–217, “Understanding Domestic Violence through Initial Case Notes for the Amarillo Case,” and complete the following:
2. Write down any questions you have after reading the “Understanding Domestic Violence” section.
3. Complete the Sorting People online activity at www.learn.texascasa.org.
4. Complete the “Exploring Culture and Perceptions” activity.
5. Complete the “Culturally Competent Child Advocacy” activity.
6. Build an Individual Action Plan for Cultural Competence.

Understanding Domestic Violence

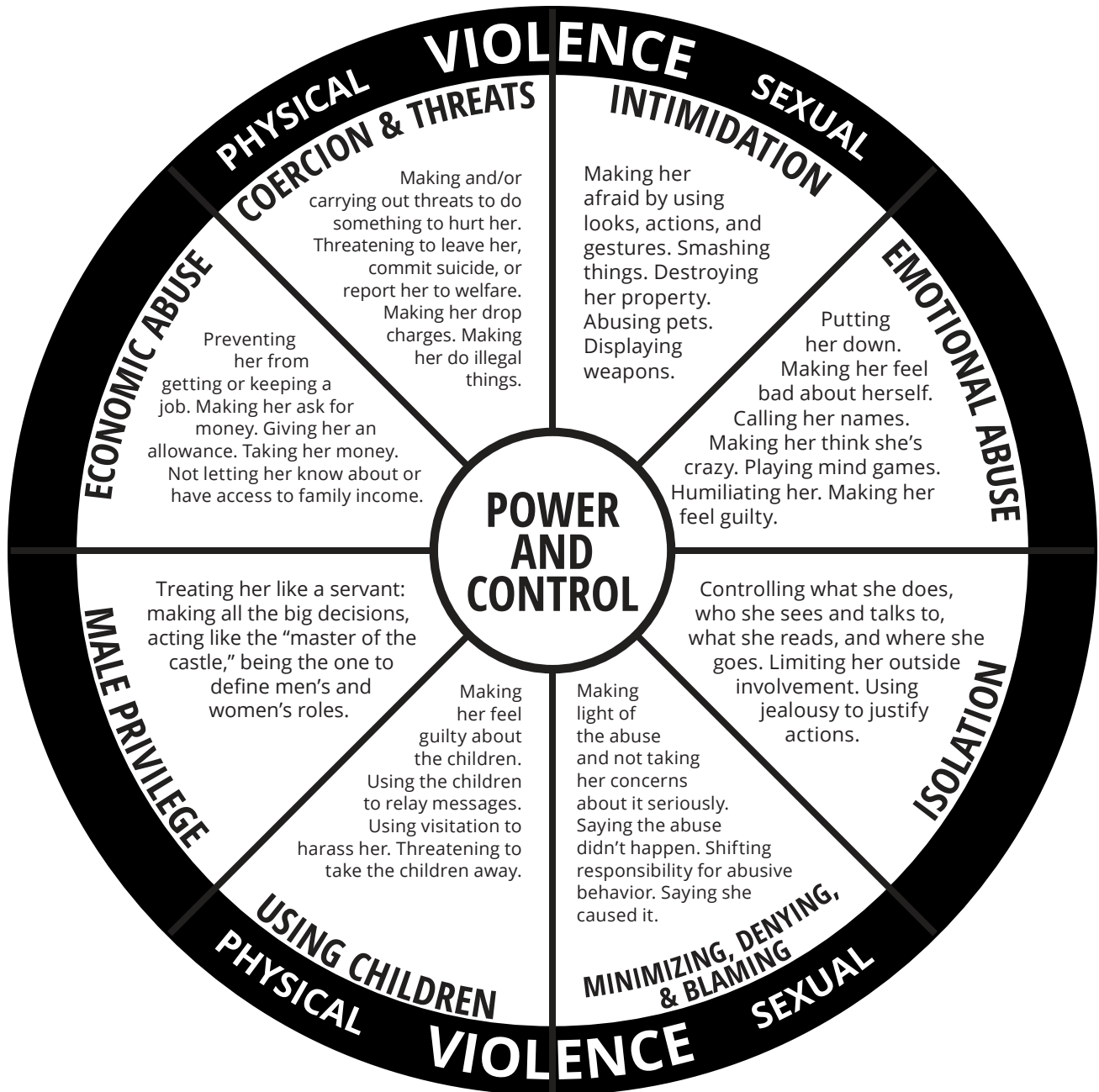
Domestic violence is the willful intimidation, physical assault, battery, sexual assault and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another. It can include physical violence, sexual abuse, psychological violence, emotional abuse, economic abuse, digital abuse and reproductive coercion. Many of these forms of abuse may be at work simultaneously. 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 emotional and verbal abuse to hitting to severe assault and even murder. Domestic violence can affect everyone, regardless of their socioeconomic background, educational level, race, age, sexual orientation, religion or gender. 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 AND CONTROL WHEEL

Abusive relationships are based on the mistaken belief that one person has the right to control another. Domestic violence doesn't look the same in every relationship because every relationship is different, but this Power and Control Wheel provides some examples of different forms of abuse. Although the wheel uses she/her pronouns, people of all genders can be victims of domestic violence. 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.

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



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 and is always 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.

The willingness of court personnel to act in domestic violence cases varies widely. Unless judges, attorneys and prosecutors have been educated about the dynamics of domestic violence, protective laws are inconsistently enforced.

The legal system and domestic violence may intersect in 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 or regain custody. The standard risk assessment, conducted by child welfare agencies to evaluate whether a child needs to be removed from their 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 brought against the victimized parent, usually the mother, for "failure to protect" the child because she did not leave the batterer—even if she lacked the resources to do so or it was not safe to do so.

It may be appropriate to advocate for the child to remain in the custody of the non-abusing parent as long as a safety plan has been developed with CPS to help protect the child from further exposure to the perpetrator. For example, this safety plan could involve the parents agreeing to live separately while they engage in services to address the concerns about domestic violence.

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 re-enter 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 attempt to 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, the 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 their abuser’s demands. Leaving a violent relationship is often a process that takes place over time, as the victim can access resources they need. The victim may leave temporarily many times before making a final separation. They need continued support and validation.

Adapted from Domestic Violence: A National Curriculum for Children’s Protective Services, Anne Ganley and Susan Schechter, Family Violence Prevention Fund.

Activity: Exploring Culture and Perceptions

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 shape (single parent, married with no children, etc.)
 - Ethnicity (cultural description or country of origin)
 - Gender/gender identity
 - Geographic identity (rural, urban; in the U.S.: Eastern, Midwestern, etc.)
 - Age
 - Sexual orientation
 - Religion or spirituality
 - Language
 - Disabilities
 - Mental illness
 - Status as a survivor of violence
 - Socioeconomic status (low-income, working-class, middle-class, wealthy)

Now imagine that you are Susan Mailer, the mother in the Bass 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.

Activity: Exploring Culture and Perceptions

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 others 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 U.S. 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.”

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.

Benefits of Practicing Culturally Competent Child Advocacy

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

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

Institutional Bias Checklist

Institutional bias differs from personal bias. It refers to practices embedded within systems and institutions—such as the banking system, the education system, the child welfare system—that systematically give advantages or disadvantages to certain groups. Often, institutional bias is harder to see, because it is simply “how things are done.” As a CASA/GAL volunteer, you can ask the questions behind the questions, and go the extra mile so that institutional bias doesn’t limit the safety, permanency or well-being of the child in your case.

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?
- If applicable, has Special Immigration Juvenile Status (SIJS) 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.

Activity: Culturally Competent Child Advocacy

Think about a time when you felt categorized or stereotyped because of an aspect of your identity, 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 Bass case. Referring to the article on “10 Benefits of Practicing Culturally Competent Child Advocacy,” what are three 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

Activity: Culturally Competent Child Advocacy

- 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
- Engaging in family finding to locate extended family relatives

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.

Tips on How to Become More Culturally Competent

- 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

Consider your strengths and weaknesses as a culturally competent person. Prepare a plan to become more personally culturally competent so that you can better champion the needs of foster youth.

Name: _____

Date: _____

Specific: Write a very specific goal that clearly defines what you are going to do to improve your cultural competence skills. What do you need to learn? What communities in your region do you know the least about? Whom do you feel most different from? Whom do you hold bias toward or stereotypes about?

Measurable: Identify how you will measure your progress. Will something look different? Will you act or feel differently? Will you receive certain types of feedback? Will you be comfortable interacting with a new community? Choose a person to be accountable to.

Attainable: Is this goal within your reach? Do you have what you need, or do you need to find books, movies, people to interview, a class, or people to practice and learn with?

Realistic: You are not expected to save the world or become perfect overnight. Identify factors in your environment that will support your progress, and people you can discuss the work with realistically. Small steps move us toward big changes.

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	Oct 8	16 Years	Unknown	F	Foster care
Joanna Amarillo	Sept 1	6 years	Hisp	F	Same
Graciela Amarillo	Aug 19	4 years	Hisp	F	Same

Current Caretaker(s)	Address	Phone
Foster Parents: Stanley & Karen Becker	406 N. Dale Street	555-5874

Attorneys for:		
Mother	Jody Franken	555-9894
Father	Mary Holzer	555-1337
CPS	Jordan Myers	555-7344
Child	Jennifer Walters	555-0616

Case History
<p>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.</p> <p>July 6 (3 years ago): Following an emergency shelter care hearing, the Amarillo children were placed in 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.</p>

Case History continued

September 17 (3 years ago): Following a dispositional hearing, parents were ordered to receive drug/alcohol screening, attend a substance abuse treatment program, and provide random urinalysis. 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 (3 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 (3 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 (2 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 (2 years ago): Maria called social worker to complain of verbal and physical abuse by foster family. Social worker visited foster home the same evening, 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 (2 years ago): Foster family of Maria Amarillo reported that she did not return home after school.

Case History continued

March 17 (2 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 (2 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 (2 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 (2 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 (2 years ago): The department visited with kinship relatives, the Valdez family, and reported that this would not be an appropriate placement due to their immigration status (undocumented), the number of people residing in their home and their reported level of income. Since that time the department has continued to allow the girls extended visitation, including overnights, at the Valdez home.

August 9 (2 years ago): Parental rights were terminated.

September 26 (2 years ago): Maria Amarillo was placed in the same foster home as her younger siblings.

Today: CASA volunteer assigned to this case.

CASA History	Person(s)	Date Assigned	Date Terminated
Case Initially Assigned to:	You and your team		
Initial CPS Social Worker:	Gerri Grady	7/3 (3 years ago)	
Previous CPS Social Worker:	Danielle Mancuso	9/19 (3 years ago)	
Current CPS Social Worker:	Alberta Gillis	Last month	

Court-Ordered Services
<p>For the Child (Maria):</p> <ul style="list-style-type: none"> • Medical health needs reviewed per physician’s orders due to issues with asthma • Educational needs to be met as appropriate <p>For the Child (Joanna):</p> <ul style="list-style-type: none"> • Educational needs to be met as appropriate <p>For the Child (Graciela):</p> <ul style="list-style-type: none"> • Age-appropriate child care to ensure educational needs are met
<p>For the Father:</p> <ul style="list-style-type: none"> • Rights have been terminated
<p>For the Mother:</p> <ul style="list-style-type: none"> • Rights have been terminated

END OF PRE-WORK FOR CHAPTER 6

Domestic Violence and CASA/GAL Volunteer Work

As a CASA/GAL volunteer, it is important for you to be aware of the possibility that domestic violence exists in the families you encounter. If you suspect domestic violence may be occurring, make sure the victim has several opportunities to talk with you alone in case there is something they do not feel safe sharing in the presence of their partner. The partner who has been victimized often feels unsafe talking about the abuse for many reasons, including fear of further violence. If the victimized partner does choose to speak with you about their situation, it is important to listen with compassion and remain nonjudgmental. Keep in mind that they are likely struggling with many barriers that may not be visible to you. Encourage them to connect with people who can offer help and support.

Advocates at the National Domestic Violence Hotline (www.thehotline.org) can be reached anytime via phone, text or online chat to offer resources, safety planning and support. This can be especially helpful for victims of domestic violence living in rural parts of Texas, where domestic violence services may be far away.

Domestic violence is about control and domination. When a victimized partner leaves the family home (or the abuser is forced to leave), the abuser feels a loss of control formerly exerted. This makes the abuser even more likely to be violent and coercive. This increased level of danger makes many victims reluctant to leave, even when the consequence of staying may be the placement of children in foster care.

IMPACT ON CHILDREN

Lenore Walker, author of *The Battered Woman*, describes the world of children who grow up in violent homes:

“Children who live in battering relationships experience the most insidious form of child abuse. Whether or not they are physically abused by either parent is less important than the psychological scars they bear from watching their fathers beat their mothers. They learn to become part of a dishonest conspiracy of silence. They learn to lie to prevent inappropriate behavior, and they learn to suspend fulfillment of their needs rather than risk another confrontation. They expend a lot of energy avoiding problems. They live in a world of make-believe.”

Another author writes,

“Children in families where there is domestic violence are at great risk of becoming victims of abuse themselves. In some cases, children may try to intervene and protect their mothers, getting caught in the middle of the violence. In most cases, however, children are also targets of the violence. Batterers sometimes deliberately arrange for children to witness the violence. The effect on children’s development can be just as severe for those who witness abuse as for those who are abused. Witnessing violence at home is even more harmful than witnessing a fight or shooting in a violent neighborhood. It has the most negative impact when the victim or perpetrator is the child’s parent or caregiver.”

J. Chiancone, “Children: The Forgotten Victims of Domestic Violence,” ABA Child Law Practice Journal, July 1997.

WHAT CAN A CASA/GAL VOLUNTEER DO?

Be both knowledgeable and concerned about domestic violence. Children from violent homes are at a higher risk for abuse than other children. According to “A Nation’s Shame,” a report compiled by the U.S. Advisory Board on Child Abuse and Neglect, “Domestic violence is the single, major precursor to child abuse and neglect fatalities in the US.”

Take into account the history and severity of family violence when making any recommendation for placement of a child. Many professionals in the field of domestic violence believe that you cannot protect the child unless you also protect the primary nurturer/victim (usually the mother). As part of that perspective, they advocate for placement of the child with the mother regardless of other factors, saying to do otherwise further victimizes the mother at the hands of the system.

Determine the best interest of the child. It may be that, with proper safeguards in place, the victim can make a safe home for the child while the threat from the abusive partner is reduced by absence, treatment and/or legal penalties. It is also possible that the victim has shortcomings that prevent her from caring for her family at even a minimally sufficient level. You should assess the situation with a clear understanding of

domestic violence dynamics, but in the end, you must make a recommendation based solely on the best interest of the child.

Seek resources for children from violent homes. Children need:

- Positive role models and supportive environments that will help them develop social skills and address feelings about the violence in a constructive manner.
- Help learning alternative, nonviolent ways to resolve conflict (through specialized counseling programs, trauma-informed therapy, domestic violence victim support groups, age-appropriate education about healthy relationship dynamics, youth mediation training and relationships with supportive mentors).

If you are concerned that a youth you are advocating for may be experiencing dating abuse, talk with your supervisor for guidance on how to respond to the situation. For more information about dating abuse, visit www.loveisrespect.org.

Recommend help for parents specific to concerns around domestic violence.

- Work to ensure that domestic violence survivors are treated fairly by the legal system and not further blamed in child abuse/neglect proceedings.
- Advocate for appropriate, supportive services for parents who are survivors of domestic violence. Become familiar with the specific resources and services offered by your local domestic violence programs, which could include:
 - individual therapy with a focus on healing from experiences of domestic violence;
 - safety planning to ensure that the survivor has support in remaining safe, coping with emotions, taking legal action (such as applying for a protective order) and more;
 - protective parenting classes focused on empowering survivors to become more effective parents as well as learning to help children cope with the trauma of witnessing domestic violence;

- domestic violence support groups to help build connections for survivors and break down the isolation that abusive relationships often create;
 - emergency shelter, transitional housing, court advocates and other services that increase the safety of survivors and children and support the autonomy of the adult victim.
- Advocate for evidence-based treatment programs for perpetrators of domestic violence. In order to begin to change, abusive partners need to be deeply committed to changing and engaged in appropriate intervention services. This could include:
 - Batterers Intervention and Prevention Programs, commonly called BIPPs, which are different than other counseling and intervention programs in that they center around full accountability, victim safety, and education about power and control within a relationship;
 - where BIPPs are not available, consider advocating for the abuser to engage in therapy with a therapist who specializes in domestic violence and may be able to integrate BIPP curricula into the treatment plan;
 - protective parenting classes or nurturing parenting classes focused on how to parent in a non-coercive, healthy manner.
 - Ensure that anger management programs are not utilized as an intervention for perpetrators of domestic violence. Research shows that anger management techniques do not work to address the dynamics of power and control that motivate domestic violence, and can actually be counterproductive to changing abusive behavior.
 - If couples counseling is appropriate, ensure that couples counseling is not initiated unless and until it is recommended by the abusive partner's therapist or BIPP provider as well as the survivor's therapist. Engaging in couples counseling can be unsafe for survivors if the dynamics of power and control have not been appropriately addressed.
 - Be sensitive to what information you share with the other parties on the case to

ensure that the safety of the survivor is not compromised. Talk with your supervisor if you're unsure what might be sensitive information.

- Be alert to any signs that domestic violence has recurred or even that contact between the abuser and the victim is ongoing, if that might compromise the child's safety. The foremost issue is the safety of the child.

For more information and resources regarding domestic violence, visit www.thehotline.org or call the National Domestic Violence Hotline at 1-800-799-7233; 1-800-787-3224 (TDD).

Chapter 7



TEXASCASA
Court Appointed Special Advocates
FOR CHILDREN

“The beauty of standing up for your rights is others see you standing and stand up as well.”

– Cassandra Duffy

Chapter 7: Educational Advocacy, Older Youth and LGBTQ Youth

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PRE-WORK INSTRUCTIONS

1. Read pages 226–260, “Youth Aging Out of Foster Care” through “Initial Case Notes for the Brown Case.”
2. Watch the “In Brief: How Resilience is Built” video at www.learn.texascasa.org and think about relationships you had as a youth that helped you build resilience.
3. Listen to the “Childhood Reflections” audio clip at www.learn.texascasa.org.
4. Watch the video “Legislative Updates to Religious Protections for Child Welfare Service Providers” video at www.learn.texascasa.org.
5. Complete the “Connecting With Your K–12 Experiences” activity.

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, have lived with instability and are unprepared for the social and financial demands of emancipation.

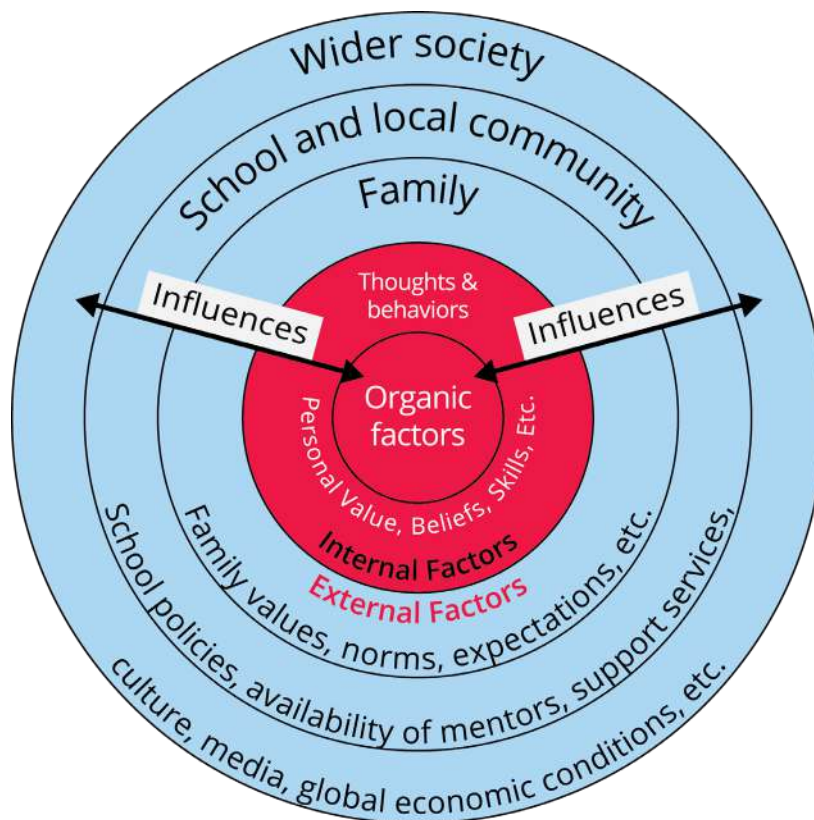
According to the National Foster Youth Institute:

- After reaching the age of 18, 20 percent of the children in foster care will become immediately homeless.
- Only 1 out of every 2 foster kids who age out of the system will have some form of gainful employment by the age of 24.
- Only 3 percent of children who aged out of foster care go on to earn a college degree.
- 7 out of 10 girls who age out of the foster care system will become pregnant before the age of 21.
- The percentage of children who age out of the foster care system and still suffer from the direct effects of PTSD: 25 percent.
- 75 percent of women and 33 percent of men receive government benefits to meet basic needs after they age out of the system.
- 1 out of every 2 kids who age out of the system will develop a substance dependence.

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 are the quality of interpersonal relationships and the availability of networks of support.



From www.embracethefuture.org.au/resiliency

Concurrent Planning

Given the various possible resolutions to a legal case, 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

Concurrent Planning

children with their parents, and if those efforts failed, a second plan would then be developed and 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. Effective family finding and family engagement efforts can help strengthen the concurrent planning process by identifying more prospective permanent placements for the child, should the goal of reunification not be successful. Keep in mind that for out-of-state relatives, an ICPC home study will need to be started as early as possible if placement with this relative is part of your concurrent plan.

Permanent Resolutions

Children are born unable to survive on their own. They need someone to provide life's basic necessities: food, shelter and protection from harm. To get beyond survival and reach normal growth and developmental milestones, children require a "primary attachment figure," that is, an adult who "is there for them," whom they can count on, who consistently meets their emotional and physical needs. For most children, this role is filled by a biological parent or parents. However, one or more other caring adults who are willing to commit unconditionally to the child can also meet the child's need for permanence.

When a child enters the child welfare system, the belief that a parent "will always be there" is shattered. One of your primary goals as a CASA/GAL volunteer is to advocate for a safe, permanent home as soon as possible, honoring the child's culture and sense of time. While there is never a guarantee of permanence, having such intentions can ensure that you are working toward a plan that supports permanence.

At a very basic level, permanence is most probable when the legal parent is also the emotional parent as well as the *parenting figure present in the child's life*.

As you work your case, you and your supervisor will have ongoing discussions about both the primary permanency plan and the concurrent plan for permanence.

One option for permanence is **return to parent(s)**. This typically begins with a monitored return, in which the children are returned to the care of the parent(s), but the case does not immediately close. During a monitored return, case parties continue to monitor the well-being of the children for up to six months to ensure the MSL for each child is able to be met before the case is closed or dismissed.

Another option for permanence is **adoption**, which requires that the parental rights of both biological parents be terminated. This means that the parents must either be willing to voluntarily relinquish their rights, or it must be proven in court that legal grounds exist for termination. There are different legal grounds for termination, and your supervisor will be able to provide you further information as it relates to your specific case and which termination grounds apply if you are recommending termination.

Another case outcome is for a relative or fictive kin caregiver to be named the **Permanent Managing Conservator (or Kinship Guardian)** of the child, which does not necessitate surrender or termination of parental rights. In this situation, the parents are typically named Possessory Conservators with limited parental rights specified in the final order. In theory, kinship guardianship is a less permanent option because parents can petition the court to regain custody later on, provided that there have been substantial changes in their circumstances.

RETURN TO PARENTS AND ADOPTION: QUESTIONS TO CONSIDER

Termination of parental rights is a drastic measure which permanently severs all legal rights biological parents have to their child. The following questions can be helpful to consider as you and your supervisor discuss your recommendations for the permanent resolution of the case.

Permanent Resolutions

Return to Parents

- Have the specific issues that brought the child into care been successfully addressed?
- Have the parents shown that they are able to meet the MSL for their child?
- Have the parents made the changes that the child protection agency requested?
- Has the child protection agency caseworker observed and documented a reduction of risk?
- Based on the parents' progress, would the child protection agency remove this child today?
- What have the visits we observed told us about the parents' ability to care for the child?
- Have we considered recommending a trial placement, such as an extended visit or a monitored return, as a way to observe actual changes in child care?
- Have any new issues that relate to risk been observed and addressed?
- Has the child protection agency changed the rules or "raised the bar" in reference to expectations that are not related to the MSL for this child?
- Is this a multi-problem family that is at risk for relapse? If so, what services and supports can be put in place to prevent relapse?

Adoption

- Based on the Holley factors, do we believe that termination and adoption are in this child's best interest?
- Do legal grounds exist for termination?
- Are there relatives who are able to adopt? What resources and assistance can be provided for adoptive relatives?
- If the child is unable to be adopted by relatives, what is the plan for maintaining a connection to the child's biological family?

- Who can offer support to the child through the adoption process?
- Have we assessed and evaluated the child's particular needs and strengths? What is the plan for the adoptive placement to meet this child's long-term needs?
- What is the child's relationship with their siblings? Will the child be able to be raised with their siblings, if appropriate?
- Have the child's ethnic and cultural needs been considered and addressed?
- Are we holding up the child's permanency waiting for a specific type of adoptive family?
- Are the parents willing to relinquish their parental rights so that the child may be adopted?
- Have the legal and/or biological father(s) been identified and engaged?

Cultural Considerations

It is important to know that some Native Americans have a strong bias against adoption, and certain tribes do not approve of adoption. Advocates should be aware of the tragic history of U.S. government boarding schools begun in the late 19th century. Tens of thousands of Native American children were taken against their families' will to abusive, church-run boarding schools designed to end Native cultures and ways of life, where the founder's motto was, "Kill the Indian, and Save the Man."

In 2011, NPR found that 32 states are in violation of the Indian Child Welfare Act, which says that except in the rarest circumstances, Native American children must be placed with their relatives or tribes. It also says states must do everything they can to keep Native families together. This requires special consideration when weighing the permanency options for an Indian child who is an identified member of a tribe. In some cases, placement with a Native American custodian can truly be considered permanent.

PLACEMENT WITH RELATIVE OR KIN: QUESTIONS TO CONSIDER

Living with someone the child already knows and feels safe with can significantly mitigate the child's feelings of loss due to being removed from their parents. 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 potential challenges and the benefits involved with kin and relative placements:

- Have the relatives/fictive kin been carefully evaluated to ensure they will be able to keep the child safe?
- Has the relative been able to pass a written home study? If not, what supports or services can be offered to mitigate any concerns identified in the home study?
- Have the relatives of both parents been identified and considered, regardless of the removal home?
- Is placement with relatives a way we can protect the child's roots in their community?
- If needed, what resources can be explored for supporting the stability of the relative placement?
- What pre-placement relationship existed between the child and the relative?
- Does the child have any attachment to these relatives?
- Have the child's wishes been considered?
- 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? If so, what support can be offered to help the placement keep the child safe?
- Will the relative be able to be positive about the parent to the child? If not, would family therapy between the relative and parent be appropriate to help heal relationship dynamics?

- Is the relative protective, or will there be an “unofficial” return to the biological parents?
- Will this relative support the service plan for the child?
- How will parental visitation be accomplished? What support can be offered to the placement for facilitating visitation (such as transportation assistance)?
- 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?
- Will a relative placement mean that the child will have to endure another move? If so, what support can be offered to help mitigate any losses the child will experience if another move is required?
- Have we considered sibling attachments? Is this relative able and willing to take all the siblings, if appropriate?
- Will this placement support the child’s ethnic and cultural identity?
- Would this relative consider adopting or becoming the permanent managing conservator of the child if necessary?

Our family-finding and family engagement efforts are critical for identifying potential relative placements for children. To help relative placements be sustainable, it is important to advocate for them to receive all support, resources and assistance they may be eligible for, such as kinship payments, food stamps/aid, Trauma-Informed Family Therapy, assistance with utilities and/or rent from social service agencies. Talk with relatives to learn what kind of support they may need, and seek guidance from your supervisor about community resources to meet these needs.

Explore these websites for community resources in your area:

- The United Way of Texas (www.211.org)
- Aunt Bertha (www.auntbertha.com)
- Catholic Charities (find your local region at catholiccharitiesusa.org/find-help/)

An Impermanent Solution—Long-Term Foster Care

Despite the advocacy efforts of CASA/GAL volunteers and the hard work by caseworkers, many children remain in foster care. These children live in foster homes or group homes—or are moved from placement to placement during their time in care.

Long-term foster care becomes the default plan for older children or children labeled as difficult* for whom there is no identified family. Sometimes these children are actually placed in a family setting but their caregivers do not want to adopt them. In any case, when the plan is permanent foster care, what the child protective services system is actually doing is planning for these children to belong to no one. Clearly this is unacceptable. When faced with this 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, even for the most “difficult” child.

**At times children diagnosed with ADHD, oppositional defiant disorder (ODD), autism, PTSD, and other disorders are labeled as difficult or challenging.*

QUESTIONS TO CONSIDER

- What other options have been explored?
- Does the child need specialized care? Is it possible for them to have a legal and emotional attachment with a person with whom they do 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 their 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 Advocacy

“It is the duty of the state to educate, and the right of the people to demand education.”

– *Edmund Barton*

Texas CASA has created a comprehensive Educational Advocacy Guidebook for advocates, which covers these topics in depth. To download or print the guidebook for free, search for “Educational Advocacy Guidebook” in the Texas CASA Learning Center.

EDUCATIONAL CHALLENGES FACED BY CHILDREN IN FOSTER CARE

Every child has the right to an education. However, due to their circumstances, children involved in the child welfare system face enormous challenges when it comes to receiving an appropriate education. As a CASA volunteer, part of your role is advocating for educational needs. Your child(ren) may be thriving in their school setting, may be just getting by or may face substantial educational challenges.

Educational Advocacy

You will need to keep up-to-date school records for each school-aged child and be in contact with their school at least once each month.

Children in the child welfare system face many obstacles that can make receiving an appropriate education difficult.

- Fear, trauma, depression and other emotional issues may make it difficult to focus, which causes educational challenges. These challenges may also be caused by a lack of educational support at home or at school, and children may not be willing to ask for help when it is needed.
- Children in the system might face inconsistency in education due to absences, tardiness or multiple school changes as they move between placements. Each school change can cause a student to fall further behind their peers.
- Stereotyping can lead to unnecessary labeling, harsher punishments, involvement with the juvenile justice system and bullying for children in the system. Sometimes they are stereotyped as angry, damaged, mentally unstable, aggressive, lazy or as troublemakers. This can lead to school personnel over-monitoring and setting poor expectations for them.

Generally, children will live up to the expectations set for them; if we expect a child to be angry and aggressive, they probably will meet our expectations. However, if we expect them to succeed, we raise the likelihood of that success.

As a CASA volunteer, it is your responsibility to ensure that your child receives an adequate education—and to advocate for it to be the best possible education.

MAKING INITIAL CONTACT WITH THE SCHOOL

The first step to ensuring that you can properly advocate for your child is to provide the correct documentation, such as your appointment by the court and any other program paperwork, to the school so they can give you information.

Once you have all of your documentation together, contact the school by phone to schedule your first meeting. During this phone call, work with the staff to find out who

at the school should be your go-to contact person. This will likely involve stating that you are the CASA volunteer for the child(ren) and you will be seeking monthly contact with someone who has easy access to the child's records and knows the child well.

For many schools, the contact person will be the child's school counselor or homeroom teacher. If your child is in special education, it might be the special education coordinator.

When speaking with your contact person for the first time:

- Explain your role briefly. This should include that you are a CASA volunteer and that you represent the child's best interests in court.
- Ask where you should send your CASA paperwork so the school feels comfortable sharing information with you.
- Ask to schedule a meeting with your contact person to discuss the child and your plan for future monthly communication. Try to have this first meeting face-to-face, as you may be able to build more rapport and gather more information.
- Ask the school to have copies of school records available when you come in for your first meeting or to fax them to the CASA office. These records should include: report cards, most recent testing scores, most recent evaluations and vaccination records. If your child is in special education, there will be paperwork specifically for that. Make sure to give your supervisor a copy of the school records as well, or to upload them into Optima.

First Meeting with School Contact

Once you have scheduled your first meeting, it is a good idea to speak with your supervisor, CPS caseworker, the child's attorney, the child's placement, the parents and the child to see if there are any issues that you need to discuss with the school.

At your first scheduled meeting (in person or by phone):

- If you go in person to the school, talk with your supervisor ahead of time to determine what paperwork and identification you need to bring. Typically, volunteers bring their CASA badge, a business card, a state-issued ID and copies

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of their CASA paperwork. Even if you already provided these documents, bring them to prevent any potential delays. If your meeting is over the phone, have your court order and CASA paperwork ready to fax or email in case the school requests it a second time.

- Identify yourself and explain your role in the child's life. Emphasize that you should be notified of all meetings and events that a parent/guardian would be notified of.
- Explain that you will be monitoring the child's educational needs on an ongoing basis, and make a plan about how future communication will look and how often it will occur.
- Mention that you can help facilitate communication with other parties and help find answers if the school has any questions. Let the school know that they can contact you about the child, especially if they have a hard time getting in touch with the CPS caseworker.
- In Texas, schools are required to transfer records within 10 working days after the date of enrollment. The Texas Student Records Exchange (TREx) is the system that facilitates exchange of all student records. Follow up to ensure this happens on time. If it has not, communicate with CPS to ensure those records get to the school. This should include vaccination records, most recent report card, transcripts, and any testing or evaluations.
- Find out if your child is receiving special education or 504 services, and if so, find out how they qualified. Some possible qualifications are a learning disability (LD), emotional disturbance (ED) or other health impairment (OHI).
- If the child receives special education services, make sure the school has the most recent Admission, Review, and Dismissal (ARD) paperwork. The ARD meeting must take place for a child to receive special education services and must be reviewed annually, as well as before a child can be dismissed from a special education program. The paperwork produced at this meeting includes the child's Individualized Education Plan (IEP) and Behavior Intervention Plan (BIP).

- Find out what is required to pick the child up from school, and ask to be added to that list of people approved to do so. While you may never need or intend to, it is important to have approval to pick the child up in the event a situation arises.
- Find out who is listed as the child's emergency contact, who is listed to be contacted about absences and who is approved to pick up the child. If this information is incorrect or out of date, make sure to correct it. If your program authorizes you to transport, you can add yourself to all of these lists. You should not be the only person on any of these lists, but you can ask to be added with the CPS caseworker or placement.
- Get the child's exact name and address as the school has it recorded and compare to your records to ensure there is no misinformation. Sometimes this information is incorrect, so it's important to double check that the child's name is spelled correctly and that the current address is on file.
- If your child is receiving special education services, find out when their most recent ARD took place and ensure that you receive a copy of the ARD paperwork.
- Find out if the school has an online grade monitoring service, and, if it does, make sure to be added as a person who can access it and receive the information. This will be an easy way to stay on top of your child's grades and attendance.

Sample Questions for Ongoing School Contact

- What successes has this child had?
- What progress has been made since we last spoke?
- How is the child doing behaviorally, academically and socially?
- Is this child involved in any special programs or extracurricular activities?
- Has this child received any special recognition?
- Do you have any concerns about this child?
- Do you believe the child has any unmet needs? If so, what?

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- Have there been any tests or evaluations since we last spoke? If so, what did they show, and can you send me a copy?
- How are this child's grades and attendance? If there are concerns, do you have any ideas how to address the concerns?

One of the main parts of your job as a volunteer and educational advocate is simply to be informed. It is imperative that you speak with the school on a regular basis and stay updated about your child's progress, setbacks, successes, challenges and needs. For some volunteers, keeping up the minimum monthly contact with the school will be all that is required. Many children do well in school and do not require extra advocacy to ensure their needs are met. For volunteers of these children, simply staying in contact and monitoring the situation is enough to ensure continued success.

However, other volunteers might find that the needs of their child are not being satisfied by the school or that the child is struggling to be successful in the school setting. This situation will require increased advocacy on behalf of the child.

SPECIAL EDUCATION

Some children will qualify to receive special education services through their school. If your child is struggling in school but not receiving any special education services, you might advocate for your child to be evaluated to see if they qualify.

Once the evaluations are complete, the school will schedule a meeting. This meeting is called an IEP (Individualized Education Plan) but is often referred to as an ARD (Admission, Review and Dismissal) meeting.

Regardless of the title, the meeting objectives are to discuss the needs of the child and determine what modifications and accommodations the school will make to meet those needs. The meeting will result in an IEP document detailing the modifications and accommodations. ARD meetings are required upon admission to special education, annually as a review and before a child can be dismissed from special education; hence the name ARD.

As a CASA volunteer, your role in an ARD meeting is similar to that of the parents. On your case, the parents may or may not have the legal right to attend these meetings depending on the legal nature of the case. Please ensure that you do not invite a parent to these meetings without getting approval from the CPS caseworker and the child's attorney.

While the CASA volunteer may play a role similar to a parent in terms of what they're advocating for, it is important to know that a CASA volunteer will not be a voting member at an ARD meeting. That means that the IEP can be approved without the volunteer agreeing to the terms. For children who are involved in the system and removed from their parents, the child's placement or CPS caseworker is named as the educational consentor and therefore must sign the IEP for it to be approved. This does not mean that the volunteer is not an important participant in the ARD meeting. It is still imperative that CASA attends these meetings to advocate for the child.

In some cases, especially if there is not a consistent caregiver, a volunteer can become the surrogate parent for the child by taking a one-hour training that gives the volunteer the right to consent in educational matters. This may be appropriate if the child lives in a residential treatment center or moves frequently. If you believe that your child would benefit from this, you can speak with your supervisor about becoming a surrogate parent.

If you do not feel that the needs of your child are being met at school or you disagree with the IEP, talk with your supervisor to determine if CASA needs to take further action in advocating for the child. Sometimes it is necessary to have an attorney appointed solely to represent the child in the school system, and your supervisor can guide you through this process.

TIPS FOR BEING A SUCCESSFUL ADVOCATE IN THE SCHOOL SYSTEM

- **Come to all meetings prepared with information and ideas.** Know your child and their needs, and brainstorm ideas of how the school can meet those needs. For example, before your meeting, ask the child's therapist if they have any advice for how the school could help manage difficult behavior.
- **Stay positive.** Starting each meeting talking about strengths and successes can set a positive tone for the rest of the meeting. This is especially important if emotions are running high or school officials are frustrated with the child.
- **Be solution-focused.** Instead of dwelling on negatives, brainstorm new ideas the school could try. Be willing to think outside the box and advocate for things that the school might not have offered.
- **Advocate for the least restrictive environment (LRE) for your child.** A student who has a disability should have the opportunity to be educated with peers who are not disabled to the greatest extent appropriate. They should have access to the general education curriculum and any other program that peers who are not disabled would. Supplementary aids should be provided to the student if placed in a setting with peers who are not disabled, as well as any services necessary to achieve educational goals. These rights are afforded them by the Individuals with Disabilities Education Act. Being involved in the system can be difficult enough, so it is important to do anything we can to not exclude children with developmental disabilities.
- **Listen to the child.** The child is your best source of information about what will best serve them. Remember to listen to the child and ask for their opinion. Talk to and not about the child whenever they are in the room for a meeting.
- **Remember to remain professional** even if you do not agree with someone else's position. Remain firm in your advocacy without becoming confrontational.
- **Attempt to get the child's parents involved.** Once it is appropriate on your particular case and all of the legal parties agree, bring the parents into the educational advocacy for the child. This type of advocacy will likely be necessary

throughout the child's educational career, so it is imperative that the parents are empowered to provide it. Inviting parents to attend school meetings or advocating for them to receive training on how to advocate for their children can help ensure your child continues to get the best education possible after the CPS case is closed. This is especially true when your child is receiving special education services. Never invite parents to attend school meetings without making sure your supervisor, the CPS caseworker, and the child's attorney agree that it is appropriate.

CONFIDENTIALITY AND SCHOOLS

It is important to remember that school faculty and staff are not legal parties to the case. This means they are not entitled to information about the legal case. Volunteers may not share any case details with anyone from the child's school. Discussing the history of abuse or the parents' progress on services is not permitted, nor is giving details about the concerns of the case or plans for the child's future.

Educational Advocacy Acronyms and Definitions

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

504 Plan - A section of the federal law designed to protect the rights of children with disabilities in programs and activities that receive federal funding. Children with disabilities who do not qualify for special education services under the Individuals with Disabilities Education Act (IDEA) may receive supports, services and accommodations under section 504 of the Rehabilitation Act of 1973.

ARD - Admission Review and Dismissal; The ARD committee is a multidisciplinary team appointed by a school's board of education that meets to guide the child's admission to and dismissal from special education. The ARD committee is responsible for students with disabilities from ages 5 to 21. The ARD committee 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.

The team meets at least annually to review a child's IEP and determine a program from that point forward. ARD meetings should include the parent or guardian of the student (including the foster parent), the district's ARD 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 ARD committee meetings.

The term "ARD" is used almost exclusively in Texas. In most other places this team is referred to as the "IEP team." The terms ARD and IEP mean the same thing.

BIP - Behavior Intervention Plan; A plan that 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

Educational Advocacy Acronyms and Definitions

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 and provide positive reinforcement to promote good behavior. Once a behavior plan is agreed to, the school and staff are legally obligated to follow it.

ECI - Early Childhood Intervention; A key program providing educational and developmental assistance for children with disabilities and medical diagnosis from birth to age 3.

FAPE - Free, Appropriate Public Education; 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 their 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.

FERPA - Family Educational Rights and Privacy Act; 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.

IDEA - Individuals with Disabilities Education Act; 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.

IEP - Individualized Education Plan; 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; 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 include the family of the child involved.

LRE - Least Restrictive Environment; 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 peers who are not disabled.

PPCD - Preschool Program for Children with Disabilities; A key program providing educational and developmental assistance for children with disabilities from age 3 to 5.

RTI - Response to Intervention; Based on a problem-solving model, this 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 intervention (such as an IEP). Often used as a first step before making a referral to a school's ARD committee.

Serving LGBTQ Youth

An informed advocate must educate themselves and become an ally to lesbian, gay, bisexual, transgender and queer (LGBTQ) youth, who are at special risk of discrimination and stigma in the child welfare system. LGBTQ youth are one and a half to two times more likely than their heterosexual peers to be placed in the foster care system, according to a recent report from the Williams Institute at the University of California, Los Angeles. Nearly 20 percent of foster youth surveyed identified themselves as LGBTQ, and in a study by UCLA and the Human Rights Campaign, nearly 40 percent of the total population of homeless youth in New York City identified as LGBTQ.

These youth may have faced intolerance, rejection and violence in their homes specifically related to their identity, leading to increased risks of homelessness and entrance into the system. In the study “Sexual and Gender Minority Youth In Los Angeles Foster Care,” researchers found that 12.9 percent of LGBTQ youth report being treated poorly by the foster care system, compared to 5.8 percent of non-LGBTQ youth.

It is an advocate’s job to ensure that the discrimination and unequal treatment stops, and that children of all gender identities and sexual orientations receive the best possible services and placement environments for them. This may involve inquiring about the attitude of the foster parents or residential treatment center towards LGBTQ equality, and advocating for safe and affirming, non-homophobic placements.

There are many ways for an advocate to educate themselves. Below are terms – a shared vocabulary is the groundwork for respectful conversations. When working with LGBTQ youth and families, the most important thing you can do as an advocate is be respectful of their experiences, open to conversations and willing to learn.

If you work with a youth who is struggling emotionally, connect them to The Trevor Project, a national 24-hour, toll free, confidential suicide hotline with text, chat and phone counselors for LGBTQ youth at www.thetrevorproject.org.

LGBTQ Glossary

The following are terms and expressions that you may find useful when working with youth or family members who identify as LGBTQ. This list is not exhaustive. Always ask people what words they prefer to use for themselves and their communities.

Ally – A person who is not LGBTQ but shows support for LGBTQ people and promotes equality in a variety of ways.

Biological sex – A designation of male or female, assigned at or before birth, based on what genitals, reproductive anatomy and chromosomes an individual is born with. This designation is then included on birth certificates.

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

Cisgender – A term used to describe a person who is not transgender; whose gender identity aligns with with the sex assigned to them at birth.

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 single life event but a lifelong process.

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

Gender – The social construct and set of ideas used to classify a person as a man, woman or another identity.

Gender binary – The idea that there are only two genders, male and female, and that a person must strictly fit into one category or the other.

Gender affirming surgery – Surgeries used to modify one’s body to be more congruent with one’s gender identity. Also referred to as sex reassignment surgery (SRS) or gender confirming surgery (GCS). Outdated terminology is “sex change operation.”

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 fluid / gender non-conforming / non-binary / gender variant / gender creative – These terms describe a person whose gender identity is not fixed in a masculine or feminine role or who falls outside of proscribed gender categories, or who chooses not to assume a gender. These people may prefer the gender pronoun “They.”

Gender identity – A person’s innate, deeply felt psychological identification as a man, woman or gender mixture, which may or may not correspond to the gender assigned to them at birth. Like gender expression, gender identity falls on a continuum of feminine and masculine. Also, some individuals identify as neither male nor female and instead identify as a third or other gender.

Heterosexism – An ideological system that denies, denigrates and stigmatizes life experiences, needs, concerns, identity or relationships of any non-heterosexual form of behavior, and awards advantages to heterosexual people. Heterosexism and homophobia are often mistakenly used interchangeably.

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

Homophobia – Biases against, and discrimination towards, people who are lesbian, gay, bisexual, or transgender; their relationships; and their families.

Homosexual – A term used to refer to a person based on their 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. This term is best to avoid.

Internalized oppression – The fear and aversion to one’s own identity or identities, which occurs for many individuals who have learned negative ideas about their identity (whether the identity is set or in the process of being explored by the individual) throughout childhood. One form of internalized oppression is the acceptance of the myths and stereotypes applied to the oppressed group.

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 persons who identify as lesbian, gay, bisexual, transgender and questioning or queer. Many use LGBTQIA+ to intentionally include and raise awareness of individuals who are Intersex and Asexual, as well as myriad other communities under this umbrella (see also queer).

Misgendering – Attributing a gender to someone that is incorrect/does not align with their gender identity. Can occur when using pronouns, gendered language (e.g., “Hello ladies!” “Hey guys”), or assigning genders to people without knowing how they identify (e.g., “Well, since we’re all women in this room, we understand . . .”).

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.

Outing/“Being outed” – Exposing someone’s lesbian, gay, bisexual or transgender identity to others without their permission. Outing someone can have serious repercussions on employment, economic stability, personal safety, or religious or family situations.

Pansexual – Used to describe people who have the potential for romantic, sexual or affectional desire for people of all genders and sexes (not necessarily simultaneously, in the same way, or to the same degree).

Pronouns – Linguistic tools used to refer to someone in the third person. Examples are they/them/theirs, ze/hir/hirs, she/her/hers, he/him/his. Since pronouns have been tied to gender, an individual’s preferred pronouns are indicative of their gender identity. Not using an individual’s preferred pronouns is a common way of misgendering.

Queer – An umbrella term for people who identify as lesbian, gay, bisexual, transgender, queer or questioning. Originally meaning “strange” or “peculiar,” queer was a pejorative word until the late 1980s, when the community reclaimed the word as the positive umbrella term it has become.

Questioning – When an individual is unsure about or is processing and exploring their own sexual orientation and/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 parts:

- 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
- Behavior – What one does sexually and/or with whom
- Sexual Identity – The language and terms one uses to refer to their sexual orientation

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).

Transition – For people who are transgender, this refers to the process of coming to recognize, accept and express one’s gender identity. Most often, this refers to the period when a person makes social, legal and/or medical changes, such as changing their clothing, name, sex designation and/or using medical interventions. Sometimes referred to as gender affirmation process. Not every person who identifies as transgender partakes in medical intervention or the same gender affirmation procedures.

For more in-depth resources to help you best serve LGBTQ youth, visit All Children–All Families LGBTQ Resources for Child Welfare Professionals at www.hrc.org/resources/all-children-all-families-additional-resources.

Laws Related to Older Youth in Foster Care

GETTING YOUTH THEIR ESSENTIAL DOCUMENTS

For a youth at least 16 years of age, Texas Family Code requires that the guardian ad litem must ascertain whether the child has received a certified copy of the child’s birth certificate; a Social Security card or a replacement Social Security card; a driver’s license or personal identification certificate under Chapter 521, Transportation Code; and any other personal document the Department of Family and Protective Services determines appropriate. If they do not have these essential documents, it is your responsibility to ensure that they get them. Work with your youth and the agencies to get them their documents. A Texas driver license is free to any foster youth who is either 1) between 15 to 18 years of age and for whom the Texas Department of Family and Protective Services (DFPS) is the legal custodian, or 2) between 18 to 21 years of age and residing in a paid DFPS foster care placement.

COMPUTERS FOR CASA

CASA programs have access to Texas' state agency surplus computers to distribute to children and youth served by CASA. Before requesting a computer, at least one CASA staff person must complete the Computers for CASA 101 training. The training, including the final assessment quiz, must be completed by at least one CASA staff person in order to receive reimbursement funds through the Computers for CASA Direct Grant. If you have a youth you would like to request a computer for, ask your supervisor to apply for it via the Texas CASA Learning Center.

PREVENTING SEX TRAFFICKING AND STRENGTHENING FAMILIES ACT

Children and youth in foster care are at an increased risk of becoming victims of sex trafficking and exploitation. 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. To learn more about resources related to sex trafficking, as well as red flags an advocate might look for to help detect child exploitation, search for Domestic Minor Sex Trafficking on the Texas CASA Learning Center.

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 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 their 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 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.
- 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

Laws Related to Older Youth in Foster Care

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

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. 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, 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 percent 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.

Laws Related to Older Youth in Foster Care

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.

** 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.*

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 could include having visits or phone calls, attending school events, providing transportation and celebrating holidays). When appropriate, volunteers should keep family engaged and informed.

Initial Case Notes for the Brown Case

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	Feb. 20	15 years	White	F	Kinship Care

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

Attorneys for:		
Mother	Dawn Schute	555-6542
Father	Nancy Andrews	555-9870
CPS	Chris Johnson	555-5428
Child	Elizabeth Summers	555-0397

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 a 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.

Initial Case Notes for the Brown Case

Case History continued
<p>November 8 (last year): Abigail Barton Home for Girls notified SW that Jessica Brown did not return to the group home after school.</p>
<p>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 Lezzie” and “dyke.” SW located emergency foster care for Jessica.</p>
<p>December 29 (last year): Youth placed with paternal cousin, Candice Clark (age 30).</p>

CASA/GAL History	Person(s)	Date Assigned	Date Terminated
Case Initially Assigned to:	June Miller	8/14 (last year)	Four months ago
Current CASA/GAL Volunteer:	You and your team	Today	
Initial CPS Caseworker:	Angela Rodriguez		
Current CPS Caseworker:	Angela Rodriguez		

Court-Ordered Services
<p>For the Child:</p> <ul style="list-style-type: none"> • Psychological evaluation and counseling (if recommended) • Educational needs met as appropriate
<p>For the Father: N/A</p>
<p>For the Mother:</p> <ul style="list-style-type: none"> • Domestic violence survivors’ classes • Parenting classes

END OF PRE-WORK FOR CHAPTER 7

EDUCATIONAL ADVOCACY QUICK ASSESSMENT FORM

1. Student's name	
2. School name	
3. Grade	
4. Special needs/IEP requirements	
5. Evidence of behavioral problems/ excessive absence	
6. Grade point average	
7. Seeing school social worker or any other support personnel?	
8. Extracurricular activities	
9. Need for tutoring?	
10. On track to graduate?	
11. Received resources for post-HS education or vocational program?	
12. Other pertinent information	



Chapter 8



TEXASCASA
Court Appointed Special Advocates
FOR CHILDREN



Children are the living messages we send to a time we will not see."

– John F. Kennedy, 35th president of the United States

Chapter 8: Moving Forward as an Advocate

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PRE-WORK INSTRUCTIONS

1. Read pages 266-292, “Initial Notes for the Redd Case” through “CASA/GAL Volunteer Competencies Review Activity.”
2. Using the Redd Case Notes and your program’s court report guide, complete the “Writing Your Court Report Activity” per your facilitator’s instructions.
3. Complete the “CASA/GAL Volunteer Competencies Review Activity.”

Initial Case Notes for the Redd Case

CPS Case File					
Last Name of Case: Redd			Legal Number(s): D-1-FM-18-123456		
Child(ren)'s Name	DOB	Age	Ethnicity	Sex	Current Location
Mariah Redd	Feb. 1	5 months	AA	F	Foster Care

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
Child	Winifred Price	555-0504

Case History
<p>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.</p> <p>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.</p>

CASA/GAL History	Person(s)	Date Assigned	Date Terminated
Case Initially Assigned to:	John Hill	2/19	6/30
Current CASA/GAL Volunteer:	You and your team	7/18	
Initial CPS Caseworker:	Heather Bunning		
Current CPS Caseworker:	Kim Ellis		

Court-Ordered Services
<p>For the Child:</p> <ul style="list-style-type: none"> • Medical health needs reviewed per physician’s orders due to high-risk birth • Educational needs met as appropriate
<p>For the Father:</p> <ul style="list-style-type: none"> • Establish paternity • If applicable, pay child support
<p>For the Mother:</p> <ul style="list-style-type: none"> • 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

2/1/18 Tele: Hospital reports birth of PCP-positive infant, female.

2/2/18 Hospital: Interview with mother, Clarissa Ann Redd, DOB 1/31/93, very hostile. Stated would not leave hospital without her baby. Hospital will discharge mother tomorrow; baby will stay for five-day detox and observation.

2/6/18 Home Visit (HV): Child placed with foster family: Julia Budd (phone and address)

2/14/18 HV: Foster home. Juvenile continues to progress well.

2/14/18 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.

2/20/18 HV: Maternal grandmother, Lela Jones, present for whole interview, supportive of daughter. Home placement not an option because Lela works. Family agreed that Mariah should 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.

2/21/18 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.

3/7/18 Tele: S/A counselor called to say Clarissa a "no show" for evaluation. (Also no show for visit with child.)

3/7/18 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."

3/14/18 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.

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

3/28/18 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.

4/4/18 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!"

4/11/18 Fresh Start: Transported mother and baby to Fresh Start program. Baby transitioned well.

4/16/18 Tele: Call to Fresh Start. Clarissa adjusting to program. Baby is fine.

5/22/18 Fresh Start: Visit. Congratulated Clarissa for hanging in with the program. Mother and baby doing well.

6/20/18 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.

6/20/18 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

DPS Criminal History Results

Person Name: Clarissa Ann Redd
Person ID: 012345678

Person Name:	CLARISSA ANN REDD
Person ID:	012345678
Requester Name:	KIM ELLIS
Requester ID:	7600200
Request Date:	06/25/2018
Date Completed:	06/28/2018
Name Returned:	REDD, CLARISSA

Comments:

The contents of this record are confidential and intended for dissemination only to criminal justice agencies or other individuals or agencies authorized by law to receive criminal history record information. Charges and dispositions contained herein have been coded under the standardized uniform offense and disposition classifications established for computerized criminal history records. Contact the contributing agency for specific or additional information regarding charges or dispositions. The use of the information contained herein must be in accordance with 28 CFR Chapter 1 Part 20 (Federal Register, Vol. 40, No. 98, PP22114-22119, as amended) and 42 USC 3789g.

UNAUTHORIZED USE OR DISCLOSURE OF THE INFORMATION CONTAINED IN THIS RECORD MAY RESULT IN SEVERE CRIMINAL PENALTIES. SEE SECTION 411.085. TEXAS GOVERNMENT CODE.

REDD,CLARISSA (SID: 012345678)

ARREST DATE 09/3/2016 (2 CHARGES)

SID	012345678
DATE LAST UPDATED	04/01/2018
SEX	FEMALE
RACE	AA
HEIGHT	4'11"
WEIGHT	110 LBS
EYES	HAZEL
HAIR	BROWN
PLACE OF BIRTH	TEXAS
FBI#	123456AZ
DNA ON FILE	NO
NAME(S)	RED, CLARISSA REDD, CLARRISSA REDD, CLARISSA (Primary) REDD, CLARISSA ANN REDD, RISSA

Criminal Records for Clarissa Redd

DPS Criminal History Results

Person Name: Clarissa Ann Redd Person ID: 012345678
--

BIRTH DATE(S)	01/31/1993
SOCIAL SECURITY NUMBER(S)	012-34-5678
SCARS, MARKS & TATTOOS	SC ABDOM TAT L ANKL TAT L WRS TAT UR ARM TAT L SHLDR
ARREST DETAIL	
ARREST DATE	02/24/15
SEQUENCE CODE	A
ARRESTING AGENCY	AUSTIN PD (TX2270100)
ARREST DATE 02/24/15 (1 CHARGE)	
OFFENSE RECORD	
INTERNAL AGENCY PERSON NUMBER	143512
ARREST OFFENSE	ASSLT-(FREE TEXT) (13000000)
ARREST OFFENSE LITERAL	ASSAULT WITH BODILY INJURY
ARREST DISPOSITION	RELEASED WITHOUT PROSECUTION (207)
ARREST DATE 12/02/14 (2 CHARGES)	
ARREST DETAIL	
ARREST DATE	12/02/14
SEQUENCE CODE	B
ARRESTING AGENCY	AUSTIN PD (TX2270100)
ARREST DATE 12/02/14 (CHARGE 001)	
OFFENSE RECORD	
ARREST OFFENSE	M POSSESS MARIJUANA UP TO 2OZ
ARREST OFFENSE LITERAL	POSS OF MARIJ
LEVEL AND DEGREE OF OFFENSE	MISDEMEANOR
COURT STATUS A	
COURT OFFENSE	MARIJUANA-POSSESS (355620000)
COURT OFFENSE LITERAL	POSS OF MARIJ
LEVEL AND DEGREE OFFENSE	MISDEMEANOR - CLASS B
COURT DISPOSITION	CONVICTED (310)
COURT OFFENCE CITATION	X
COURT FINE:	90

DPS Criminal History Results

Person Name: Clarissa Ann Redd Person ID: 012345678
--

COURT DISPOSITION DATE

04/18/14

ARREST DATE 12/02/14 (CHARGE *002)

OFFENSE RECORD

ARREST OFFENSE

M POS DRUG PARAPHERNALIA

ARREST OFFENSE LITERAL

POSS DRUG PARAPHERNALIA

ARREST DATE 06/17/13 (1 CHARGE)

ARREST DETAIL

ARREST DATE

06/17/13

SEQUENCE CODE

A

ARRESTING AGENCY

AUSTIN PD (TX2270100)

ARREST DATE 06/17/13 (CHARGE *001)

OFFENSE RECORD

INTERNAL AGENCY PERSON NUMBER

143512

OFFENSE ADDRESS:

WILMINGTON ST., 78702

ARREST OFFENSE

M SIMPLE ASSAULT

ARREST OFFENSE LITERAL

M SIMPLE ASSAULT

LEVEL AND DEGREE OF OFFENSE

MISDEMEANOR - CLASS B

COURT DISPOSITION

CONVICTED (310)

COURT OFFENCE CITATION

X

COURT FINE:

65

COURT DISPOSITION DATE

10/20/13

SPECIAL CONDITIONS:

NO FURTHER CONTACT W/GINA M

ARREST DATE 02/19/12 (1 CHARGE)

ARREST DETAIL

ARREST DATE

02/19/12

SEQUENCE CODE

B

ARRESTING AGENCY

AUSTIN PD (TX2270100)

ARREST DATE 02/19/12 (CHARGE *001)

OFFENSE RECORD

INTERNAL AGENCY PERSON NUMBER

143512

ARREST OFFENSE

M SIMPLE WORTHLESS CHECK

SPECIAL CONDITIONS:

DISMISSED BY DA BECAUSE CHECK PD AND WITNESS WHO TOOK CHECK COMP

Criminal Records for Clarissa Redd

DPS Criminal History Results

Person Name: Clarissa Ann Redd Person ID: 012345678
--

ARREST DATE 12/14/11 (1 CHARGE)

ARREST DETAIL

ARREST DATE	12/14/11
SEQUENCE CODE	B
ARRESTING AGENCY	AUSTIN PD (TX2270100)
ARREST DATE 12/14/11 (CHARGE *001)	
OFFENSE RECORD	
INTERNAL AGENCY PERSON NUMBER	143512
ARREST OFFENSE	M DISORDERLY CONDUCT
ARREST OFFENSE LITERAL	DISORDERLY CONDUCT
COURT FINE	101
SPECIAL CONDITIONS	SUSO ON COND PAY FINE AND COSTS

ARREST DATE 08/05/11 (1 CHARGE)

ARREST DETAIL

ARREST DATE	08/05/11
SEQUENCE CODE	B
ARRESTING AGENCY	AUSTIN PD (TX2270100)
ARREST DATE 08/05/11 (CHARGE *001)	
OFFENSE RECORD	
INTERNAL AGENCY PERSON NUMBER	143512
ARREST OFFENSE	M MISDEMEANOR LARCENY
ARREST OFFENSE LITERAL	M MISDEMEANOR LARCENY
COURT FINE	150
SPECIAL CONDITIONS	24 HRS COMM SERV, EGT

Criminal Records for Charles Jones

DPS Criminal History Results

Person Name: Charles E Jones
Person ID: 456780123

Person Name:	CHARLES E JONES
Person ID:	456780123
Requester Name:	KIM ELLIS
Requester ID:	7600200
Request Date:	04/01/2018
Date Completed:	01/01/2018
Name Returned:	JONES, CHARLES

Comments:

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UNAUTHORIZED USE OR DISCLOSURE OF THE INFORMATION CONTAINED IN THIS RECORD MAY RESULT IN SEVERE CRIMINAL PENALTIES. SEE SECTION 411.085. TEXAS GOVERNMENT CODE.

JONES, CHARLES (SID: 456780123)

SID	456780123
DATE LAST UPDATED	08/15/2017
SEX	MALE
RACE	WHITE
HEIGHT	5'9"
WEIGHT	190 LBS
EYES	BROWN
HAIR	AUBURN
PLACE OF BIRTH	TEXAS
FBI#	456123ZA
DNA ON FILE	NO
NAME(S)	JONES, CHUCK JONES, CHARLIE JONES, CHARLES (Primary) JONES, CHUCKY JONAS, CHARLES
BIRTH DATE(S)	01/31/1965
SOCIAL SECURITY NUMBER(S)	456-78-0123

Criminal Records for Charles Jones

DPS Criminal History Results

Person Name: Charles E Jones Person ID: 456780123
--

BIRTH DATE(S)	01/31/1965
SOCIAL SECURITY NUMBER(S)	456-78-0123
SCARS, MARKS & TATTOOS	SC L EYEBROW TAT L SLEEVE TAT FULL BACK TAT L BRST
ARREST DETAIL	
ARREST DATE	08/15/17
SEQUENCE CODE	A
ARRESTING AGENCY	AUSTIN PD (TX2270100)
ARREST DATE 08/15/17 (1 CHARGE)	
OFFENSE RECORD	
INTERNAL AGENCY PERSON NUMBER	143512
ARREST OFFENSE	ASSLT-(FREE TEXT) (13000000)
ARREST OFFENSE LITERAL	M ASSAULT ON A FEMALE
COURT FINE:	100
RESTITUTION:	588.25
SPECIAL CONDITIONS:	PAY REST TO ARMC BY 09/15/17, COURT COSTS TO BE PAID TODAY
ARREST DATE 08/07/96 (1 CHARGE)	
ARREST DETAIL	
ARREST DATE	08/07/96
SEQUENCE CODE	A
ARRESTING AGENCY	AUSTIN PD (TX2270100)
ARREST DATE 08/07/96 (1 CHARGE)	
OFFENSE RECORD	
ARREST OFFENSE	F PWIMSD MARIJUANA
ARREST OFFENSE LITERAL	F PWIMSD MARIJUANA
LEVEL AND DEGREE OF OFFENSE	FELONY
COURT STATUS A	
COURT OFFENSE	MARIJUANA-POSSESS (355620000)
COURT OFFENSE LITERAL	POSS OF MARIJ
LEVEL AND DEGREE OFFENSE	FELONY
COURT DISPOSITION	CONVICTED (310)

DPS Criminal History Results

Person Name: Charles E Jones Person ID: 456780123
--

CONVICTED: 09/10/96
TIME SERVED: 271 DAY
RELEASE DATE: 06/08/97

ARREST DATE 09/17/90 (CHARGE 001)

OFFENSE RECORD

ARREST OFFENSE M ASSAULT BY POINTING A GUN
ARREST OFFENSE LITERAL M ASSAULT BY POINTING A GUN
SPECIAL CONDITION: DISMISSED BY JUDGE

ARREST DATE 06/17/89 (1 CHARGE)

ARREST DETAIL

ARREST DATE 06/17/89
SEQUENCE CODE B
ARRESTING AGENCY AUSTIN PD (TX2270100)

ARREST DATE 06/17/89 (CHARGE *001)

OFFENSE RECORD

INTERNAL AGENCY PERSON NUMBER 143512
ARREST OFFENSE M POSSESS DRUG PARAPHERNA
ARREST OFFENSE LITERAL M POSSESS DRUG PARAPHERNA

ARREST DATE 03/19/83 (1 CHARGES)

ARREST DETAIL

ARREST DATE 03/19/83
SEQUENCE CODE B
ARRESTING AGENCY AUSTIN PD (TX2270100)

ARREST DATE 03/19/83 (CHARGE *001)

OFFENSE RECORD

INTERNAL AGENCY PERSON NUMBER 143512
ARREST OFFENSE M ILLEGITIMATE CHILD/NON-SUPPORT
ARREST OFFENSE LITERAL M ILLEGITIMATE CHILD/NON-SUPPORT
SPECIAL CONDITIONS: SIGN WAGE WITHOLDING. SUPPORT COREY MILES – 70 PER WEEK

Substance Abuse Assessment

Family Name: Clarissa Redd

Case No: 123.456

Name: 07456

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."

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

9. Treatment/Intervention

She attended NA weekly for four 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.

Substance Abuse Assessment

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 two months before leaving AMA (against medical advice). Per clinicians, the usual stay is six 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 was 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

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)

Foster Mother: Julia Budd (First Contact)

Julia Budd is a Caucasian single mom who runs an in-home day care. 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.

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

Redd Case Interviews

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 she 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."

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 six years and has a 3-year-old son, Antoine.

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.

Redd Case Interviews

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 fifth 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.

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 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.

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

Redd Case Interviews

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.”

Foster Mother: Julia Budd (Second Contact)

On this visit Julia Budd's three biological children were present and the day care 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 day care 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.

CASA/GAL Volunteer Competencies Review Activity: Reflections on Your Growth and Learning

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: _____

CASA/GAL Volunteer Competencies Review Activity

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: _____

CASA/GAL Volunteer Competencies Review Activity

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: _____

END OF PRE-WORK FOR CHAPTER 8

Trial Preparation



TEXASCASA
Court Appointed Special Advocates
FOR CHILDREN

Trial Preparation

Trial Preparation

Please refer to your program's guidance for trial preparation. Below is some general information to assist you in preparing for trial, but this might not apply to all programs.

Unfortunately, there are times when families cannot alleviate the original issues that brought them into the CPS system. When we feel it's in the best interest of kids not to return home, we may have to advocate for the termination of parental rights. This often starts with mediation, but if the parents are not in a place to voluntarily relinquish their rights, sometimes cases do go to trial.

The attorney representing CPS has to have legal grounds to take the case to trial. The most common termination grounds you will hear referenced are **D**, **E**, and **O** grounds. D and E are often referenced together.

- D** – Knowingly placed or knowingly allowed the child to remain in conditions or surroundings that endanger the physical or emotional well-being of the child.
- E** – Engaged in conduct or knowingly placed the child with persons who engaged in conduct that endangers the physical or emotional well-being of the child.
- O** – Failed to comply with the provisions of a court order that specifically established the actions necessary for the parent to obtain the return of the child who has been in the permanent or temporary managing conservatorship of the Department of Family and Protective Services for not less than nine months as a result of the child's removal from the parent under Chapter 262 for the abuse or neglect of the child.

Your supervisor will be able to provide you further information as it relates to your specific case and which termination grounds might be applied.

You should work your case from day one as if you're going to trial. This will ensure you stay up to date with necessary documentation and help you be prepared should trial happen.

As a CASA volunteer, if you've done your work consistently and documented everything thoroughly, you will be fine to prep for trial. You will use your documentation to develop a timeline for trial, and your supervisor will support you in all preparation

Trial Preparation

needed for trial. You will also meet with any other parties on the case that CASA is in agreement with to prep with them and review the types of questions you might be asked on the stand.

Generally, CASA is used to paint a picture of the children during a trial. We are often the ones with the most contact. The attorneys will be looking for descriptions of the children, especially over time. CASA will often testify to the children's emotional and psychological well-being. How do we expect the final decision will impact them? If we do not win, what will be the impact on the kids?

Our job is simply to answer questions honestly. The only exceptions are the identity of the person who made the initial call to CPS and any discussion that took place during mediation. These are always kept confidential. The attorneys know this and should not lead to you answer these types of questions.

TESTIFYING

CASA volunteers should be ready to testify regarding the following information:

CASA Related

- Your general background
- Description of CASA training
- Date you were sworn in
- The definition of guardian ad litem, if applicable
- Components of best interest

Legal Information

- What we are asking for, why we're asking for it, and the impact it will have on the children
- The legal alternatives
- How long a case lasts
- How long we will be appointed

Case Related

- When CASA was appointed
- Description of the children at beginning of case
- Changes in the children over time
- Specific conversations with the children about their wishes (to go home or not)
- Any other specifics from conversations with the children (outcries, stories about abuse) and when those conversations took place
- What is in the best interest of each child and why
- General description of contact with the parents
- Recommendations received from the parents' service providers
- Recommendations from children's therapists
- Educational information on each child
- Current needs of all children
- General description of contact with the caregivers
- Information from any other services the children are receiving
- General description of meetings (FGC, PC, Mediation)

Permanency Options

- Reunification
- Adoption
- Permanent Managing Conservatorship (PMC) to the Department
- PMC to another person
- Joint Managing Conservatorship (JMC)
- Possessory Conservatorship

Sample Trial Questions

1. Please state your name for the record.
2. What is your occupation?
3. How are you involved with this case?
4. What is the purpose of CASA?
5. What training did you receive with CASA?
6. What other experience do you have with children?
7. When were you appointed to this case?
8. How old were the children when you were appointed?
9. How old are they now?
10. What are the children's likes and dislikes?
11. How do the children perform in school?
12. Do the children have any significant behavioral, medical, or therapeutic issues?
13. How are the children doing today compared to when they were first brought into care?
14. What responsibilities have you had as the children's CASA?
15. How often have you seen the children?
16. Have you maintained contact with the parents?
17. To your knowledge, have the parents completed all of their court-ordered services?
18. Have the parents had regular visitation with their children?
19. How do the parents interact with the children?
20. How do the children react to the parents?

21. Do you think the parents are capable of providing a safe and stable environment for their children?
22. What other professionals or family members have you contacted regarding this case?
23. What other placement options have been considered during the course of the case?
24. What is your definition of permanency?
25. What is CASA's proposed permanency plan for the children?
26. Why do you believe this is in the children's best interest?

Sample Timeline

Part of your prep for trial might be to develop a timeline of your work. If you have been consistent about thoroughly documenting your work, you will easily be able to build this timeline. The timeline is generally shared with the AAL and the attorney representing CPS to give a clear picture of our work on a case and to help guide the types of questions they might ask us on the stand. This is what a trial timeline might look like.

DATE	ACTION
9/10/2015	Referral alleging physical neglect of all five children; Disposition of Reason to Believe, family fled area.
9/13/2015	The Department went out to investigate and found Reason to Believe of physical neglect of all 5 children.
9/15/2015	CASA appointed.
9/16/2015	CASA supervisor met the children and the family. CASA visits with the children in the home and shares the same concerns as the Department. There is glass and empty beer bottles on the floor. One of the children is 1.5 years old and was picking up cigarette butts off of the carpet. No food was in home available for the children.

Sample Timeline

DATE	ACTION
9/20/2015	The Department requested Temporary Managing Conservatorship (TMC) of the children. CASA is in agreement with the Department's request. Court granted TMC of all 5 children to the Department.
9/21/2015	Children removed and placed in emergency shelter.
10/20/2015	CASA supervisor observed a supervised family visit at the Department.
10/21/2015	CASA Volunteer is assigned to the case.
10/23/2015	CASA (Sup and Vol) visited at emergency shelter. Children are adjusting. Shelter shared some concerns about the children's behavior. Therapy is recommended for all children except the 1.5-year-old.
10/25/2015	Family Group Conference held. CASA Sup and volunteer attend the meeting. Parents had a neighbor attend the meeting. Neighbor is not able to be a placement at the moment.
11/9/2015	Status Hearing: (CASA Sup and Vol attend) TMC continues. CASA requested play therapy for the oldest 4 children (court granted it). Parents have registered for protective parenting, psychological, individual therapy and have submitted a UA.
11/16/2015	Family visit attended by CASA Sup and Vol (parents arrived 10 min late). Parents did not engage with the children. They were on their phones most of the visit.
11/20/2015	Children are all placed together in basic foster home.
11/20/15– 4/5/16	CASA maintained monthly phone contact with foster parents and children.
11/20/2015	Family visit was cancelled due to conflicts of schedules around Thanksgiving.
12/5/2015	Family visit attended by CASA Vol. Parents continue to be on their phones during the visit. Youngest child was crying and parents ignored him until the visit supervisor stepped in.
12/8/2015	Permanency Conference meeting held. Parents did not show up.
12/13/2015	Family Visit. Parents are a No Show for their visit. Children are very upset and have a hard time back at the foster home.

DATE	ACTION
12/18/2015	CASA Vol visited the children in their foster home and dropped off presents.
12/20/2015	Family visit, parents were inappropriate with the children. Yelled at them for being loud, threatened them. Dad fell asleep the last hour.
12/27/2015	Outcries from 3 oldest children reported by foster mom to the child advocates.
1/2/2016	CAC Interview (Jenny)
1/3/2016	CAC Interview (Fran, Sara)
1/10/2016	Met children and foster parents after therapy sessions,
1/12/2016	FA arrested for sexual assault of a child on the way to the family visit, MO too upset to attend family visit.
1/13/2016	Special review hearing to suspend visitation for parents. Judge granted the suspension of visits for both parents. Concerns about mom knowing of the abuse and not doing anything about it.
1/20/2016	Met children and foster parents to provide coats.
1/28/2016	CAC Interview (Evan, Fran, Jenny)
2/13/2016	Met children and foster parents. All children had a great time. Foster parents informed they were overwhelmed.
2/15/2016	Lengthy phone discussion with children's therapist.
2/20/2016	Foster parents put a notice on the children. They cannot handle their behaviors.
3/10/2016	Children placed together in new therapeutic foster home.
3/11/2016	1st Permanency Hearing: parents did not show up. Mom has not been in touch with parties or her attorney. Dad continues to be incarcerated. Trial Dates are announced and Mediation is authorized. Next hearing is set as merits.
3/15/2016	Visit with the children at their new foster home. They seem to be doing well.
3/22/2016	Mom is arrested for possession of a controlled substance.

Sample Timeline

DATE	ACTION
3/29/2016	Permanency Conference is cancelled due to both parents being incarcerated.
4/5/2016	CASA visited children at foster home. Children are all doing well. None of them asked about their parents. Foster parents report that they are all great and have no concerns.
4/20/2016	CASA visited principal at Evan, Fran, and Jenny's school. They are struggling at school and receiving services. Grades are slowly improving.
4/25/2016	Conversation with the children's therapist. Children have experienced a significant amount of trauma while in their biological parents' home. Does not recommend contact with parents by phone at the moment.
5/12/2016	Visit with the children at foster home. Children continue to do great.
5/20/2016	Mediation takes place. Parents were brought in for mediation. Neither parent signed a relinquishment of parental rights.
6/2/2016	Visit with the children at their foster home. Conversation with foster family about adoption. Foster parents are willing to adopt all 5 children.
6/20/2016	CASA visit with the children. Oldest 3 children tell CASA they want to stay with their foster parents forever.
7/13/2016	Trial Begins

