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CASA of LOS ANGELES

Volunteer Training Manual

A child's voice. A child's life. Lifted up. By you.

CASA
Court Appointed Special Advocates
FOR CHILDREN

CASA OF LOS ANGELES

www.casala.org

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Court Appointed Special Advocate Pre-service Training Manual

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CHAPTER 1

Defining the CASA Volunteer

PURPOSE: *To introduce the role & responsibilities of being a CASA volunteer*

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Additional information:
California Welfare and Institutions Code: Section 100-110
Monthly Data Sheet
CASA Activity Log

Objectives

By the end of this chapter, I will be able to…

- ✓ Describe the role as a CASA volunteer.
- ✓ Begin to understand the principles and concepts that guide CASA volunteer advocacy.
- ✓ Begin to consider the boundaries of the relationship between CASA and the child.
- ✓ Engage the attitudes, values, and skills that will make me an effective CASA volunteer.

UNIT 1: Welcome

Welcome to your Court Appointed Special Advocate (CASA) training. This represents a step toward making a huge difference in the life of a child. We at California CASA have designed this training manual to provide you with the knowledge, skill, and understanding that can help you effectively advocate for children and youth in the child welfare system. The hope is that this training will combine with your heart, common sense, determination, and life experience to improve the life of a young person in need.

As a CASA volunteer, you will be empowered to advocate for the most vulnerable among us – children who have been abused, neglected, or abandoned. Your goal will be to engage your child's circumstance. You will act as the eyes and ears of the court, and report the facts that you have learned and give the recommendations that will lead to important interventions in the child's life.

The keystones of your work will be safety, permanence, and well-being. Everything that you do should connect to one of these three needs of your child. ***Safety*** comes first, and as a CASA volunteer you are required to report facts to the court, and report abuse or neglect that comes to your attention while acting as an advocate. Next is ***Permanence***, whether it means returning to a parent, connecting with other family or community, or beginning a new family, it is simply essential to a child's growth and success. Finally, there is ***Well-being***, a measure of the child's emotional and physical health. You will need to identify educational, material, and health related needs and ensure that the resources actually reach your child in an intelligent and timely fashion.

Being a CASA volunteer is not an easy undertaking. It requires commitment, time, dedication, and courage. You are about to embark upon a journey that will no doubt test you, but it will also thrill you, warm you, and give you back more than you ever thought possible. You are about to become a CASA volunteer advocate. Welcome.

Activity 1A: Purpose & Concerns

In the large group, please share what you think is the role of a CASA volunteer, your reasons for wanting to be a CASA advocate, and one concern that you have about volunteering.

Activity 1B: Expectations of Training

Take a few minutes to think about your expectations from this initial CASA training and write them on a post-it. Once completed, please put your post-it on the poster marked "Expectations." We will revisit these at the end of training to ensure that the training met your expectations.

UNIT 2: The CASA Organizational Structure

CASA began in 1977, and the idea of using trained volunteer citizens as advocates engulfed the nation. Today, CASA has a nationwide network of more than 59,000 volunteers who serve 243,000 abused and neglected children through more than 900 local programs.

CASA stands for **C**ourt **A**ppointed **S**pecial **A**dvocate, and as a CASA volunteer you will be part of this large, 30 year-long, national movement. There is a national, state, and local structure, each independent and serving different functions. In California, we have the National CASA Association, the California CASA Association, as well as 43 local programs that serve our children.

1. **National CASA Association (NCASAA) www.nationalcasa.org**

National CASA offers leadership and support to grow the CASA network nationally. It provide training, technical assistance, and produces a volunteer training curriculum. National CASA also promotes public awareness of the CASA movement and provides pass-through funding to local and state CASA programs.

2. **California CASA Association (CalCASA) www.californiacasa.org**

Similarly, CalCASA fortifies local programs with leadership, support, and technical assistance focused solely on the vast and varied needs of California's youth. Likewise, CalCASA has developed a specialized California-centered volunteer training curriculum (you are reading it now). CalCASA works closely with the Administrative Office of the Courts to ensure local program quality and effectiveness, and provides a strategic advancement of the CASA mission by promoting progressive child welfare policy and legislation, and sharing the best practices developed by local programs and discovered by volunteers like you.

3. **Local Programs**

California hosts 41 local programs, each operated independently, that serve children throughout the state. Some are small, others are quite large, but they all adhere to the CASA mission of serving children and youth.

UNIT 3: Principles & Concepts That Guide CASA Volunteer Advocacy

A. Who is a CASA Volunteer?

A CASA volunteer is a specially trained member of the community who becomes a sworn officer of the court and is appointed to:

- Independently investigate a child's circumstances, talk to those involved, and gather relevant information
- Write reports for the court that identify and highlight important facts and make thoughtful recommendations that are in the best interests of the child
- Advocate to ensure that the child receives the attention and services needed to advance his or her safety, permanence, and well-being
- Establish a strong and stable connection with the child, enabling the child to grow and be resilient and interdependent

B. Effective Advocacy Requires Training

As you will learn in Chapter 2, the child welfare system can prove incredibly complex. Effective advocacy requires specialized training, knowledge, understanding, and skill. The successful advocate will:

1. Seek to establish permanence for the child as soon as possible.
2. Approach each case with the goal of ensuring the child's safety and increasing the child's permanence, well-being, resilience, and interdependence.
3. Work within the parameters of federal and state laws governing child abuse, neglect, and dependency cases.
4. Utilize the guidance from your CASA program staff to:
   - Conduct an independent investigation to gather facts and research the case to ascertain the needs and wishes of the child.
   - Present fact-based recommendations so that the court can order appropriate resources and actions that will meet the needs of the child.
   - Advocate for services and results that increase the safety, permanence, well-being, resilience, and interdependence of the child.
   - Collaborate with the child (whenever possible), and the child's family, social worker, attorney, therapist, and other service providers to identify the child's needs and the resources available to meet those needs.
   - Ensure that the child receives, in an intelligent and timely fashion, any and all identified resources and services, whether court-ordered or not.
   - Strengthen and extend the child's professional and personal support network.
   - Work to establish permanence for the child.

C. Introducing the "Best Interests" Principle – What Does It Mean?

Parens patriae is Latin for "father of the people," and describes the power of the state to step in and assume the role of a parent when a child needs protection. When needed, the court, in its *parens patriae* role, becomes the parent, and thus makes decisions as a parent would – in the best interests if the child. Therefore, this principle is imbedded in every decision the court makes such that all decisions or actions are in "the best interests of the child."

So how does this affect you as a CASA? When making your recommendations, it is important to formulate them with the child's best interests at the forefront. Your recommendations should not become a compromise of what you think are the needs of others involved. For example, if the child needs a winter coat, but the social worker has already told you that there is no money available, you should still inform the court of the need and recommend that the court order the provision of a winter coat. The child's best interests are always at the center of what you do.

Of course, there are rules and laws that the court must follow while acting in the best interest of the child. Often, the law forces a certain action or order from the court. In this instance, it is as if the law presumes that a certain course of action is in a child's best interests. For example, when a the court removes a child from his or her parent, the law presumes that it is in the child's best interests to return home after six months unless further detriment can be proven. Thus, the court must do so, even if there are second thoughts or concerns expressed by other parties.

This is true of the CASA as well. The primary purpose of a CASA volunteer is to provide accurate and detailed fact-based information to the court so that it can make decisions that truly reflect the best interests of the child. You definitely provide your opinion as to what is in the best interests of the child, in the form of recommendations. However, you are not the decision maker – the judge is. Your role is to ensure that the judge has the best information possible to make his or her decision. Remember, the judge can only act on information that he or she knows. If no one has made the court aware of important facts, then the court cannot do its best to protect the best interests of the minor. This is why a CASA is so essential and effective in court.

Further, there will be times when rules seem to contradict what you think is in the best interest of the child. However, like the judge, you must follow the rules and law before you. For example, National CASA standards, and the California Rules of Court prohibit a CASA volunteer from taking a child to the volunteer's home. It is presumed to be against the child's best interests for you to do so. So, as you go through training, keep the best interests standard in mind, and take note of areas where it may run contrary to your thinking.

D. Minimum Sufficient Level of Care

When the state removes a child from his or her home, it is a highly traumatic and invasive action. The parent/child relationship is constitutionally protected and important to the well-being of both the child and parent. Therefore, both California law and good practice require that the social services agency keep the child in the home when it is at all possible, as long as it is safe to do so.

The "minimum sufficient level of care" is a standard that means that the care provided meets the child's basic needs and that the child is not harmed physically, sexually or emotionally. If the child's home meets this standard, then the child should be home.

Now, there is an inherent contradiction here. We were just saying that the court should always act in the "best interests" of the child, and now we are saying that the child should remain in home as long as the home meets the *minimum* sufficient level of care. The way to look at this is that remaining home is presumed to be in the best interest of the child – above all else – as long as the minimum sufficient level of care is met. The harm that is done by removing a child, and the invasion into the family is so great, that removal must be a last resort.

Therefore, keep in mind, that when you are working with a child who has been removed from home, the goal is to return that child as soon as the home is safe – even if the foster home appears better, or seems to provide more advantages or offer a better future.

The minimum sufficient level of care standard is not the same across the state, instead, it is determined by each community. When thinking about the standard in your community, consider these factors:

1. **The Child's Needs**

   Is the parent providing basic physical, emotional, and developmental support?
   (Physical support can mean food, clothing, shelter, medical care, safety, protection)
   (Emotional support includes attachment and care between parent and child) and
   (Developmental support includes education, special help for children with disabilities, etc.)

2. **Social Standards**

   Is the parent's behavior within or outside of commonly accepted child-rearing practices in our society?
   Here are some examples: In terms of discipline, during the first half of the twentieth century, whipping a child with a belt was generally thought to be appropriate. Now, however, it is widely considered abusive, and families now opt for a short "time out" to discipline children. In terms of school attendance, it is a widely held expectation that parents send all children to school (or provide home schooling). Social standards also apply in medical care, where immunizations and regular medical/dental care are the standard.

3. 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 a child can be safely left alone varies significantly from urban to suburban to rural communities. Another question that often arises is, what age is old enough to babysit? The answer to these questions are at least partly determined by cultural and community norms. Even something as simple as sending a nine-year-old child to the store might fall within or outside those standards, depending on neighborhood safety, 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.

Keep in mind that different communities may have different standards from yours. These differences can be geographical (rural vs. urban) or cultural (wealthy vs. poor). A cultural community standard, for example, is when an Indian tribe has members who live in a variety of locales but still share a common child-rearing standard. According to the Indian Child Welfare Act, the minimum sufficient level of care standard must reflect the community standards of the tribe of the Indian child.

4. Why Do We Use a "Minimum Sufficient Level of Care" Standard?

- It maintains the child's right to safety and permanence while not ignoring the parents' right to raise their children.
- It is realistic.
- 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 focuses decision makers on what is the least detrimental alternative for the child.
- It is culturally appropriate.

Activity 1C: Poverty vs. Neglect

Let's take a moment to consider the differences between poverty and actual neglect that places a child's safety at risk. Please complete the sentences in each of the following examples:

1. Billy, a brown-haired, eight-year-old boy eats the free lunch provided at school. Other than that, he doesn't have any regular meals – though he does snack whenever food is around. Is this is a child safety issue?

Yes, if _____.

No, if _____.

2. Lilly, a sweet child, lives with her family in a notoriously rough neighborhood, well known for drugs, robberies, and gangs. Is this a child safety issue?

Yes, if _____.

No, if _____.

3. Little Charles, lives with his father who struggles to make ends meet. Each winter, the cost of heating the home skyrockets, and this – the coldest month, the gas was shut off, and they have no heat. Is this a child safety issue?

Yes, if _____.

No, if _____.

4. Gina is two, and adorable. She lives with her family in a small trailer and they have "a few" cats and the living quarters are described as "really tight." Is this a child safety issue?

Yes, if _____.

No, if _____.

5. Sara, Mona, and Joe are three playful siblings, two girls and one boy. They share a full-sized bed. Is this a child safety issue?

Yes, if _____.

No, if _____.

UNIT 4: Responsibilities of the CASA Volunteer

As a CASA volunteer, you will:

1. **Investigate**: seeking a clear and deep understanding of the child's situation.
2. **Plan**: working with child welfare professionals to determine what strategies promote the best interests of the child.
3. **Advocate**: reporting to the court what you have discovered and working within other systems (such as education and health care) to make sure that the child receives the services needed to advance his or her safety, permanency, well-being, resilience, and interdependence.
4. **Connect**: strengthening and building the child's personal and professional support network, continuously seeking to establish permanence and family for the child.

A. The CASA Role

After you complete the training, and complete a background check, you must take an oath and be sworn in before the court. This oath requires that you fulfill the CASA role, which means you:

1. Gather Information and:

- Have regular, in-person contact with the child sufficient for you to have in-depth knowledge of the case and make fact-based recommendations.
- Learn the needs and situation of the child by reviewing all relevant documents and records and interviewing the child, parents, social workers, teachers, and other relevant people.
- Determine if a permanent plan has been created for the child.

2. Facilitate Communication and Collaboration by:

- Seeking cooperative solutions by acting as a facilitator among involved parties or as a bridge to the many professionals working with the child and the family.
- Finding resources for the child and family and working with those agencies to ensure services are being rendered as promised.
- Looking for opportunities to facilitate communication between parties that should be communicating (*i.e.*, child and caregiver or child and relative).

3. Advocate by:

- Identifying and communicating the best interests of the child.
- Providing reports that include factual findings and recommendations at every hearing.
- Appearing at all hearings to advocate for the child's interests and providing testimony when necessary.
- Making recommendations for specific services that are appropriate for the child and family.

- Informing the court promptly of important developments in the case by filing interim court reports.
- Advocating for the child's interests in the community by engaging mental health, education, and other systems to assure that the child's needs are met.
- Participating in all scheduled case conferences with CASA program staff.

4. Monitor the Case by:

- Maintaining regular, in-person contact with the child so that you can develop the depth of knowledge necessary to make intelligent, fact-based recommendations.
- Ensuring that services and court orders are implemented in an intelligent and timely fashion.

5. Protect Confidentiality/Maintain Records by:

- Respecting the child's right to privacy by maintaining confidential information.
- Complying with all confidentiality laws.
- Safely and securely maintaining all relevant case records.
- Returning case files to the program after you are dismissed from the case.
- Maintaining complete records about the case, including appointments, interviews, and information gathered about the child and his/her circumstances.

6. Comply with Program/Administration by:

- Recording volunteer hours and submitting your activity log to the CASA program office.
- Participating in all scheduled case conferences with CASA supervisory staff.
- Participating in at least 12 hours of continuing or in-service training a year.

B. The CASA Volunteer's Relationship with the Child

One of the essential components of effective advocacy is building a strong, trusting relationship with your CASA child. This one-on-one relationship will give you much needed access to information and the needs of your child. The stronger the relationship, the more effective an advocate you can be. Here are some basic guidelines:

- Know the child well enough to make appropriate recommendations to the court.
- Remember that you are, by design, a temporary intervention in the child's life.
- Establish and maintain proper boundaries with the child and model a healthy adult/child relationship.
- Be a consistent, stable, and supportive presence in the child's life.
- Do not take the child to your home or work, and do not introduce him/her to your family or friends.
- Collaborate with other professionals in the child's life to ensure that the child is receiving appropriate attention.
- Respect the privacy of the relationship while also letting the child know that you are a mandated reporter.

Activity 1D: Volunteer-Child Relationship Scenarios

Consider the following volunteer-child relationship scenarios. What do you think may be an appropriate way to react to the situation?

1) You've met with your CASA child three times, and on the fourth visit he wants to go to the mall. "Sure," you say, and you both head down to mall. While there, he spots a great pair of sneakers and gets very excited. They are $100, and he only has $20. You can see that he is thrilled at the thought of having something nice – for once. He turns to you and asks, "Will you buy them for me, please?"

2) You and your CASA child have built a solid relationship. She has shared several intimate details about her life with her "real" mother. You are driving her home one day and she curiously asks, "So, where do you live?"

3) One day your CASA child tells you that he hardly ever gets to see his older brother Pete and he misses him terribly. The foster father has said that Pete is a "bad egg" and the boys shouldn't really spend too much time together.

4) While at court, your CASA child's mother approaches you. She tells you, "This social worker is terrible! She still hasn't set up my visits, and today is the first time I've seen my son in over a month! I don't know what to do." Your CASA child has told you several times that he misses his mother more than anything. The mother says that she would really like to talk with you more in depth and then asks you for your phone number.

5) After eight months of working with your CASA child, you feel like perhaps you are not ever going to get through to her. But over a hamburger, she suddenly opens up, and out of nowhere tells you stories about how she was abused by her grandfather – clearly painful memories.

6) Your 12-year-old CASA child will turn 13 next month. She confides in you that she has never had a birthday party. You would like to plan one for her.

7) Right after court, your CASA child's mother approaches you and teary-eyed, asks, "Do you think I will get my little boy back in six months?"

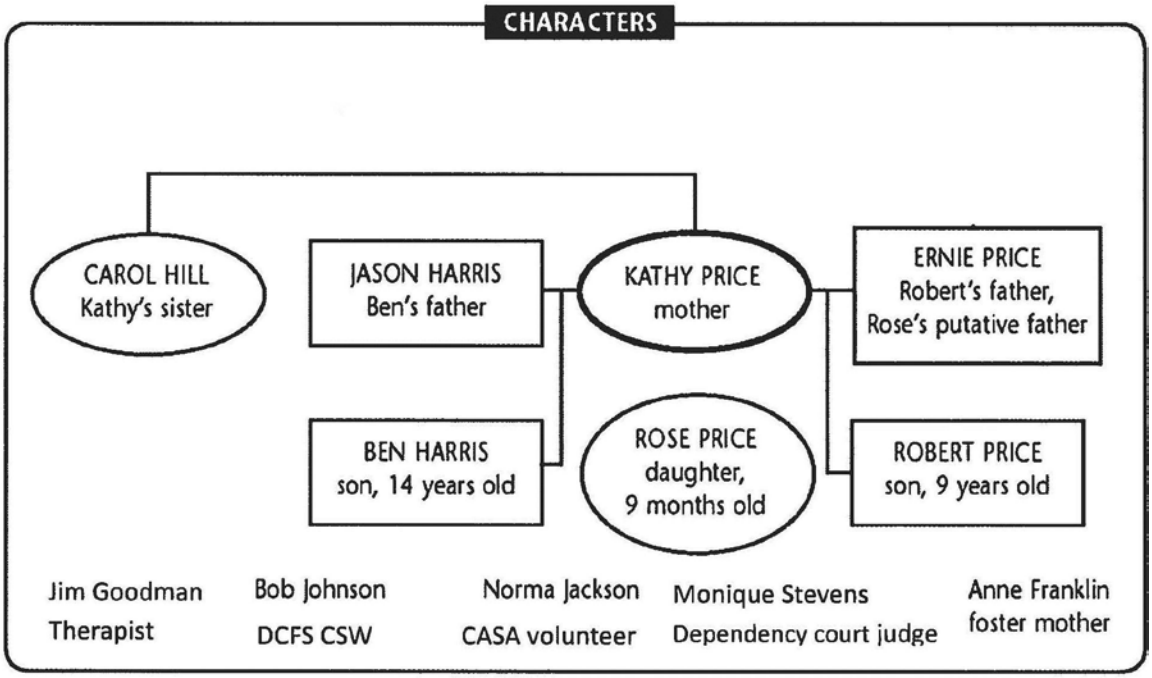
Adapted from Humboldt and
San Bernardino County CASA

UNIT 5: Harris-Price Family Case Scenario

(Adapted from National CASA Association 2007 Volunteer Training Manual)

Please read and review the following case scenario. We will use this case as a common reference point in discussing various aspects of the CASA volunteer role.

Harris-Price Family Case Scenario



Kathy Price-birth mother of Ben, Robert and Rose
Ben Harris-youth, 14 years old DOB 12-01-1995
Robert Price- brother, 9 years old; Rose Price, sister, 9 months old
Carol Hill- Kathy's sister, maternal aunt
Jason Harris-Ben's birth father
Ernie Price-Robert's birth father, Rose's alleged father
Judge Monique Stevens Dept 520
Norma Jackson-CASA volunteer
Anita Dashee-Ben's school counselor
Bob Johnson, CSW
Marley Smith, SCSW
Jim Goodman, therapist

Kathy's story- Every day I have to get up early so I can get Rose dressed and fed and get Ben and Robert up and ready for school. I take Rose to daycare and make sure the boys leave for school. Ben's a big help-sometimes he has dinner ready when I get home. I work long days. I clean a motel and I also wash dishes at the restaurant around the corner. I get minimum wage. My jobs aren't so great, but I need every penny and can't miss a day. Sometimes after the kids go to sleep, I have a drink or two. It helps me sleep and is the only thing that helps my aching back-cleaning is hard work. My sister nags me about it, but it's not like alcohol is illegal or anything.
When DCFS took my kids, it was awful for me.
On New Year's eve, I had run out of formula for Rose, so after I put her to bed I went to get some. The boys were watching TV and Ben was in charge. The formula is really expensive. I was out of vodka, too, so I stopped to buy some. After that I didn't have
enough money for the formula, so I took a can. No big deal. But the lady saw me and called the cops. They arrested me-for a can of formula! Worst of all, I was already on probation, so I'm really afraid they're going to throw the book at me.

Ben's story- When mom left to go to the store, she didn't come home. I didn't know why. Robert and I went to bed, but when I woke up mom still wasn't there. I went over to Mr. Burns' house, our neighbor, and told him I didn't know what to do, because I had Rose and Robert in the house . We didn't have to go to school, because it was Christmas break.
I have asthma and sometimes have trouble breathing and Mr. Burns asked me where my inhaler was. Mom can't pay for it, so I told him I didn't have one now. Mr. Burns came over to our house and helped me take Rose and Robert to his house. He called the police and then a social worker came and took us back to our house.
Rose and Robert's dad, Ernie, is a nice guy and I knew he would come and take them and I would probably go to see my Aunt Carol. I was hoping my mom was okay and not drunk somewhere.

Robert's story-I was scared, too. My dad is a soldier and just got back from Iraq. He comes to visit me and Rose every week. He likes Aunt Carol, but doesn't like to talk to my mom.

Bob Johnson, CSW for DCFS- I have been a CSW in Los Angeles for five years. I was called because these kids were in an apartment by themselves, left unsupervised. The officer told me their names, so before I left the office I checked our records. We had a file on them. Earlier in the year, Kathy Price had signed an agreement that she wouldn't leave Rose without an adult present. While I was at the apartment, Carol Hill arrived. I knew from the file that she was Kathy's sister. Kathy had called her from jail and
asked her to come over and to get the kids. Carol said Kathy was still in jail because they'd also charged her with violating probation by having the vodka. Ben is placed with Aunt Carol. We called Ernie Price, father of Robert and alleged father of Rose, and he came and took the two siblings.

Marley Smith, SCSW- Supervisor of Bob Johnson

Carol Hill's story,maternal aunt- I was happy to take Ben. He's a good kid. I've got two kids of my own and we live in a small place.
Kathy's trouble. She drinks too much. I only hear from her when there's another crisis.

Kathy's story(continued) I got out of jail and I went to the motel to report for work, but that jerk of a manager fired me for being late again. Then, the next day, I had to go to court. The judge wouldn't let me take my kids home with me. I couldn't believe it. He said I could visit them.

Jason Harris, Ben's father- Ben is my son. He's a good kid and all, but I have a new family now-my wife and I have a new baby. I can't get involved in Ben's life and support my wife and baby. They have to come first. I know it's not Ben's fault that his mother is so messed up, but I want to steer clear of anything to do with Kathy.

Ernie Price, Robert's father and Rose's alleged father- I just got back from overseas. I sent money to Kathy while I was gone-to help her out with Robert. She moves so much that I got it back. I got a job when I returned home and am able to take care of Robert
and Rose. I don't even know if Rose is mine. She has my name, but this is the first I've even heard about her. Kathy and I divorced a year and a half ago-about the time I went overseas. I love Robert and I will take care of Rose, too.

Assigning the case to a CASA

Norma Jackson, CASA volunteer- A Supervisor from the CASA office called me about the Harris-Price case to see if I would come in to review the file. At the Disposition, the court asked for a CASA to be assigned. I agreed to take the case in late March, 2010. I knew that Ben was placed with his aunt and the other children went home with Mr. Price. I got a copy of my Appointment Order and was ready to talk to parties on the case.
I called and set up times to meet Carol Hill and talk to the CSW. I also wanted to meet mother and talk to her. I knew that Mr. Price was not a party to the case, but he did have Ben's brother and sister, so I hoped he would talk to me as well.

First person I talked to was Bob Johnson, CSW. I introduced myself as the Court Appointed Special Advocate (CASA) for Ben. I explained what a CASA does and that he would be getting a copy of my Appointment Order soon. Bob and I talked about the case
I brought up the fact that Kathy had been working pretty steadily and always had an appropriate apartment. Bob reassured me that her drinking was causing problems. He'd gotten police reports where she'd been arrested for public drunkenness, and this wasn't the first time she'd left the kids alone. The night she was arrested, she hadn't told the police the kids were home alone. He said that was abandonment. And he pointed out that Kathy fails to get Ben's inhaler for him. He said she wouldn't fill out the forms to get Medi-Cal for the kids and to get child support from the fathers. I asked Bob if Kathy is literate, and he said "barely".
Case plan for Kathy includes:

1. drug testing and an outpatient substance abuse clinic.
2. he is happy that Kathy has employment still and;
3. she is testing negative on her drug testing so far.

I next visited Ben. I explained my role as CASA to Ben and he asked if I was going to make him move back with his mom. I asked him if that is what he wanted. He said he loved his mom and wanted to see her, but it was hard for her to take care of them and he liked living with his aunt. Ben said he was afraid he wouldn't get to see Robert and Rose, so I explained that the judge said he was allowed to visit his brother and sister. He said the kids at school pick on Robert and he always stood up for him, and now he wouldn't be able to do that. He was worried about Robert.

I visited with Carol.

I asked Carol how she thought Ben was adjusting to the new arrangement with her. She said he liked living with her and his cousins. She had taken him to the family physician and he had started to take the medication that had been prescribed a while back(the inhaler). So far it helped his breathing but made him feel jittery. Ben started El Rancho High School where he is in 9th grade. He is a little below grade level in performance, but Carol is hoping the school will have a tutoring program for after school times. She said Ben does his homework most of the times. She encourages him to complete his assignments.

When I asked her about Kathy, she said Kathy never contacts her unless she is in trouble.

I called Kathy and she was very willing to talk to me. I told her I was concerned about Ben's asthma and she said she had taken him to the clinic, but after taking a whole day off work and taking two buses to get there, the people at the clinic told them they needed to change the appointment. Ben couldn't get in that day to see the doctor or get the medicine. She said she couldn't afford to lose work. She said she wanted her children back and she realized she had a drinking problem, but she wasn't an alcoholic, she just needed a little more time to get used to not drinking. I told her that the CSW would talk to her about that and she could talk to him about a plan on how to get sober. I thanked her for her time and told her I would touch base with her regularly if she wanted me to. She said that would be fine as long as her cell phone bill was paid, she would have a way to talk to people. She said she was making progress on her case plan. She was going to an outpatient substance abuse clinic and trying to make one job's income be enough for supporting her and the children. She said it is enough for her but not enough money for when the kids come home. She said she cooperates with her social worker and is asking for help on how to make this work. She said she was going to drug testing as ordered and trying to find a second job.

I called Ernie Price and he said he felt fortunate to have gotten a job as a car mechanic when he returned from the war. He expressed his excitement at getting to reconnect with Robert. He would not leave Rose alone or send her elsewhere; he would care for her, too. I told him I would like to meet Robert and Rose some day, and he said that would be fine. He understood

my role in helping Ben. He said he was fine with the kids visiting Ben at Carol's house, as he and Carol get along well, but he didn't want to deal with Kathy.

I called the therapist, Mr Jim Goodman, and he said he could only give me a progress report on how Ben is doing in therapy. I thanked him and said I really appreciated it. He said that Ben was attending the sessions once a week and was making progress. He said I could call him once a month to get a progress report on how things are going.

He said he couldn't be more specific than that, as he was protecting Ben's right to confidentiality. I told him I understood.

I visited Anita Dashee at El Rancho High School and she said she was the School Counselor and kept in touch with Ben's teachers on a regular basis. She knows Ben lives with his aunt and is a child in dependency court. The social worker was thoughtful enough to meet with her one day to let her know. She said Ben was a bright young man, but daydreamed a lot in class. He gets along with most of the kids and has a few close friends. He was not turning in all of his homework assignments, according to his math teacher, and when she talked to him about it, he just kinda shrugged his shoulders. Ms. Dashee said she felt a tutor after school would be good for Ben. She talked to Ms. Hill about it. I told Ms. Dashee I would want to attach the end of year report card to my report for the court hearing on September 11, 2010. She said she would have that for me by the end of June. She said she didn't think Ben would have to go to summer school, but she would recommend that he stay busy with some kind of school emphasis throughout the summer, so he would be better prepared for Fall 2010 school year. She said she thought Ben actually did pretty well for starting a new school in January.

She said mom showed up one day at school and wanted to see Ben. Since Kathy holds the educational rights and she is his mother, Ms. Dashee let Ben have a few moments with her. Ben was quiet when he came back in the classroom, but continued with his work in a comfortable way. He wanted to talk to his mother.

My recommendations for the 21e hearing:

1. Ben remains placed with maternal aunt, Carol Hill
2. Mom be offered 6 more months of FR(family reunification)
3. Ben continue to see therapist
4. DCFS assist Carol Hill in arranging visits with Robert and Rose
5. DCFS work with Ms. Hill to ensure Ben has tutoring to help with his math homework

NOTES

CALIFORNIA CODES
WELFARE AND INSTITUTIONS CODE
SECTION 100-110

100. The Judicial Council shall establish a planning and advisory group consisting of appropriate professional and program specialists to recommend on the development of program guidelines and funding procedures consistent with this chapter. At a minimum, the council shall adopt program guidelines consistent with the guidelines established by the National Court Appointed Special Advocate Association, and with California law; but the council may require additional or more stringent standards. State funding shall be contingent on a program adopting and adhering to the program guidelines adopted by the council.

The program guidelines adopted by the council shall be adopted and incorporated into local rules of court by each participating superior court as a prerequisite to funding pursuant to this chapter.

The council shall adopt program guidelines and criteria for funding which encourage multicounty CASA programs where appropriate, and shall in no case provide for funding more than one program per county.

The council shall establish in a timely fashion a request-for-proposal process to establish, maintain, or expand local CASA programs and require local matching funds or in-kind funds equal to the proposal request. The maximum state grant per county program per year shall not exceed seventy thousand dollars ($70,000) in counties in which the population is less than 700,000 and shall not exceed one hundred thousand dollars ($100,000) in counties in which the population is 700,000 or more, according to the annual population report provided by the Department of Finance.

101. As used in this chapter, the following definitions shall apply:

(a) "Adult" means a person 18 years of age or older.

(b) "Child or minor" means a person under 18 years of age.

(c) "CASA" means a Court-Appointed Special Advocate. "CASA" also refers to a Court Designated Child Advocate in programs which have utilized that title. A CASA has the duties and responsibilities described in this chapter and shall be trained by and function under the auspices of a court-appointed special advocate program as set forth in this chapter.

(d) "Court" means the superior court, including the juvenile court.

(e) "Dependent" means a child described in Section 300 of the Welfare and Institutions Code.

102. (a) Each CASA program shall, if feasible, be staffed by a minimum of one paid administrator. The staff shall be directly accountable to the presiding juvenile court judge and the CASA program board of directors, as applicable.

(b) The program shall provide for volunteers to serve as CASAs. A CASA may be appointed in juvenile dependency proceedings under Section 300 and in actions to terminate parental rights to custody and control, as deemed appropriate by the juvenile or other superior court judge hearing the matter.

(c) Each CASA shall serve at the pleasure of the court having jurisdiction over the proceedings in which a CASA has been appointed.

A CASA shall do all of the following:

(1) Provide independent, factual information to the court regarding the cases to which he or she is appointed.

(2) Represent the best interests of the children involved, and consider the best interests of the family, in the cases to which he or she is appointed.

(3) At the request of the judge, monitor cases to which he or she has been appointed to assure that the court's orders have been fulfilled.

(d) The Judicial Council, through its rules and regulations, shall require an initial and ongoing training program consistent with this chapter to all persons acting as a CASA, including, but not limited to, each of the following:

(1) Dynamics of child abuse and neglect.
(2) Court structure, including juvenile court laws regarding dependency.
(3) Social service systems.
(4) Child development.
(5) Interviewing techniques.
(6) Report writing.
(7) Roles and responsibilities of a CASA.
(8) Rules of evidence and discovery procedures.
(9) Problems associated with verifying reports.

(e) The Judicial Council, through its CASA Advisory Committee, shall adopt guidelines for the screening of CASA volunteers, which shall include personal interviews, reference checks, checks for records of sex offenses and other criminal records, information from the Department of Motor Vehicles, and other information as the Judicial Council deems appropriate.

103. (a) Persons acting as a CASA shall be individuals who have demonstrated an interest in children and their welfare. Each CASA shall participate in a training course conducted under the rules and regulations adopted by the Judicial Council and in ongoing training and supervision throughout his or her involvement in the program. Each CASA shall be evaluated before and after initial training to determine his or her fitness for these responsibilities. Ongoing training shall be provided at least monthly.

(b) Each CASA shall commit a minimum of one year of service to a child until a permanent placement is achieved for the child or until relieved by the court, whichever is first. At the end of each year of service, the CASA, with the approval of the court, may recommit for an additional year.

(c) A CASA shall have no associations that create a conflict of interest with his or her duties as a CASA.

(d) An adult otherwise qualified to act as a CASA shall not be discriminated against based upon marital status, socioeconomic factors, or because of any characteristic listed or defined in Section 11135 of the Government Code.

(e) Each CASA is an officer of the court, with the relevant rights and responsibilities that pertain to that role and shall act consistently with the local rules of court pertaining to CASAs.

(f) Each CASA shall be sworn in by a superior court judge or commissioner before beginning his or her duties.

(g) A judge may appoint a CASA when, in the opinion of the judge, a child requires services which can be provided by the CASA, consistent with the local rules of court.

(h) To accomplish the appointment of a CASA, the judge making the appointment shall sign an order, which may grant the CASA the authority to review specific relevant documents and interview parties involved in the case, as well as other persons having significant information relating to the child, to the same extent as any other officer of the court appointed to investigate proceedings on behalf of the court.

104. (a) The court shall determine the extent of the CASA's duties in each case. These duties may include an independent investigation of the circumstances surrounding a case to which he or she has been appointed, interviewing and observing the child and other appropriate individuals, and the reviewing of appropriate records and reports.

(b) The CASA shall report the results of the investigation to the court.

(c) The CASA shall follow the direction and orders of the court and shall provide information specifically requested by the court.

105. All otherwise confidential records and information acquired or reviewed by a CASA during the course of his or her duties shall remain confidential and shall be disclosed only pursuant to a court order.

106. The CASA shall be notified of hearings and other proceedings concerning the case to which he or she has been appointed.

107. Upon presentation of the order of his or her appointment by the CASA, and upon specific court order and consistent with the rules of evidence, any agency, hospital, school, organization, division or department of the state, physician and surgeon, nurse, other health care provider, psychologist, psychiatrist, police department, or mental health clinic shall permit the CASA to inspect and copy any records relating to the child involved in the case of appointment without the consent of the child or parents.

108. The Judicial Council shall report to the Legislature on the implementation of the program, and shall include recommendations on the continued funding and expansion of the program, as appropriate.

109. Nothing in this chapter permits a person acting as a CASA to participate or appear in criminal proceedings or in proceedings to declare a person a ward of the juvenile court pursuant to Section 601 or 602.

110. Nothing in this chapter shall be construed as limiting the right of an Indian tribe or Indian organization to establish or operate CASA programs independent of state funding or the discretion of the court to appoint CASAs from those programs in Indian child custody proceedings.

Please Use a Separate Data Sheet for Each Child

CASA Monthly Data Sheet

Each CASA must complete and return this form by the 15th of the month for the previous month

For the Month of:	**Year:**	**CASA Name:**
Name of Child:		**Supervisor Name:**
Case #:		**Continuing Education hours completed during this month:** **Activity/Title:**
Total hours worked on this case during this month:		
Dates of CASA's contact with child during this month:		

Section 1: Court-Ordered Sibling Visitation

Is there a sibling visitation order in effect: Y / N ☐ ☐ ***(If no, go on to Section 2, on back)***	
Sibling visitations ordered for (name of CASA child):	
Date of order:	
Sibling(s) named on order:	
Terms of order (frequency of visits):	
Number of visits that have occurred:	**Next hearing date:**
Source(s) of CASA's information about visitations:	

Section 2. Placement Changes

There has been at least one placement change since the last Data Sheet: Y / N
(If no, skip this section) ☐ ☐

							To Be Completed by CASA Supervisor	
New placement name	**Date of new placement[1]**	**Street address**	**City, State, Zip**	**Contact name**	**Contact phone**	**Fax**	**Type[2]**	**ICWA (Y/N)**

Comments: _____

_____

_____

[1] *If you do not know the exact date, record the month.*

[2] 1: Birth parent 2a: Guardianship/Kin 2b: Guardianship/Non-Kin 3a: Foster parent/Kin 3b: Foster parent/Non-Kin 4:Group home 5: Shelter 6: Hospital 7: CYA/Juvenile Hall 8: Transitional Housing 9: Other

CASA
Court Appointed Special Advocates
FOR CHILDREN
CASA OF LOS ANGELES

CASA Activity Log

CASA: _____ **Month/Year:** _____ **Total Hrs. for Month:** _____

Case Name: _____ **Case#:** _____

Coordinator: _____

DATE	ACTIVIITY	TIME SPENT	ACTIVITY NOTES:

Activity Abbreviations:

V = Visit In Person
PH = Phone Call
MTG = Meeting Concerning Case Issues
RPT = Writing Report
CRT = Court Appearance
SCH = School Conference
INSV = In Service Training

CHAPTER 2

The Law, the Child Protective System, and the Dependency Court Process

TABLE OF CONTENTS

Additional information:
Flowchart of Dependency Proceedings

Unit 1: Setting the Context - Evolution of Child Abuse and Neglect Laws in the United States

✓ In the city of New York in 1874, the case of "Mary Ellen" triggered public concern about abused and neglected children.

✓ Until the early part of the twentieth century, little attention was paid to the fates of children who were used as cheap labor in mines and factories.

- Textile mills, glass factories, and coal mines relied heavily on child labor during the nineteenth and early twentieth centuries.
- Many of these child laborers were under age twelve and some were as young as age four; they worked twelve to fifteen hours a day for minimal wages; many died from on-the-job injuries or suffered from occupational diseases such as black lung.
- Child labor was cheap and there were no controls or regulations regarding safety, health, and sanitation.
- In 1938, the Fair Labor Standards Act provided the first legal rights of children by setting the minimum age for child labor at sixteen for employment during school hours.

✓ Medical attention to the problem of abused and neglected children occurred in the middle of the twentieth century.

- The x-ray was developed in 1910, and by 1946, Dr. John Caffey was reporting cases of children with subcutaneous (under the skin) injuries and untreated fractures.
- In 1955, Wooley and Evans spoke out against physicians ignoring the fact that multiple injuries to children were being willfully committed by their parents.
- In 1962, Dr. C. Henry Kempe's term "battered child syndrome" captured public attention.
- With leadership from the medical profession, legislative action followed. By 1965, every state had enacted a child abuse reporting law.

✓ 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 and their families.

- In **1974**, Congress enacted the Child Abuse Prevention and Treatment Act (Public Law 93-247, amended in 1996), which created the National Center on Child Abuse and Neglect and earmarked federal funds for states to establish special programs for child victims of abuse or neglect. This law requires that states:
  - Have child abuse and neglect reporting laws;
  - Investigate reports of abuse and neglect;
  - Educate the public about abuse and neglect;

- Provide a guardian ad litem to every abused or neglected child whose case results in a judicial proceeding; and
- Maintain the confidentiality of child protective services records.

- In **1978**, Congress enacted the Indian Child Welfare Act (Public Law 95-608) as a result of congressional hearings in the 1970s that had revealed a pattern of public and private removal of Indian children from their homes, undermining Indian families and threatening tribal survival and Indian culture. The act was designed to implement the federal government's trust responsibility to tribes by protecting and preserving the bond between Indian children and their tribe and culture. The act sets up placement preference schemes for foster care placements and adoptions of children who have been determined to be Indian children. It also establishes the right of certain entities to appear as parties, including the tribe and the Indian custodian, if one exists. The act determines when and if a case should be transferred to tribal court. Many procedural and substantive rights of the Indian child and the child's tribe exist under the act.

- In **1980**, Congress enacted the Adoption Assistance and Child Welfare Act (Public Law 96-272), which is a blueprint for combined efforts of the judicial, executive, and legislative branches of government to preserve families and, if necessary, to build new families for children. The Adoption Assistance and Child Welfare Act of 1980 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 a plan for the number of children who will be in foster care for more than twenty-four months;
  - Provide "reasonable efforts" to prevent or eliminate the need for removal of the child from his or her home or to make it possible for the child to return to his home;
  - Provide a dispositional hearing for every child in foster care within eighteen months of placement and every twelve months thereafter; and
  - Have a data collection and reporting system about the children in care.

- In **1993**, through court improvement legislation, Congress recognized the courts' critical role in child welfare and encouraged reform in the court system.

- In **1994**, the Multi-Ethnic Placement Act was made law. The goals of the Multi-Ethnic Placement Act of 1994 are to:
  - Decrease the time children wait to be adopted;
  - Prevent discrimination on the basis of race, color, or national origin in the placement of children and in the selection of foster and adoptive placements; and
  - Facilitate the development of a diverse pool of foster and adoptive families.

- In **1996**, the Child Abuse Prevention and Treatment Act was amended to include **Court Appointed Special Advocates** as guardians ad litem.

- In **1997**, Congress passed the Adoption and Safe Families Act (Public Law 105-89), which 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; and
    - Permanency planning should begin as soon as the child enters foster care.

    Additionally, the Adoption and Safe Families Act stresses that the child welfare system must focus on positive results and accountability and that innovative approaches are needed to achieve the goals of safety, permanence, and well-being for children. ASFA is the guiding law that directs the time lines under which we currently operate—ASFA requires that plans must be in place after twelve rather than twenty-four months, dispositional hearings must be held within twelve months rather than eighteen months of placement, and court reviews occur every six months rather than every twelve months.

- In **1999**, the Foster Care Independence Act addressed the needs of older youth in foster care, particularly those youth aging out of the system.

From a historical perspective, it can be said that we are still relatively new to the concepts of protecting abused and neglected children and developing appropriate systems, methods, and programs to cope with the problems these children face.

UNIT 2: Who's Who is the Dependency Court

There are many people involved in a dependency case. For our purposes, we will look at them in two categories: 1) Parties, and 2) Players.

Parties

A "party" in a civil case is someone who has an actual, personal stake in the outcome of the hearing. Parties are entitled to be present at every stage of the proceedings, have a right to an attorney, and can act in the court case by putting on evidence, calling witnesses, etc. In a dependency case, the legal parties are:

- Child
- Mother
- Father
- The Agency, in the form of social workers on the case
- De facto parents, if any
- Legal guardians, if any
- Native American tribe, if any – and if the Tribe so chooses

Players

We'll call a player someone who cares about the people involved, is involved in the case, or in some other way important to the process. These individuals are essential to the process, but do not get an absolute right to be present at all stages, or have the right to an attorney.

These players are:

- Hearing Officer
  Attorneys (any party can have an attorney who will speak for the party)
- CASA volunteer
- Social workers
- Mothers and fathers who might be a parent (they have standing to assert parentage)
- Family members
- Siblings
- Important people (like step-parents, god parents, friends, etc.)
- Service providers (foster parents, therapists, teachers, doctors, etc.)

A. The Child and Child's Attorney

In California, the child is actually a party to the action. This means that the child has all the rights that any party has. The child always has a right to be in court, they can look at his/her file, and has a right to an attorney.

Also, the court must appoint a "CAPTA Guardian ad litem" (CAPTA GAL) for every dependent child. This person is charged with conducting an independent investigation of the circumstances and reporting the best interests of the child to the court. When the court appoints an attorney to a child (which is virtually always) that attorney will also be appointed as the CAPTA GAL. If there is not an attorney, then the child must be given a CASA volunteer who will become the CAPTA GAL.

Therefore, the attorney's role can be tricky, as he or she must strike a balance between representing the stated interests of the child versus what the attorney feels is best for the child (what the child wants versus what is best in the attorney's opinion). Unlike a CASA the child's attorney is also bound by the attorney-client privilege, and cannot reveal secrets that the child confides. The result is that the child's attorney is a very powerful player.

As a CASA, even if you are not officially appointed as the CAPTA GAL, your role is very much the same: investigate independently and report your understanding of the child's best interests to the court.

B. The Social Worker and County Counsel

Probably the most powerful player – who is also a party in his or her official capacity – is the social worker. Simply put, the social worker is the key player in the delivery of services to the family and child. The social worker has a duty to ensure the child's safety, investigate and report to the court, engage the family with referrals and services, respond to requests from the court, and basically do all of the social work and paperwork on the case.

This is a very large task indeed. If something happens with the school – call the social worker; child needs therapy – call the social worker; child has an issue with the medical insurance – call the social worker; mother needs to drug test – social worker will set it up; father needs a job – there must be something the social worker can do. The result is a social worker who has limited time but unlimited responsibility.

Because of this, the court will often give the social worker the discretion to make most decisions for the child – until someone requests review by the court. Therefore, the social

worker uses his or her education, experience, and understanding to best serve the family. Because of this, the social worker is one of the most important individuals in the child's case.

C. The Different Social Worker Roles

Some argue that it is best for there to be one social worker assigned to a child's case, and for that worker to stay from beginning to end. However, while this is not true for every county, many social service agencies choose to compartmentalize the work. This means that the child may have several different social workers, each who works on only one stage of the case. Each Department of Social Services determines how to best use its resources, so each county is different.

Since each county does things differently, it is nearly impossible to give an exhaustive list of the social workers who might work on a child's case. Here are a few examples to give an idea of how workers might be assigned. For example:

- **Informal FM** Worker – aka Informal Family Maintenance Worker. It is possible that the court is not yet involved in the case, but the Agency is. If this is the case, then there will be a social worker trying to work with the family to keep a safe environment for the children.

- **ER** Worker –aka Emergency Response worker. This social worker may respond to the report of child abuse and make the preliminary investigation and may make the decision to detain a child from the home until more investigation can be done.

- **DI** Worker – aka Dependency Investigations worker. This social worker may take the case over and investigate more thoroughly. This worker might determine whether or not to file a petition and what the petition says. He or she would be responsible for drafting a case plan for the family and ensuring that services start as soon as possible.

- **FR** Worker – aka Family Reunification worker. This worker would be assigned if the child is removed from the home and juvenile court jurisdiction is taken. Here, the social worker will work to provide the family with referrals and services to reunify the family.

- **FM** Worker – aka Family Maintenance worker. This is the worker assigned to a child and family when the child is a dependent of the court but still living at home. He or she does their best to ensure that services are given to make the home safe so that the child does not need to be removed.

- **Permanency** Worker. This is the worker who is assigned to a child once services have stopped and the child is placed into long-term foster care or a legal guardianship. He or

she focuses on the child and ensuring that the child finds permanent connections with people the child cares about.

- **Adoptions** Worker. This is the social worker who is assigned to the case when the child is going to be adopted. He or she focuses on getting the necessary documents and clearances needed to finalize an adoption.

D. Understanding Role Differences

It can be difficult to be a CASA volunteer. Oftentimes the things you do will look like a friend, others it will look like an attorney, and other a social worker.

Therefore, it can be necessary to clarify the difference between a CASA volunteer and a Social Worker. The comparison below may help to define the responsibilities of each.

Social Worker	CASA Volunteer
Writes petition to the juvenile court, is responsible for substantiating allegations in the petition.	Does not participate in substantiating allegations.
Is responsible for development and management of the case plan.	Works with the social worker to identify gaps in services to the child.
Provides and oversees services to the family, i.e., transportation, supervised visitation, mental health services, parenting classes, domestic violence classes, drug treatment and testing, etc.	Ensures that the court is aware of any needed services and if they are being delivered.
Visits the child once a month at least and has a caseload of 30-50 children.	Visits the child much more frequently, usually has only one CASA child or sibling group.
Makes reports and recommendations to the court.	Investigates the child's situation, gathers information, and makes recommendations to court.

E. Parties and Players

To encourage discussion, here is a listing of some of the parties and players involved, along with some of their roles and responsibilities.

The Child (Party)

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 that he/she can live in a safe, stable home without ongoing need for intervention.

An appropriate plan will address safety/protection, placement if the child is out of the home, family contact, belonging to a family, financial support, a support system, education, mental health, physical health, and other "quality of life" issues.

The child needs services to be provided that will meet his/her needs.

Other _____

CASA Volunteer (Player)

The role of the CASA volunteer is to:

Independently investigate the child's case.

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 within and outside the courtroom.

Monitor the case.

Be the voice of what is in the child's best interest.

Be the voice of the child's expressed wishes.

Other _____

The CASA volunteer brings to the case:

An interest in improving the life of the child through the court process.

Time, energy, focus, and longevity.

An "outside the system" point of view and an independent perspective.

The community's standard for the care and protection of its children.

Other _____

Attorney for the Child (Player)

The role of the child's attorney is to:

Represent the child's wishes and/or best interests and protect their legal rights.

Translate his/her (and, ideally, the CASA volunteer's research and recommendations from his or her court reports) recommendations into a form that the court can effectively use to address the child's needs.

File legal documents relevant to the child's case and ensure that the child's rights are respected throughout the case.

Other _____

What does the child's attorney bring to the case?

Attorneys bring legal expertise, facilitation and negotiation skills, and courtroom experience.

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

He or she is involved from the petition filing through the end of the court case.

Parents or Caretakers Named in the Petition (Party)

Why are the parents/caretakers involved in the case?

They have been forced into the court action because the child welfare agency asked the court to intervene to protect their child.

They need to comply with the child welfare agency's intervention plan and correct the conditions that led to the child's removal, which means effectively protecting their child and/or enabling their child to return home.

They need to follow the orders of the court – or they risk having their parental rights taken away ("terminated").

What do the parents/caretakers bring to the case?

The parents bring their love of the child, family ties, a history of parenting, abilities, and skills as parents, interactions with the child and with each other, mental and emotional health, physical health, support systems, housing, income, and their own set of challenges.

Attorney for the Parent/Caretaker (Player)

The role of the attorney for the parent/caretaker is to:

Represent the wishes of the parent/caretaker he/she represents.

Protect the legal rights of the parent/caretaker in court.

Advise the parent/caretaker on legal matters.

File legal documents relevant to the case.

Other _____

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

He/she brings legal expertise, facilitation and negotiation skills, and courtroom experience.

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

He/she is involved from the petition filing through the end of the court case.

Social Worker/ Child Welfare Worker / CPS Worker (Party in their official capacity)

What is the role of the child-protection agency caseworker in the case?

The caseworker has completed a risk assessment process and, based on risk or substantiated allegations of abuse and/or neglect, has determined the need for court intervention. The caseworker petitioned the court to intervene on the child's behalf because:

- He/she has developed an intervention plan with the family, which has not sufficiently eliminated the risk that child maltreatment will happen again, or
- Due to risk of imminent danger, the caseworker has already removed the child from her home to ensure the child's safety.

The caseworker needs the court to order that the agency's intervention and treatment plan be followed by the parents/caretakers and other service providers so that the child receives proper care and protection without continuing 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.

Other _____

The child-protection agency caseworker brings:

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 the family can access resources outside the child protective services system.

When is the child-protection agency caseworker involved in the case?

A caseworker is involved from the initial contact with the family and/or child until the agency's services are no longer needed.

Attorney for the Child Welfare Agency (County Counsel) (Player)

The role of County Counsel is to:

Represent the position of the agency/county/state (who employs the social worker) in court.

Protect the agency from liability.

Advise the agency regarding its responsibilities as outlined in the law.

File legal documents relevant to the case.

Other _____

What does this attorney bring to the case?

He/she brings legal expertise, facilitation and negotiation skills, and courtroom experience.

When is this attorney involved in the case?

He/she is involved from the petition filing through the end of the case.

Indian Child's Tribe (Party or Player – they decide)

The role of the Indian child's tribe is to:

Represent the "best interest of the child" as defined by the Indian Child Welfare Act (ICWA) to the courts.

Ensure the parents, child, and tribe's rights as required by ICWA are respected.

Bring culturally relevant service options and recommendations about what should happen to the attention of the court.

Protect the tribe's interest in the child and ensure the preservation of their relationship.

Where appropriate, offer or require that the tribe take jurisdiction of the matter.

File legal documents when it is necessary.

Other _____

What does the tribe bring to the case?

The tribe brings its special perspective on preservation of the child's ties to the tribe. In addition, the tribe has the knowledge of relevant cultural practices and culturally relevant services that can be considered as potential resources for the child.

JUDGES, COMMISSIONERS AND REFEREES

Judges, commissioners and referees hear cases in Juvenile Court.

JUDGES are elected officials. Their term of office is 6 years. Most judges first become judges not by election, however, but by being appointed by the Governor to fill a term left vacant by a sitting judge's resignation, retirement, or death. The newly appointed judge finishes out the unexpired term, but then must run for re-election. If no one files to run against a judge in a re-election, the judge is automatically re-elected and his or her name never appears on the election ballot. The only time judicial candidates' names are on the ballot is when someone files to run against an already sitting judge, or when a judge decides to retire at the time of re-election and the seat is then "open" and candidates run for election to the seat. Since it often happens that only one person files for an open seat sometimes a candidate's name appears on the ballot with no opposition.

Judge are appointed or elected to serve the Superior Court of a particular county, but they are employed and paid by the state. Juvenile Court is a division of the Superior Court, just like civil, criminal, and probate. A Superior Court judge may sit in any of the divisions, by assignment of the Presiding Judge of the Superior Court of the county. The number of judges a county has is determined by the legislature.

Los Angeles County, like many counties, does not have enough judges to manage its heavy caseloads. So, like other counties, it uses commissioners and sometimes referees.

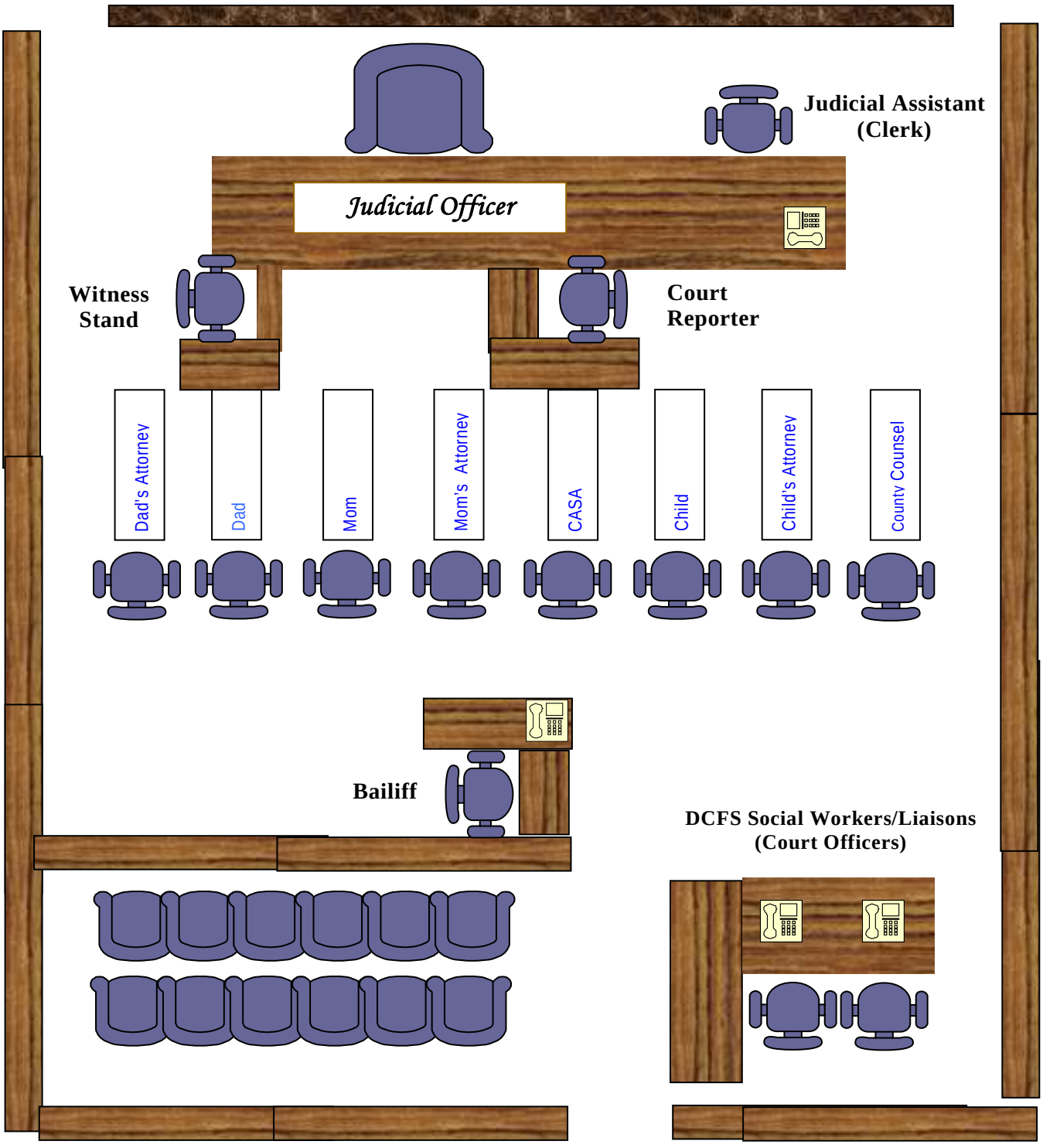
COMMISSIONERS are selected and hired by a Superior Court Committee of Judges, and they are full time court employees. They do not serve for a particular term; they serve "at the pleasure of" the judges. There are some civil service protections, but commissioners can be fired by the Judge's Committee. Commissioners must be stipulated to before they can hear cases. This means all the parties in a case must acknowledge, in writing, that they understand the person hearing the case is not a judge and agree to allow that person to hear the case anyway as a judge pro temp (temporary judge). In Dependency Court, stipulations are not mandatory, but they are strongly encouraged because Court orders made by a commissioner or referee which involve removing a child from a parent or keeping a child out of a parent's home must be countersigned by a judge, and all orders are automatically subject to an application for rehearing by a judge.

The number of commissioners in a county is set by a County's Board of Supervisors. Los Angeles has 226 judgeships and 63 commissioners. The word "judgeships" is used rather than judges because there are usually vacant judicial seats.

Because even with commissioners there is still a shortage of judicial officers in Los Angeles, there are currently approximately 20 referees serving as judicial officers mostly in the Juvenile Courts.

REFEREES are court employees, hired by the Superior Court on an "as needed" basis. They are paid a daily rate for each day they serve. Some referees serve on a regular daily basis, and some only occasionally in emergencies, such as when judges or commissioners are ill or are on vacation. Referees are also used to fill in temporary vacancies caused by the reassignment of a judge or commissioner. In Delinquency Court, referees must be stipulated to as judges pro temp. The stipulation is preferred in Dependency Court, but it isn't required and may or may not be requested on a particular case, just as with commissioners.

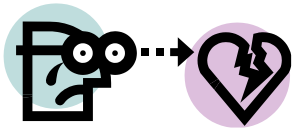
The most important thing to remember about judges, commissioners and referees is that they are all to be addressed as "Your Honor" and they are the decision makers on the cases.



Unit 3: Dependency Court Process and the CASA

How a Child Enters the Dependency System

A child is either abused, neglected, or at risk for abuse or neglect.



Child Protective Services discovers the situation, and investigates.

The next step depends on what the Agency finds.

If the abuse is unsubstantiated,

Then, nothing is done, but a record is kept of the report. This is also known as being "evaluated out." The Agency may provide referrals to help the family.

If the abuse is substantiated,

but is unlikely to reoccur, or is correctable,

Then, depending on the need, the Agency either does nothing, offers some quick help, or if the family needs more help, then the Agency may refer the family to "Informal Family Maintenance," which means that the Agency works with the family on a voluntary basis. While there is no court involvement, the Agency works with the family for a few months to try to correct any problems and reduce any risks.

If the abuse is serious enough to need court intervention,

or

If the child needs to be

removed from the home,

Then, the Agency files a "petition" in court to ask that the child come under the protection of the Juvenile Court.

Once the Agency files a petition, the court gets involved.

File Petition

Welfare and Institutions Code §300

Detention Hearing

Court determines, based on prima facie evidence, if the child must be detained pending Adjudication; appoints attorneys, makes Paternity and ICWA inquiries, and orders services. Court may refer the case for a CASA at this hearing or any subsequent hearing.

Adjudication (aka Jurisdiction Hearing or Pre-Trial Resolution Conference)

Focus is on the facts of the petition allegations. Court hears arguments, and allegations are sustained or dismissed. CASA Report may not address allegation issues. At this and every hearing, the CASA should always inform the Court of the child's needs and circumstances and make appropriate recommendations.

Disposition Hearing

Court formally declares child to be a dependent of the court and determines if the parents shall receive Family Reunification (FR) services in order for the child to return home. If so, the Court orders parents to follow the Case Plan for reunification and sets a review hearing (.21e) in six months. CASA Report should focus on return to parent, placement with relatives or foster care placement. It should also make recommendations regarding visitation as well as any services the child and family may need in accordance with the best interest of the child. If FR services are not ordered, the Court will set a date for a P.26 Hearing to make a permanent plan for the child.

Six-Month Review Hearing §366.21(e)

The CASA Report should address if return to the parent is safe and in the best interest of the child. If not, and the child was over the age of 3 at the time of detention, the court will grant 6 more months of reunification services. The CASA should recommend services needed to reunify the family. If the child was under three, the CASA should address if there is a substantial probability for safe return if six more months of FR services were granted. Otherwise, the CASA should address the need for FR to be terminated and a date set for a .26 Permanency Planning Hearing.

Permanency Planning Hearing §366.26

A .26 hearing may be set at any time after FR is terminated in order to make a permanent plan. At this hearing, the CASA should address what permanent plan is in the best interest of the child: adoption, legal guardianship, or another planned permanent living arrangement. A permanent plan of adoption requires parental rights to be terminated at this hearing.

Review of Permanent Plan (RPP)

After the Court orders a permanent plan and Court jurisdiction continues (e.g. the child is in long-term foster care, guardianship, or the adoption has not been finalized) the Court will continue to review the case every six months. At this hearing the Court must consider what progress has been made to provide the child with a permanent home. The CASA should address the appropriateness of the permanent plan and inform the Court of the child's circumstances and needs and make appropriate recommendations.

Twelve-Month Review Hearing §366.21(f)

The CASA should address the same issues as those that are addressed at the .21(e) hearing. If it is not possible at this hearing for the child to be returned to the parent, the CASA should address the likelihood of the child being returned if FR services were extended until 18 months after the initial removal date.

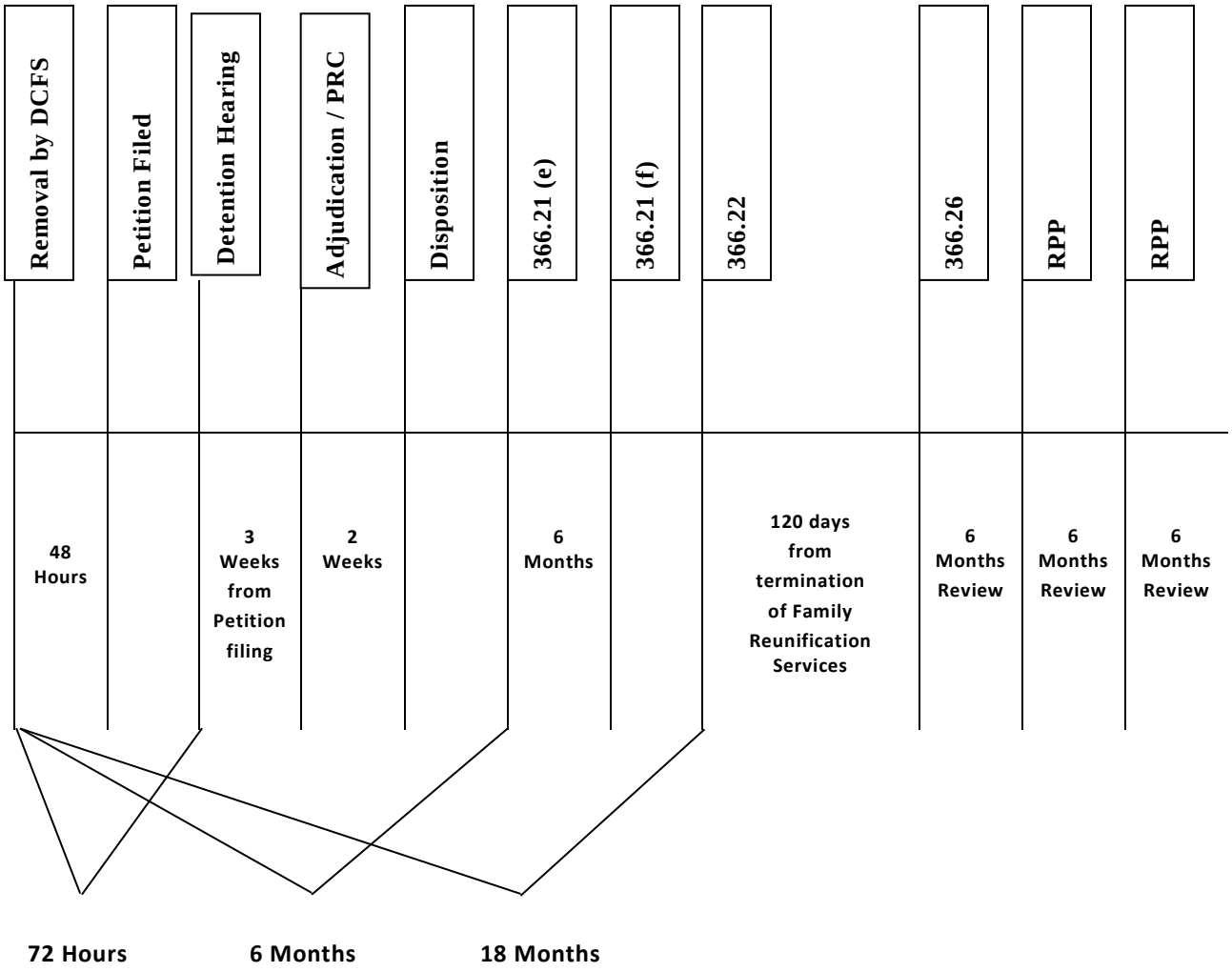
Eighteen Month Review Hearing §366.22

This is the last hearing to address the likelihood of a safe return to the parents. The CASA should state a position about whether or not the child can be returned home. If not, the Court must terminate Family Reunification services and proceed to a permanent plan hearing.

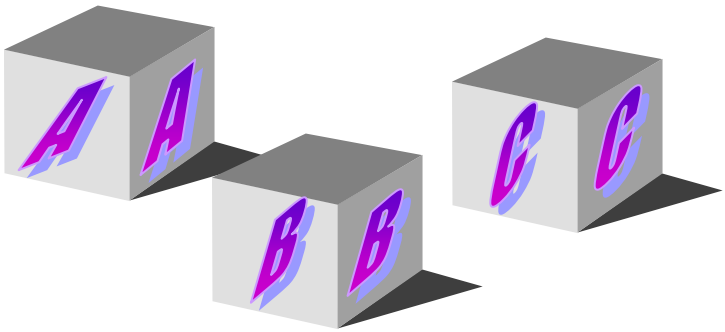
Return to Parents

Unless parental rights are terminated, the court may order the child Home of Parent at any hearing. The court may terminate jurisdiction at that time or order that Family Maintenance services be provided and set a review hearing (JR 364) to determine if the case may be closed.

Unit 4: Timeline for Hearings



The ABC's of the Los Angeles Dependency Court System



Amy M. Pellman,
Los Angeles Superior Court Judge
January 2012

Individual children, circumstances, and cases vary greatly, and the laws and regulations governing children in dependency are subject to change at any time.

The ABC's of the Los Angeles Children's Court

1. ENTERING THE DEPENDENCY SYSTEM

How Children Come Into The System

Children (any person under the age of 18 years) are referred to the dependency court system in a variety of ways. Any person can call the child abuse hotline and make a report of suspected child abuse or neglect. Some of these calls may be from relatives and others from anonymous sources. Referrals are also made by mandated reporters such as teachers, doctors and other health care professionals who, by statute, must report suspected child abuse. Some children are referred at birth if they are born with drugs in their system.

Are All The Children Detained?

A Department of Children and Family Services (DCFS) social worker who has reasonable cause to believe that a child has been abused, neglected or abandoned and therefore falls within the description of Welfare and Institutions Code (WIC) Section 300 (a-j), and is in immediate danger, may detain (take temporary custody of) a child. (WIC 305) Children may also be detained if they are left without adequate supervision or are abandoned. If a child is left unattended, the social worker (known as Emergency Response (ER) workers) must first try and locate a parent or guardian before detaining the child. Before detaining the child, the social workers must first consider whether providing child welfare services would prevent or eliminate the need for removal. (WIC 319) Voluntary services can be provided in lieu of filing a petition and detention. See WIC 16506(b), 16507.4, 16507.5.

There are situations where the ER worker determines that the child is not in immediate danger but there are facts sufficient to file a dependency petition under WIC 300. In those cases, the parent(s) are ordered to bring their child(ren) to dependency court for an Initial Hearing where the court will determine whether detention of the child(ren) is necessary. (WIC 319) Children brought under the jurisdiction of dependency court are commonly referred to as “dependents” while children who commit crimes and are brought under the jurisdiction of the delinquency system are referred to as “wards” or “delinquents”.

What Happens To Cases In Other Courts?

When a case comes to dependency court there may be related proceedings in other courts. For example, if a parent is being criminally prosecuted for child abuse, that court action can proceed simultaneously. Similarly, if a child has a personal injury action, this can also proceed. However, dependency court has superior and sole jurisdiction for all issues involving a child’s custody from the date the petition is filed until the case is either dismissed or jurisdiction is terminated. (WIC 304) Thus, any family court action or guardianship proceedings are stayed (stopped) until the dependency proceeding is over. At the conclusion of the dependency court case, the court may make final custody and visitation orders that would remain in effect indefinitely unless a modification is sought in family court. A custody order of the Juvenile Court cannot be modified unless the party can show that there is a significant change in circumstances since the Juvenile Court issued its order and it is in the best interest of the child. (WIC 302)

When a Dependent Commits a Crime

The most common situation occurs when a child who is already a dependent of the Juvenile Court is charged with a crime and in danger of becoming a delinquent. In this situation, the Probation Department and DCFS are mandated to file a joint assessment report. The report recommends which status would serve the child's best interest and at the same time protect the public safety. (WIC 241.1) The assessment report should consider all relevant data on the child and include a statement from the child's attorney and a Court Appointed Special Advocate, if the child has one. The 241.1 protocol was recently expanded to include other California counties outside of Los Angeles County. Thus, if a child is a dependent in Los Angeles County but is arrested in San Diego, then a 241.1 joint assessment must still be made.

The most common situations where a 241.1 joint assessment is called for are the following:

1. When a dependent child commits a crime.
2. When a child is home on probation and is the victim of child abuse.
3. If probation seeks to terminate a delinquency case but the child cannot be returned home due to the potential of abuse or neglect in the home, or there is no home to which the child can returned.
4. A delinquency petition is filed (WIC 602) on a child who is not a dependent but the arraignment report suggests that abuse or neglect may have played a significant role in the criminal act.

Under WIC 241(e), a county can create a jointly written protocol to allow a child to simultaneously be a dependent child and a ward of the court. The protocol must be signed by the chief probation officer, the director of the county social services agency, and the presiding judge of the juvenile court prior to the implementation. Los Angeles County currently has a pilot project for this new protocol.

As of 2011, 241.1 has been amended to allow a former dependent child who has become a delinquent or dual status child and no longer fits the description of a delinquent to petition the dependency court under WIC 387 or WIC 388 to reassert his or her status as a dependent as long as they fit that description under WIC 300.

Confidentiality of Dependency Court Cases

Dependency (and delinquency) court records and proceedings are confidential to protect the identity of children from public exposure. (WIC 827 - 828.3, California Juvenile Court Rule 1423) Those entitled to have access to the records and proceedings include the parties (parents, guardians and children), their attorneys, the District Attorney, City Attorney or prosecutor, Court staff and the social worker and probation officer assigned to the case. Also entitled to access is "any person or agency providing treatment or supervision of the child", a judge, court-appointed child custody evaluator or mediator assigned to a family law case, a court-appointed evaluator in a probate guardianship case and Juvenile Justice Commissions. These recent additions are a result of a trend toward loosening the confidentiality requirements. Although these individuals are entitled to access, they may not disseminate any case related information to the media or any other individual or entity who is not a party to the case.

Other individuals or organizations such as a representative from a TV station, newspaper or other media organization or a defendant or plaintiff in a civil or criminal matter, are not automatically entitled to access the court files. In order to gain access, the individual or organization must file a Petition for Disclosure of

Juvenile Records with the Presiding Judge of the Juvenile Court. The Presiding Judge reviews each petition on a case-by-case basis.

2. COMMENCEMENT PROCEEDINGS

Who Are The Players And How Are The Parties Appointed Counsel?

In dependency court proceedings, parents, children and the county all have appointed counsel. Below is a description of the different organizations that represent the parties as well as the other important players in the court.

County Counsel

County Counsel represents The Department of Children and Family Services (DCFS) and appear with the DCFS social workers on behalf of DCFS. They are not prosecutors, since no criminal charges are heard by the dependency court, but County Counsel is sometimes thought of as being most analogous to prosecutors as they bear the burden of proof on behalf of DCFS in the dependency action.

Children's Law Center of Los Angeles (CLCLA)

Children's Law Center, formally known as Dependency Court Legal Services, is a legal services organization which is devoted to representing children in dependency proceedings. Established in 1990, CLC formerly represented both children and parents. On May 9, 1996, the Local Rules of the Juvenile Court were amended (Local Rule 17.16) making CLC the primary representative for children in dependency court proceedings in Los Angeles. Children in a dependency proceeding are considered separate parties and are therefore entitled to separate counsel. (WIC 317.5, WIC 317(c)) The local rules also state that County Counsel can no longer represent children under any circumstances.

Parents' Attorneys/ Los Angles Dependency Lawyers, Inc.

Until January 1, 2007, parents were presented by "panel attorneys" who were generally solo practitioners paid on a flat fee basis. The Juvenile Court presiding judge concluded that an organization similar to CLCLA would better serve the needs of the parents and a new nonprofit was formed, named Los Angeles Dependency Lawyers Inc.(LADL) This organization is comprised of four firms (to avoid conflicts of interest) that represent the parents in dependency actions.

Court Officers

Each courtroom has assigned attorneys from the above categories and one or two court officers. These individuals are social workers employed by DCFS. Their function in the court includes: acting as a liaison between the County Counsel and the social worker in the field, organizing and handing out reports on each case to the attorneys, and being a consultant on the cases pending in the court.

Court Reporters

Court Reporters transcribe all the proceedings at every court hearing. If a case goes up on appeal, the court reporter will be required to transcribe the entire court hearing and the parties will receive a copy of the transcript.

Bailiff

The bailiff is employed by the Sheriff's department. Clients and attorneys must check in with the bailiff when they arrive in the morning. The bailiff then also makes a list on the dry erase board in the courtroom of everyone present. Their main responsibilities are protecting the hearing officer and the rest of the court staff and making sure that there are no violent altercations. If a parent is incarcerated, bailiffs supervise that individual and bring him or her from a cell on the bottom floor to a separate holding cell outside the courtroom.

Court Clerks

Dependency court clerks are responsible for taking down the orders of the court and memorializing them in a "minute order" after each court case. The minute order is the critical instrument in a Dependency case as it contains all the orders and findings of the Judicial Officer at each court hearing. The clerk also keeps the court's calendar and advises the court when it has a busy schedule and when there may be openings for trials.

Judicial Officers

Judicial Officers (also referred to as "hearing officers") who sit in dependency court may be referees, commissioners or judges, including temporary judges or "pro tems." There are currently twenty-two courtrooms in dependency court. If a referee is sitting, any party may request a rehearing on an order or finding. A rehearing application must be filed within ten days of the written order. If a rehearing is granted, a judge will hold a hearing on that issue. (WIC 252)

The Application for Petition, Petition and Detention Report

When the case first arrives in court, the attorneys assigned to the case will receive the above named documents. An emergency response (ER) worker writes the application for petition and the detention report but the actual petition is written by a social worker who specializes in drafting legally correct petitions. The name of the oldest child becomes the name of the case. If there is more than one child, the case name will be "name of oldest child, et al."

The application for petition lists the names of the children and the parents and the whereabouts of all the parties. It describes the situation which led to the filing of the petition and the efforts of the social worker, if any, to alleviate the need to detain or file the petition. The application may also include interviews with the parties.
The petition is the legal document by which the court determines whether there is sufficient evidence to find that the child falls within the jurisdiction of the dependency court. (WIC 332) The "counts" are factual allegations against the parent(s), which correspond to the legal paragraphs WIC 300 (a)-(j). These sections will be described in more detail below. The petition is the key document in any dependency case.

Finally, the detention report states the name(s) of the child(ren), if and where they are detained, reasons and recommendations for detention and statements from the child(ren) (if age appropriate) and the parent(s) concerning the detention.

Registered Domestic Partners

Registered domestic partners now share the same rights and responsibilities as are granted or imposed on spouses, including rights and obligations with respect to a child of either partner. Family Code §297.5(a), (d). Gender-specific terms referring to spouses now must be construed to include domestic partners. Family Code §297.5(l). Thus, parents who are registered domestic partners have the same right to attend and participate in dependency hearings as heterosexual parents.

Welfare and Institutions Code 300

Section 300 describes the various types of abuse and neglect that, if the court finds to be **true by a preponderance of the evidence,** would be the basis for court jurisdiction. The following is a summary of the subdivisions:

300(a) Physical Abuse

The child has suffered, or there is a substantial risk that the child will suffer, serious physical harm inflicted non-accidentally by the child's parent or guardian. This type of abuse does not include age-appropriate spanking to the buttocks. The key word in this subdivision is that the child has suffered injury or is at risk to suffer injury "non-accidentally." "Non-accidentally" means the parent or guardian inflicted the abuse through a volitional act, even if the parent or guardian did not actually intend to harm the child.

300(b) Neglect

The child has suffered, or there is a substantial risk that the child will suffer, serious physical harm or illness, as a result of the failure of his or her parent or guardian to: (1) adequately supervise or protect the child; (2) provide adequate food, shelter, or medical treatment; or (3) provide adequate care due to mental illness, developmental disability or substance abuse. If a child is born with a positive toxicology for drugs or alcohol, the court can take jurisdiction under this section. Unlike the above subdivision, this subdivision refers to neglect or omission to act but not intentional abuse.

300(c) Emotional Damage

The child is suffering serious emotional damage, evidenced by severe anxiety, depression and/or aggression to oneself or others, or is at substantial risk of suffering serious emotional damage as a result of the conduct of the parent or guardian.

This subdivision is applicable when the parent or guardian is responsible for the child's severe emotional problems or does not have adequate resources to care for a child with serious emotional problems. It is not necessary that the parent or guardian actually caused the initial psychological trauma that resulted in the serious emotional damage, so long as the parent or guardian has failed to take the steps necessary to help the child deal with that emotional damage. An example would be if the child suffers psychological trauma at the hands of a third party, and the parent or guardian fails to secure counseling for the child which results in the child suffering serious emotional damage.

300(d) Sexual Abuse

The child has been sexually abused or there is a substantial risk of being sexually abused by his or her parent, or a member of the household. Sexual abuse is defined in Section 11165.1 of the Penal Code. Or, the parent or guardian has failed to adequately protect the child from sexual abuse when the parent or guardian knew or reasonably should have known that the child was in danger of sexual abuse.

Attorneys should be familiar with Penal Code section 11165.1 when this subdivision is pled, since it is controlling in this instance.

300(e) Severe Physical and Sexual Abuse

The child is under five years of age and has suffered severe physical or sexual abuse by the parent, guardian or a person known by the parent. If a parent or guardian knew, or reasonably should have known that the person was physically abusing the child, they are similarly culpable.

This subdivision is important not only because of the seriousness of the abuse but also because if this allegation is found to be true (sustained) the court must deny family reunification services unless: the court can find, based on competent evidence that reunification services would prevent re-abuse or that not ordering services would be detrimental to the child because of the child's close attachment to the parent. (WIC 361.5(b)(5)) Under this subdivision, a parent may be denied family reunification services not only for personally inflicting the injury, but also if they knew or should have reasonably known that the abuse was taking place.

300(f) Causing the Death of Another Child

The child's parent or guardian has caused the death of another child through abuse or neglect.

Like subdivision 300(e), a perpetrator can be denied family reunification services if this count is sustained. However, a parent can only win those services back if the court finds by clear and convincing evidence that offering those services would be in the best interest of the child. (WIC 361.5(b)(4), 361.5(c)) Since the perpetrator need only have caused the death, but not necessarily been convicted by a criminal court, the Juvenile court could be put in the position of conducting murder trials. This can be especially complicated when a parent is awaiting trial in criminal court and the proceedings in juvenile court are used as discovery in the criminal trial.

300(g) Abandonment

The child has been left without any provision for support; parent has been incarcerated or institutionalized and cannot arrange for the care of the child; parent or guardian is unable or unwilling to provide support; or the whereabouts of the parent(s) is unknown. An incarcerated or institutionalized parent can rebut the presumption of abandonment if they prove they made adequate arrangements for the care of the child.

In January 2001, subdivision (g) was amended to include a situation where a parent "voluntarily surrenders" a child who is 72 hours old or younger and does not reclaim that infant within 14 days. This and related statutes were enacted to save infants whose parents abandon them at birth. The most common and often tragic of these situations is where a mother places a newborn

in a dumpster in the hopes that no one will discover that the mother was both pregnant and gave birth. Now, a parent can drop off a baby at a hospital without being questioned or prosecuted. Thus, a parent who voluntarily surrenders an infant within the statutory time (72 hours of birth) will not be **criminally** prosecuted for abandonment. However, the entity that receives the child must notify the applicable social service agency (DCFS in Los Angeles) and the agency must then file a petition pursuant to subdivision (g) of the Welfare and Institutions Code and any other applicable subdivision. (See also, Health and Safety Code 1255.7 and Penal Code 271.5)

300(h) Freed for Adoption

The child has been freed for adoption by either relinquishment or termination of parental rights for twelve months, or an adoption petition has not been granted.

300(i) Cruelty

The child has been subjected to an act or acts of cruelty by the parent or guardian or a member of the household, or the parent or guardian has failed to adequately protect the child from acts of cruelty when they knew or reasonably should have known that the child was in danger.

This subdivision can only be sustained if there are extreme and severe acts of maltreatment such as starvation or torture. Or where the abuse "shocks the conscience" such as where the child is locked in a closet for extended periods of time, or kept in a dog crate for extended periods of time.

300(j) Abuse of Sibling

The child's sibling has been abused or neglected as defined in subdivision 300(a), (b), (d), (e), or (i), and there is a substantial risk that the child will be abused or neglected, as defined in those subdivisions.

This subdivision allows siblings who may not have been abused or neglected to become dependents of the court. The rationale is that if one child has been abused, there is a substantial likelihood that other children in the family may also be abused. There is no need for the child who was abused or neglected to have been adjudicated a dependent or even still to be a child, as long as the abused or neglected sibling suffered abuse or neglect by the parent or guardian as defined in the above subdivisions. The court must, however, consider other factors such as age, gender and the nature of the abuse or neglect when deciding whether to take jurisdiction under this subdivision.

3. STATUTORY HEARINGS

Detention Hearing/Arraignment

The first hearing in a dependency proceeding is the Detention (WIC 319) and Arraignment hearing. Under Juvenile Court Rule 1440, the detention hearing is now referred to as the "Initial Hearing," because it is the first hearing conducted by the juvenile court in a dependency case and is conducted regardless of whether the child was actually removed from the home or not. Although "arraignment" is a term used in criminal cases, not dependency cases, the Los Angeles County Juvenile Court follows a local practice of referring to this as an "arraignment" since the parents are advised of the allegations in the petition and of their rights at

this hearing, much as they are at a criminal arraignment. As stated above, the application for petition, the petition and a detention report are the documents that are filed with the court. Statutorily, DCFS must file a petition within 48 hours after a child is detained and a hearing must be scheduled as soon as possible or before the expiration of the next judicial day after the petition is filed. (WIC 313, 315) If a child has not been detained but a petition has been filed, the initial hearing must take place as soon as possible.

DCFS is obligated to place children who are detained with a relative or an able and willing non relative extended family member (WIC 362.7, 309(d)). In January 2002, the California legislature allowed a new group of individuals to be available for placements for children in foster care. These individuals, called "**non relative extended family members,**" are defined as any adult with an established familial or mentoring relationship with the child. Examples may include distant relatives, relatives of half-siblings, teachers, clergy, neighbors, and family friends. Like relatives, the non relative extended family member's placement must comply with the same requirements of a foster parent. (WIC 362.7)

If a relative or non relative extended family member is unavailable or unsuitable, the child will be placed in a foster home, group home or a non-secure facility. DCFS must notify the parent or guardian immediately (usually within five hours) that the child has been detained and must provide a telephone number at which the child can be contacted. (WIC 308)

The address of the foster home can remain confidential until the disposition hearing unless the disposition hearing is more than sixty days from the date of detention, at which time the judge may authorize the disclosure of the address. DCFS may, in its discretion, deny telephone contact before the detention hearing if they deem that contact detrimental. When a child is over the age of ten and detained, that child is entitled to make two phone calls - one to his or her parent, guardian or other relative and one to his or her attorney. (WIC 308)

When children are in foster care, they are generally brought to court (if four years or older) to an area in the courthouse called "Shelter Care." This is a private area where children can take part in a variety of activities until they are called to court. The Court Appointed Special Advocate's office does a general introduction to dependency court for the children in shelter care and accompanies them to and from court hearings. Shelter Care also has areas for attorney interviews and family visits.

The issue at the detention hearing is whether the child should be detained pending the jurisdictional hearing. (WIC 319) Any party or person with relevant knowledge may present testimony on the issue of detention. If the court finds a "prima facie" case (just enough evidence on the face of the court documents) and one or more enunciated circumstances, the child will be detained out of the home of the parent(s). The court must find that the child comes within the description of WIC 300, that continuation of the child in the parent's home is contrary to the welfare of the child and any one of the following circumstances exist: (1) there are circumstances which show a substantial risk to the physical safety of the child, (2) the parent is likely to flee, (3) the child left a court ordered placement, or (4) the child refuses to return to the home where the alleged physical or sexual abuse occurred. If these elements cannot be proven, the child must be released to the parent(s). (WIC 319)

Children who are 10 years of age or older are entitled to be present at all hearings. If a child is not present, the court must determine whether the child was properly notified of their right to attend the hearing and ask why the child is not present. (Cal. Rules of Ct., Rule 1412(n))

Relative Placement

As stated above, if a child is detained, DCFS must attempt to place the child with an appropriate relative. If the child was not initially placed with relatives but there are relatives available, the court will order a pre-release investigation (PRI). The purpose of this order is to investigate the safety of the relative's home and determine whether the caretaker/relative has a history of criminal convictions and is a suitable placement for the child.

The definition of a relative is any adult who is related to the child by blood, adoption or affinity within the fifth degree of kinship, including stepparents, stepsiblings and all relatives whose status begins with the words great, great-great, or grand, or the spouse of any of these persons, even if the marriage was terminated by death or divorce. Preferential consideration, however, is given only to a child's grandparent, aunt, uncle or sibling. (WIC 319) Before placing the child with a relative, DCFS must consider the relative's suitability. Some elements that are assessed include: an in-home assessment, the results of a criminal records check (commonly referred to as a "CLETS"), fingerprinting (commonly referred to as "livescan") and any prior child abuse allegations. (See also, WIC 309) A child can be placed in a home of a relative or nonrelative extended family member whose home has been "assessed" but not "approved" by DCFS.

Criminal Records Exemptions

A criminal conviction is not always an absolute bar to placement. DCFS can grant an exemption and allow the child to be placed in the home as long as there is enough evidence to support a reasonable belief that the person with the criminal conviction is of such good character as to justify the placement and not present a danger to the child. (WIC 309 (d)(4)). Certain felony crimes are not available for exemption such as drug or alcohol related convictions within the past five years, assault and battery and other violent crimes. (See Health and Safety Code 1522)

Sibling Placement

The court must also consider sibling relationships at placement. The court must investigate whether there are any siblings currently under the court's jurisdiction, the nature of the sibling relationship and the appropriateness of developing or maintaining that sibling relationship. (WIC 361.2(j)) As of January 2004, notice of court hearings must now be given to other dependent siblings. As of 2011, siblings must be placed together unless the court finds that such placement would be contrary to the safety or well-being of any one of the siblings. (WIC 16002)

In addition to the sibling relationship, the court and DCFS are required to consider other factors when placing a child including but not limited to: the best interest of the child, the protection of the child from their parents, relative's ability/willingness to assist with the implementation of the case plan (although the inability to facilitate the case plan cannot be the sole basis for precluding preferential placement with a relative), whether there are other siblings or half-siblings in the home and whether that relative could provide legal permanence if reunification with the parents fails. (WIC 361.3 (a)(6))

The dual consideration of facilitating reunification with a parent while at the same time planning for legal permanence (which usually means adoption or guardianship) is called "**concurrent planning**"; the concept of concurrent planning was introduced in 1998 and is discussed further below.

Paternity

At the detention hearing or as soon thereafter as practical, the court must inquire as to the paternity of the child. All men alleged to be the father must establish paternity either through a legal presumption or by showing that he is the biological father of the child. A presumption of paternity arises when the parents were married at the time of conception, signed a declaration of paternity or the court is otherwise satisfied that he is the "presumed" father because he can satisfy the requirements set forth in Family Code section 7611(d). "Mere biological" means a biological father who has done almost nothing to develop a relationship with the child either before or during the dependency hearing. An alleged father is a person who may be the father but whose biological paternity has not been established. An alleged father only has the right to notice of the proceedings and of the opportunity to establish paternity. An alleged father is not a father until paternity is established and therefore cannot be given services or be considered for placement as a father. The relatives of an alleged father are not relatives of the child for purposes of placement, but an alleged father and his relatives may qualify as non-relative extended family members in an appropriate case. Once biological paternity is established, the alleged father becomes a legally recognized biological father and then may participate in the proceedings and be considered for services and placement. Even a mere biological father is not automatically entitled to family reunification, which is why it is important for the court to make the required inquiries under this code section. Even if a man is present at the hearing claiming to be the father, this does not relieve the court of its duty. (WIC 316.2) This is especially true in light of recent cases that have held that a man can be a presumed father even if evidence is produced proving the man is not the child's biological father. This major change in the law has cast great uncertainty in the area of paternity and thus even greater attention will have to be paid to this critical area of law.

At the arraignment part of the hearing (which generally takes place at the same time), the petition must be read to the parents, and the court's procedure and possible consequences of the petition explained. After a parent has been advised of his or her rights, the court inquires whether that parent admits or denies the petition. Almost universally, attorneys for the parent will waive reading of the petition and advisement of rights and enter a denial of the petition.

Pre-Trial Resolution Conference (PRC)

A PRC report (also known as a social study report) is almost always ordered unless the case is set for a no time waiver trial (within 15 days of the detention hearing) and there is not enough time for a detailed report. The PRC report contains a detailed description of the circumstances surrounding the filing of the petition. (WIC 355) This report is supposed to be an objective investigation and include both positive and negative information about the family. The social workers that generate these reports are called "Dependency Investigators" or "DI's." Their job is to gather enough evidence through interviews and other documents to legally prove or disprove the allegations set forth in the petition.

Even though reports are often replete with statements made to the social worker (hearsay), they can still be submitted to the court for the truth of the matter asserted (to prove the contents of the petition). (WIC 355) In the case of In re: Malinda S., 272 Cal.Rptr. 787 (1990), the Supreme Court held that a court can admit the hearsay evidence contained in a PRC/social study report as long as the preparer of the report is available to testify. This case was modified in part and codified in WIC 355. WIC 355 provides that even if a party makes a timely objection to a statement in the social study, the statements of certain hearsay declarants (people quoted in the report) can be exclusively relied upon to prove an allegation in the petition. These individuals include peace officers, health practitioners, teachers and any child who is the subject of the petition and is under the age twelve, unless the statement was the product of fraud, deceit or undue influence. Additionally, any statement that would already be admissible in a civil or criminal proceeding can also be used to prove an allegation in the petition.

Any other individual's statement (not named above) is admissible only if those individuals are made available for cross-examination if an objection is made. Thus, a "lay" witness who is quoted in the social study report must be made available. This type of witness may be a relative, friend, neighbor or child under twelve who is not a party to the proceeding. This is a complicated statute and should be read carefully.

Most cases are resolved at the PRC hearing. If the case is contested, both the social worker and the individuals who are quoted in the report can be subpoenaed to court and cross-examined. If the parties cannot resolve their case informally, the case can be referred to mediation for settlement. (WIC 350)

Mediation is a process by which the disputants voluntarily come to a mutually accepted agreement. The mediators are facilitators rather than fact finders or judges and have a duty to help the parties come to a mutually satisfactory agreement. Dependency court has a group of professional mediators who, along with a DCFS social worker, assist the parties in reaching a fair resolution. If the case is "resolved" this only means that the parties have changed the language of the petition so that it more truly reflects the situation surrounding the filing of the petition. The parties also agree to the particular subdivisions of WIC 300 that are relevant to the case.

If a parent does not attend the PRC hearing, the court may sustain the petition as written or set the case for a hearing where DCFS must prove the allegations in the petition based on their witnesses, reports and other admissible evidence. Some parties will agree to the dispositional issues and others will continue the case for an actual dispositional hearing. If the parties cannot come to an agreement, the case is set for adjudication (trial).

Adjudication/Trial

At an adjudication of the petition, the judicial officer must determine whether the child is a person described by WIC 300. (WIC 355) DCFS must prove the allegations by a preponderance of the evidence (sometimes described as a little more than "51%"). DCFS, represented by County Counsel, and any other party, may present both written and testimonial evidence proving or disproving the specific allegations of the petition. As mentioned above, County Counsel may offer into evidence the PRC report, which, though it contains hearsay statements, is often admissible. At the conclusion of the trial the judicial officer will make findings of fact for the allegations that can be legally sustained and which should be dismissed for lack of evidence.

Disposition

At the disposition ("dispo") hearing (WIC 358) the court makes the legal finding that the child(ren) are dependents of the Juvenile Court. The purpose of the hearing is to determine whether the child(ren) should be released to the parents (if they are still detained), and what type of visitation and counseling programs are recommended. If the disposition hearing is set to take place at a different time than the trial or PRC, a disposition report is ordered. This report should include a discussion of the appropriate services for the parents, whether or not the child should be detained, and a plan of recommended visitation if the child is detained. If the child has siblings, the report must also address visitation for the child with the siblings. In order for the court not to order sibling visitation, it must find by clear and convincing evidence that the sibling interaction would be detrimental to the child or sibling. The court should also address grandparent visitation, if applicable. These orders are commonly referred to as "the case plan."

In 2006, a new section was added to specify that the child should also be involved in developing the case plan in an age and developmentally appropriate manner. If a child is aged twelve or older, the child shall have the opportunity to review, sign, and receive a copy of the case plan and if the permanent plan is adoption or placement in another permanent home, the case plan should now include a statement of the child's wishes and an assessment of those wishes. (WIC 16001.9, 16500.1)

The purpose of the case plan is to help the parents address the problems that brought them (and the children) into the system. The parents must participate in the court ordered programs and consistently visit the children. For example, if a petition was sustained because children were put at risk due to a parent with drug problems, DCFS may request that the court order the parent into a drug program that has a testing component; or if a parent inappropriately disciplined a child, a parenting class may be ordered. The implementation of the case plan is referred to as "family reunification."

Unlike the adjudication stage during which County Counsel must prove its case by a preponderance of the evidence, at the dispositional hearing the standard of proof depends on whether the child remains in the custody of the parents. If DCFS recommends continued detention of the child, the burden of proof is higher than if the child is to remain in the custody of the parent. If the child is to remain in the custody of his or her parent, the burden of proof is a preponderance of the evidence. However, if the child is to be removed, or remain removed, DCFS must prove by clear and convincing evidence that there would be a substantial danger to the child's physical health, safety, protection, or physical or emotional well-being, or that there are no reasonable means to protect the child's physical health if the child were returned home.

If a non-custodial parent comes forward and seeks custody of the child, the court must release the child to that parent unless the court finds that such placement would be detrimental to the child's safety, protection, or physical or emotional well-being. (WIC 361.2)

Family Reunification and Family Maintenance

At the disposition hearing the court develops a case plan to address the issues that gave rise to the filing of the petition and directs DCFS to provide appropriate services for the purpose of reunifying the family. If the child is ordered home with the parent and the case is not terminated after disposition, the court will order

family maintenance services. (WIC 364) Family maintenance services are the same as family reunification services without the time limitation set by statute. The case is reviewed every six months, at which time DCFS must prove by a preponderance of the evidence that conditions still exist that warrant jurisdiction, or that such conditions would be likely to exist if dependency jurisdiction was terminated. If DCFS cannot meet that burden and the case does not warrant further supervision, the court will terminate jurisdiction (close the case).

Unlike family maintenance services, the family reunification ("FR") period lasts for generally six to twelve months and in some circumstances eighteen to twenty-four months depending on the age of the child at the time of removal, the participation of the parents in the court ordered programs and the reasons for removal. This will be more fully explained in the section entitled "Review Hearings."
The court must offer family reunification except under certain circumstances. Historically, the denial of family reunification was reserved for only the most serious types of abuse. The statute has expanded and now includes sixteen circumstances under which family reunification services may not be offered. (See WIC 361.5(b)(1) - (15) and WIC 361.5(e)(1)). If the court is considering denying family reunification, the parent(s) have a right to notice of that recommendation in advance of the hearing, and a right to present their own evidence to show that family reunification should be provided. (See WIC 361.5(b) and 361.5(c))
DCFS must provide proof at this hearing by clear and convincing evidence. If reunification is not offered, the court will immediately set a hearing to determine which permanent plan best suits the child's needs (long-term foster care, guardianship or adoption). (WIC 366.26) When considering the most appropriate permanent plan for the child, the court must also consider a sibling relationship if one exists, and the impact that plan would have on the placement and visitation with the sibling(s).

Depending on the code section alleged, the denial of services is either mandatory or discretionary. If it is mandatory, the burden of proof shifts to the parent (and/or the child's attorney if they want reunification) to convince the court by clear and convincing evidence that reunification is in the best interests of the child. (WIC 361.5 (c)) The denial of services is mandatory in WIC 361.5 (b)(3), (4), (6), (7), (8), (9), (10), (11), (12), (13), (14), and (15). Under WIC 361.5(b)(5), reunification services shall not be offered unless the parent(s) can prove by competent evidence that those services would likely prevent re-abuse or continued neglect or that the failure to try reunification would be detrimental to the child. The disposition statute explains the type of relevant information that the court should consider when making its determination. (See WIC 361.5(h) and 361.5(c))

Below is a brief description of the disposition statute:

- The whereabouts of the parent(s) are unknown and there has been a diligent search to find their whereabouts and that search was unsuccessful. (WIC 361.5(b)(1));
- The parent is suffering from a mental disability that renders him or her incapable of utilizing any reunification services. (WIC 361.5(b)(2));
- The child was declared a dependent due to sexual or physical abuse, removed from the parents, returned to their custody and then is removed again due to the same allegations of sexual or physical abuse. (WIC 361.5(b)(3));
- The parent has caused the death of a child through abuse or neglect (See WIC 361.5(b)(4));
- The child was brought within the jurisdiction of the court under WIC 300(e) because of the conduct of the parent. (WIC 361.5(b)(5));

- The parent has severely sexually or physically abused the sibling or half-sibling of the child. (WIC 361.5(b)(6) A recent amendment to this statute defines sibling as any person related by blood, adoption or affinity through *a common legal* or biological parent. This will allow reunification to be denied to a child who would otherwise be unrelated except if they share a legal guardian;
- The parent is not receiving reunification services for a sibling or half-sibling due to the circumstances described in WIC 361.5(b)(3), (5) or (6). (WIC 361.5(b)(7));
- The child was conceived out of a rape (this only applies to the parent who committed the crime) (See WIC 361.5(b)(8));
- The child was abandoned and the court finds that the abandonment itself posed a serious danger to the child or the child was voluntarily surrendered. (See WIC 361.5(b)(9));
- The court ordered termination of reunification services for any sibling or half-sibling of the child because the parent failed to successfully reunify with that sibling or half-sibling and according to the findings of the court, the parent has not made a subsequent effort to treat the problem that led to the removal of that sibling or half-sibling. (WIC 361.5(b)(10));
- The parental rights of a sibling or half-sibling of the child have been permanently severed and the parent has not made a reasonable effort to treat the problems that led to the removal of that sibling or half-sibling. (WIC 361.5(b)(11));
- The parent has been convicted of certain violent felonies. (WIC 361.5(b)(12));
- The parent has an extensive history of drugs or alcohol, has resisted prior court-ordered treatment in the past three years or has failed or refused prior dependency court-ordered treatment on at least two occasions even though it was available and accessible. (WIC 361.5(13));
- The parent voluntarily wishes to give up reunification services. (WIC 361.5(b)(14));
- The parent has on one or more occasions willfully abducted the child, the child's sibling or half-sibling from their placement and refused to disclose the child's whereabouts or return the child to the social worker. (WIC 361.5(15))

The denial of family reunification services is discretionary if a parent's whereabouts are unknown (WIC 361.5(b)(1)) or if a parent is suffering from a mental disability (WIC 361.5(b)(2)). Finally, if a parent is incarcerated or institutionalized, the court must order reunification unless it finds by clear and convincing evidence that those services would be detrimental to the child. (WIC 361.5(e)(1)) If a parent is incarcerated or institutionalized, the court must consider the length of time, and the barriers the parent could encounter to services and ability to maintain services due to incarceration and institutionalization.

This is an extremely complex statute that must be studied carefully.

Visitation Orders

If a child is detained, there are various visitation plans that the court may implement throughout the life of the case. Below are some of the most common visitation plans:

Monitored

- This order usually occurs either at the beginning of a case before a court has gathered relevant facts, or if a court is concerned about leaving a child alone with a parent without supervision. Thus monitored means that another DCFS approved adult or a DCFS worker must be present at all times during a visit. Sometimes visits can be monitored outside of a caretaker's home but unmonitored in the caretaker's home.

Monitored in a neutral setting

- This visitation plan is the most restrictive. It generally means that visits will either take place at a DCFS office or in a park or other neutral setting.

Unmonitored/Reasonable

- Under this order a parent can see a child without supervision. Sometimes that time period is specified by the court, e.g., reasonable day visits.

Weekend/overnights

- This means unsupervised contact with weekend and/or overnight visits.

Types of Placements and Funding

If a child is not returned home, he or she is "suitably placed (s/p)" under DCFS supervision. This term means that the child is placed outside of the family residence. In January 2004, the legislature enacted a statute that addresses a child in foster care's extracurricular, enrichment and social activities. Caregivers now can use a "prudent parent standard" when deciding whether to give to permission for activities such as sleepovers, dances and other age appropriate activities. (WIC 408) Below are some examples of placement options:

Non Relative Extended Family Member

As explained above, this new category of individuals is defined as any adult with an established familial or mentoring relationship with the child. Examples may include distant relatives, relatives of half-siblings, teachers, clergy, neighbors, and family friends. (WIC 352.7)

Home of Relative

If at all possible, a relative placement is preferable. DCFS, the Court and the parties all bear responsibility in helping to identify viable relatives for placement. (WIC 361.3)

Foster Homes

A non-related foster care home is usually a family residence with six or fewer children, including the parents' biological children. There are two types of foster homes: DCFS licensed homes and Foster Family Agencies (FFAs) homes. FFAs are licensed from the State of California and then in turn certify foster homes under their supervision. FFAs generally provide a higher rate to foster parents and additional support. Most FFAs visit their homes on a weekly basis whereas DCFS is legally required to visit foster homes on a monthly basis. There is a great deal of paperwork that goes into certifying the home for a license. A home can be temporarily certified for the purpose of a placement as long as the foster care provider has filed an application with DCFS and DCFS has visited the home and completed a home study.

Foster care providers are also entitled to funding and other assistance such as Medi-Cal, free lunches and a clothing allowance. If a child has special needs, he/she may be entitled to higher rates to help pay for therapy or other services.

Group Homes

Group homes contain more than six children and are generally for children who are over ten years of age. When a child is hard to place due to emotional or behavioral problems, he or she is more likely to be placed in a group home.

Funding

All children in foster care are entitled to monetary aid for their care and support. The aid (also known as a benefit or grant) is paid to the caregiver. Children placed with a non-relative qualify for federal foster care (as per the Social Security Act, Title IV-E) or state foster care. There are three levels of foster care funding: basic, F-rate and D-rate. The "F" and "D" rates are known as "specialized care rates" and they give the caregiver more money due to the high level of care required by these children. The F-rate is for children with special medical or developmental needs, while D-rate is for children with severe emotional or behavioral problems. Children without special medical or emotional needs receive the basic rate. Expert consultation is highly recommended in areas related to funding.

In January 1998, the legislature introduced the concept of **concurrent planning**. (See WIC 366.21(c), 366.22 (a), (c) and 366.21 (e), (f), and (g)) Under concurrent planning, DCFS provides services for reunifying the family while at the same time plans for the legal permanence if reunification efforts should fail. As of January 2004, new legislation was introduced to assure that throughout the proceedings, the court is informed about the caregiver's willingness to provide legal permanency for the child if reunification services are unsuccessful. (See WIC 358.1(i), 358(b), 361.3(a)(6)) Adoption is the most preferred of these plans as it is the most legally permanent of the options. Thus, DCFS may place a child in a foster home that is eligible to adopt and provide services to achieve legal permanence at the same time they are attempting to reunify a child with a parent.

Review Hearings

As of January 2010, a child, regardless of their age, is deemed to **have entered foster care** on the earlier of two dates: ***the jurisdictional hearing (WIC 356) or sixty days after the child was initially removed from the physical custody of the parent. (WIC 361.49)*** This is consistent with federal law.

In January 2009, a provision was enacted to allow reunification services to be extended to 24 months from the original removal of the child in limited circumstances. These circumstances include parents who are in **substance abuse programs, parents recently released from incarceration and parents recently released from institutionalization.** (WIC 361.5(a)(3), 266,22(b), 366,25). As further explained below, the Court will have to make numerous findings in order to extend the time period.

Review hearings are referred to by a variety of acronyms such as: ".21(e)," ".21(f)," ".22". These acronyms are shorthand for the actual statute numbers, WIC 366.21(e), 366.21(f) and 366.22.

366.21(e) Hearing

This first status review hearing is held six months after the disposition.
There is a two-tier analysis depending on the age of the children:
For children who were **under** three years of age on the date of the initial removal (or are part of a sibling group where one child is under three on the date of the initial removal and will likely be placed together), reunification services shall be provided for **no less** than six months from the date of disposition and continue **no longer** than 12 months from the date the child entered foster care, unless the child is returned home to the parents. WIC 361.5(a)(1)(B)

For a child who is **three years or older on the date of initial removal,** reunification services shall begin at the disposition date and continue no longer than 12 months from the date the child entered foster care, unless the child is returned home to the parents. WIC 361.5(a)(1)(A)
Under the 6 month review statute, the court must order the return of the child to his/her parents *unless the court finds by a preponderance of the evidence that the return of the child would create a substantial risk of detriment to the safety, protection, or physical or emotional well-being of the child.*

DCFS has the burden of establishing detriment. If the parent fails to participate regularly and make substantial progress in court-ordered treatment programs, this will constitute prima facie evidence that the return of the child would be detrimental.

The services worker writes a report for each of these review hearings which discusses the progress of the parent(s) in the court ordered programs, how the visits have been proceeding, how the child is doing in placement, and any other relevant evidence. The report must also address sibling visitation, if applicable. If there are siblings, the report must address the nature of the relationship, the frequency and nature of sibling visitation, and the appropriateness of developing or maintaining the sibling relationship. If the siblings are not placed together, the report must state what efforts are being made to place them together, or why such efforts are not appropriate. In determining the nature of the sibling relationship, the court should consider factors including but not limited to: whether the siblings were raised together, shared common experiences, have existing close and strong bonds, whether either sibling expresses a desire to visit or to live with his/her sibling, and whether ongoing contact is in the “child’s best emotional interest.” (WIC 366, 366.1(c))

After considering all evidence, the court will either return the child to the custody of the parents or terminate reunification services for a child under three. If the child is not returned, the Court must determine whether DCFS has offered appropriate and sufficient services to the parent(s) that would help alleviate the problems that led to the removal of the child. This finding by the Court is called "**Reasonable Efforts**" and the Court must make a "Reasonable Efforts" finding at all three review hearings. (WIC 366.21(e), 366.21(f) and 366.22) If the parent disagrees with the recommendation, they have the right to set the matter for "contest.” A contest is an evidentiary hearing where DCFS has the burden of showing that it would be detrimental to return the child home.

Extension of Services for Children under Three

The court will only give the parents six more months of services if the parent proves there is **a substantial probability that the child may be returned to the parent's custody within the next six months (or reasonable efforts were not provided).**

The court must consider **certain exceptional circumstances** such as whether the **parent** has been **incarcerated**, or **institutionalized** or been participating in a **court ordered substance abuse residential treatment program** and whether these circumstances have been legitimate barriers to the parent's abilities to access services and/or ability of the parent to maintain contact with the child. The court must also consider, among other factors, the parent's efforts to maintain contact with the child.

If a child is over the age of three at the time of initial removal, and the child is not returned home, reunification services are extended for six more months but not more than 12 months from the date **the child entered foster care.**

Additional Important Relationships

If a child is 10 years of age or older and has been in foster care for over six months, DCFS also has an obligation to identify and maintain relationships with persons who are important to the child. These efforts are to be made throughout the dependency case. It is hoped that these efforts will identify permanent placement options for the child or if no permanent placement option is available, he or she will have a life-long connection with a committed adult. (WIC1601.1(i), 366.1(g), 366.(a)(1)(B), 366.21, 366.22, 366.26(c)(3), 366(c)(1)(A), 366.3,(e), 16500.1(b)(11), 10609.4(b)(1)(G), 16501.1(f)(14), 391(b)(5))

366.21(f) Hearing

This hearing, entitled the "Permanency Hearing", is scheduled to take place no later than twelve months after the child entered foster care. Like the six month review hearing described above, DCFS has the burden of establishing by a preponderance of the evidence that *the return of the child would create a substantial risk of detriment to the safety, protection, or physical or emotional well-being of the child.* For a youth who is 16 years or older, the court must also determine whether services have been made available to assist him or her in making the transition from foster care to independent living.

The court must also make a finding at this hearing whether the child has in-state or out-of-state placement options. If the child is placed out-of-state, the court must determine whether that placement continues to be appropriate and in the best interest of the minor.

At the twelve-month hearing, the court will either terminate family reunification services or give the parent six more months of family reunification.

As with the six month hearing, the court again must consider:

Whether certain **exceptional circumstances** such as whether the **parent** has been **incarcerated**, or **institutionalized** or been participating in a **court ordered substance abuse residential treatment program** and whether these circumstances have been legitimate barriers to the parent's abilities to access services

and/or ability of the parent to maintain contact with the child. The court must also consider, among other factors, the parent's efforts to maintain contact with the child.

The court will only give the parents six more months of services if it can be proven that there is a substantial probability that the child will be returned within the next six months and that this is a "compelling reason" not to terminate family reunification services. (WIC 366.21 and 366.22)

In order for the court to find a substantial probability that the child will be returned to the parent, the court must find:

1. The parent has consistently contacted and visited the child;
2. the parent has made significant progress in resolving the problems that led to the child's removal; and
3. the parent has demonstrated the capacity and ability to complete the objectives of the treatment plan and provide for the child's safety, protection, physical and emotional well-being. (WIC 366.21(g)(1))

This is a higher standard than the previous two hearings, making it more difficult for parents to receive more than twelve months of reunification services.

If six more months are ordered, the next hearing must be held within 18 months from the date the child was originally taken from the physical custody of the parent.
If the court terminates family reunification services, it must find by clear and convincing evidence that DCFS has offered reasonable services to the parents and set a WIC 366.26 hearing within 120 days to determine the most appropriate permanent plan for the child.

366.22 Hearing

The eighteen-month permanency hearing is eighteen months from the date of the initial removal of the child (this is in accordance with Federal law). If the child is not returned to the home of the parent, the court will terminate family reunification services and order a "permanent plan" for the child. As in the six and twelve month review hearings, the court must order the return of the child to the physical custody of his or her parent(s) unless it finds by *a preponderance of the evidence that returning the child would create a substantial risk of detriment to the safety, protection, or physical or emotional well-being of the child*. DCFS has the burden of establishing detriment. The failure of the parent to participate regularly and make substantial progress in the court ordered treatment plan is prima facie evidence of that detriment. Again, like the six and twelve month hearing, the court must consider:

Whether certain **exceptional circumstances** such as whether the **parent** has been **incarcerated**, or **institutionalized** or been participating in a **court ordered substance abuse residential treatment program** and whether these circumstances have been legitimate barriers to the parent's abilities to access services and/or ability of the parent to maintain contact with the child. The court must also consider, among other factors, the parent's efforts to maintain contact with the child.

24 Month Option

As of January 2009, the court may extend reunification services to the parent to 24 months **from the date the child entered foster care** if the court determines by **clear and convincing evidence** that it would be in

the best interest of the child and makes a finding that there is a substantial probability the child will be returned to the physical custody of the parent.

The parent must show they are making significant and consistent progress in a substance abuse treatment program or was recently discharged from incarceration or institutionalization and is making significant and consistent progress in establishing a safe home for the child's return. The extension of services may also be provided if reasonable services have not been provided. The court will consider the following factors in its decision: whether the parent has consistently and regularly contacted the child, whether the parent has made consistent progress in the prior 18 months in resolving the problems that led to the child's initial removal, whether the parent can produce evidence that they have the capacity and ability to complete the objectives of the substance abuse plan or a post discharge from incarceration or institutionalization, and whether there is a substantial probability the parent will be able to provide for the child's safety, protection, physical and emotional well-being, and special needs. (WIC 366.22(b), 361.5(a)(3)).

If the court cannot make the above findings, the court shall order a hearing under WIC 366.26 as long as the court can find by clear and convincing evidence that reasonable services were provided by DCFS to the parent.

Selection and Implementation Hearing – WIC 366.26

At the 366.26 hearing the court will determine whether adoption, legal guardianship with a relative or non-relative or long-term foster care is the most appropriate permanent plan for the child. When determining a permanent plan, the court must also consider all factors related to maintaining and/or developing sibling contact. If the court finds by clear and convincing evidence that the child is not a proper subject for adoption and there is no one willing to accept legal guardianship, the court may order that the child remain in long-term foster care.

In determining a permanent plan, DCFS must submit an adoption assessment. (WIC 366.21 (I)) This document should provide a complete assessment of the child and include the following factors: contact with his or her parent(s), an evaluation of the child's mental, medical, scholastic, developmental and emotional status, whether there are prospective or interested adoptive families for the child, the nature of the relationship between the child and prospective family, and an analysis of the likelihood that the child will be adopted if parental rights are terminated.

Only if the court determines by clear and convincing evidence that the child will be adopted based on these criteria can parental rights be terminated. Some practitioners confuse the concept "likelihood that a child will be adopted" with whether the child is "adoptable." The statute clearly states the standard is whether the child is "likely to be adopted." Many argue that "likely to be adopted" means that adoptive parents have already been found for the child. However, case law has consistently declined to accept this interpretation. If a parent objects and claims that a child is not likely to be adopted (based, for example, on a child's age or disability), DCFS will rebut with testimony from an experienced adoption worker who will testify that based on his or her experience, a home could be located for that child, making them "likely to be adopted."

If the child is placed with a relative caregiver, the assessment must include whether the relative caregiver has a preference for legal guardianship or adoption. If the preference is for legal guardianship, the

assessment must state whether or not the preference is due to an unwillingness to accept legal or financial responsibility for the child. If the caregiver's only concern is financial, the court may not remove the child for that sole reason.

In making its recommendation for a permanent plan for a child, DCFS considers the following in order of preference:

1. Adoption - a legal process in which the child is freed from the birth parents either by relinquishment or termination of parental rights. The child is then adopted, a new birth certificate is issued and the adoptive parents become the sole legal parents of the child.

2. Relative Legal Guardianship - suspends, but does not terminate the rights and responsibilities of the birth parents. The guardian becomes the legal caregiver and is entitled to make all decisions concerning the child's health, education and well-being. The court must order visitation for the parents unless it finds by a preponderance of the evidence that visitation would be detrimental to the physical or emotional well-being of the child. (WIC 366.26 (c)(4)) All guardianships terminate by operation of law once the child reaches eighteen (18) years of age. The relative must be **the current caretaker** of the child.

3. Identify adoption as the permanent placement goal and order efforts to be made to locate an appropriate adoptive family for the child within 180 days.

4. Non-Relative Legal Guardianship – The Non-relative Legal Guardian has the same rights and responsibilities as a Relative Legal Guardian. The Guardian who is a relative versus a non-relative receives different types and amounts of assistance.

5. Long Term Foster Care - the child remains in foster care until the age of eighteen or graduation from high school, whichever is later. The rights and responsibilities of the birth parents are not terminated, but the care and control of the child is transferred to the Juvenile Court. Federal law has eliminated the phrase "long term foster care" and replaced it with "Another Planned Permanent Living Arrangement" to emphasize the fact that even children who do not receive the benefits of adoption or legal guardianship are in need of and should receive as much stability and permanency as possible. It is anticipated this term will find its way into the California rules and statutes in the future. As with a Legal Guardianship, court must order visitation for the parents unless it finds by a preponderance of the evidence that visitation would be detrimental to the physical or emotional well-being of the child. (WIC 366.26 (c)(4))

If the evidence already exists at the time of the review to show neither adoption or legal guardianship is appropriate, the court may order an alternative permanent plan of long term foster care without the necessity of a WIC 366.26 hearing. Otherwise the court will set a WIC 366.26 hearing (also known as the Selection and Implementation hearing). If a 366.26 hearing is ordered and the parent wishes to appeal the finding of the court, they must first file a Petition for Extraordinary Relief (also known as a "writ"). The parent must sign and the trial attorney must file an "Intent to file a Writ Petition" within seven days of the court's order. The petition must be prepared in accordance with the California Rules of court, rules 39.1B and 1402.

366.26 Hearing

At this hearing, the court will choose between guardianship, adoption, or long-term foster care.

If the court chooses adoption, it can either terminate parental rights or identify adoption as the permanent plan without permanently severing parental rights and order that efforts be made to identify an appropriate adoptive family within 180 days. The court generally continues the termination when an adoptive home may be harder to identify because the child is part of a large sibling group or has multiple disabilities. If a family is identified and the adoption is finalized, the court will close the case (terminate jurisdiction). As stated above, a plan of adoption can only be chosen if the court makes a finding by **clear and convincing evidence** that the child is "**likely to be adopted**." When that finding is made, the child will then be "freed" and parental rights will be terminated. There are only five exceptions to this rule and the burden shifts to the parent to prove by a preponderance of the evidence one or more of the following circumstances:

1. The parents have maintained regular visitation and the child would benefit from continuing the relationship.
2. The child is twelve years old or older and objects to the termination of parental rights.
3. The child is in a residential treatment facility and finding an adoptive home is unlikely or undesirable, and the child will still be able to find a permanent family placement if parents cannot resume custody when residential care is no longer necessary.
4. The child is living with a relative or foster parent who cannot adopt the child due to exceptional circumstances that do not include an unwillingness to accept legal or financial responsibility. However, the relative or foster parent can provide a stable and permanent home and the removal of the child from that home would adversely affect the child's emotional well-being. This exception does not apply if the child is living with a non-relative or if the child is either under six years of age or a member of a sibling group where at least one child is under six years of age and the siblings are or should be placed together. The court must make these findings by a preponderance of the evidence. (WIC 366.26(A)(B i-vi)). Other exceptions also apply where the child is an Indian child. Please consult an expert where issues involving ICWA and Indian children apply.
5. A fifth exception to adoption includes sibling rights and states: where there would be substantial interference with the child's sibling relationship, termination of parental rights would be detrimental to the child's best interest. The court must consider the nature and extent of that relationship and whether the child was raised in the same home, shared significant common experiences or had a close and strong bond. Further, the court must consider whether the ongoing contact is in the child's best interest including the child's long-term emotional interest, as balanced against the benefit of legal permanence through adoption. (WIC 366.26 (B)(v)

Removal of Child from Prospective Adoptive Parent

Until recently, DCFS was legally able to remove a child from a prospective adoptive home without any redress from the caregiver or prospective adoptive parent. A new subdivision of WIC 366.26 now allows a prospective adoptive parent the right to petition the court for a hearing to object to the removal of a child. The caregiver must have had the child in his or her home for at least 6 months, expressed a commitment to adopt the child or taken at least one of the specified steps to complete the adoption process. The court must designate the caregiver as a "prospective adoptive parent" either before or during the hearing on the removal of the child.

Prior to a change in placement of a prospective adoptive parent, DCFS must provide notice to the court, the child's attorney, the child if over 10 years of age, and a designated prospective adoptive parent or a caregiver if that caregiver would likely meet the designation of a prospective adoptive parent. Any of these noticed parties may file a petition objecting to the removal within five court days or 7 calendar days whichever is longer. The hearing must be held no later than five dates after the petition is filed.

At the hearing, the court must first determine whether the caregiver meets the threshold criteria to be a prospective adoptive parent, and then must determine whether the removal would be in the best interest of the child. (WIC366.26(n))

If a petition objecting to removal of a child is not filed by a noticed party or the court does not set a hearing on its own motion, the child may be removed from a designated prospective parent without a hearing.

Reinstatement of Parental Rights

The order permanently terminating parental rights under WIC 366.26 is final and binding once the 60 day appeal period lapses or a parent's appeal is denied. The court has no power to set aside that final order except in a very limited circumstance.

A new statute now allows a child who has not been adopted for three years after his/her parental rights were terminated, to petition the court to reinstate parental rights. The petition may be filed earlier than three years if there is a stipulation among the parties. If the court determines that reinstatement is in the best interest of the child, a hearing will be set and notice to the parties will be made. The court will only grant the petition if the court can find by clear and convincing evidence that the child is no longer likely to be adopted and reinstatement of parental rights is in the child's best interest.

If the court orders reinstatement of parental rights over a child twelve or younger but the new permanent plan does not included reunification with the parent or legal guardian, the court must specify the factual basis for its findings that reinstatement is in the best interest of the child. (WIC 366.26 (i)(2))

Review of Permanent Plan (RPP)

If the juvenile court orders a permanent plan and court jurisdiction continues, i.e., the child is in long-term foster care, guardianship or the adoption is not finalized, the court will continue to review the case every six months until the child is adopted, turns 18 years old, marries, or graduates from high school. (WIC 366) There are also limited circumstances when the court can retain jurisdiction until the child reaches the age of 21 if that child has special needs.

At the RPP hearing, the court must consider what progress has been made to provide a more permanent home for the child and the safety of the child as well as the following factors including:

- The continuing necessity for and appropriateness of the placement;
- the continuing appropriateness and extent of compliance with the permanent plan;
- the extent of the agency's compliance in making reasonable efforts to return the child to a safe home and complete whatever steps necessary to finalize the permanent placement of the child;

- the adequacy of services provided to the child;
- the extent of any progress the parents have made in alleviating the necessity of the child to be placed in foster care;
- the likely date the child may be returned to a safely maintained home, placed for adoption, legal guardianship or another planned permanent living arrangement;
- what services for transition to independent living a child aged 16 or older is receiving;
- the nature and appropriateness of developing and/or maintaining a sibling relationship;
- if siblings are placed together, the frequency and nature of the visits;
- whether or not reasonable efforts have been made to make and finalize a permanent placement for the child and the impact of the sibling relationship on the child's placement and plan for legal permanence.

<u>When does the court terminate jurisdiction for a child in long term foster care who reaches the age of majority (18 years old)?</u>

A child who has not returned to the custody of his/her parents, has no legal guardian or has not been adopted will generally remain in foster care until the age of 18 (also known as the age of majority). In limited circumstances, such as a child with developmental delays, the court can retain jurisdiction until the child reaches 21 years of age. (WIC 303)

When a court terminates jurisdiction, the child must be present at the hearing, unless the child wishes not be present or the child cannot be located and DCFS has thoroughly documented its efforts to find the child. (WIC 391(a)) A court cannot terminate a child's case unless DCFS submits a court report, which verifies that certain services and information have been provided to the child. The report must represent that the following information and services were provided to the child:

1. Written information regarding the dependency case including placement history, whereabouts of any siblings under the court's jurisdiction, unless that information would jeopardize the sibling's safety or welfare, direction on how to access the juvenile dependency records, and the date jurisdiction will be terminated.
2. A social security card, certified birth certificate, identification card, death certificate of parent(s), and proof of citizenship or residence.
3. Assistance in completing an application for Medi-Cal or other health insurance, obtaining employment, admission to college or other educational institution, obtaining any financial aid, and a referral for transitional housing or other housing. (WIC 391 (b))

If DCFS has offered the above services but the child has either refused the services or cannot be located, the court may terminate jurisdiction. Jurisdiction can also be continued if termination would be harmful to the best interests of the child. (WIC 391(c))

Nonminor Dependents

In January 2012, the law will recognize "nonminor dependents" as defined as foster children (or wards – not addressed in this manual) who have attained the age of 18, remain in foster care, and qualify under the eligibility requirements such as completed high school, enrolled in higher

education, employed for at least 80 hours per week or participating in a program designed to assist achieve employment and have signed an agreement to accept support and live in a supervised placement. (See WIC 11400 et seq.). WIC 391 will be amended and require the court to continue jurisdiction for "nonminor dependents" unless it finds that after reasonable and documented efforts, the youth cannot be located or does not wish to remain a dependent. In making that finding, the court must ensure the youth has been informed of available options, including the right to resume dependency via a new section of a WIC 338 petition, and that the youth has conferred with counsel. Jurisdiction will be continued to be terminated in accordance with the old law if the court the youth is not eligible to meet the criteria under WIC 11403. There is an implementation timeline which begins in 2012, extending services to youth up to 19, 2013 extending services to youth up to 20 years old and 2014, extending benefits to youth up to 21 years old subject to budget appropriation. These are complex statutes that need to be studied carefully for their significance and interface with other statutes.

388 Hearing

The WIC 388 hearing is the most common vehicle by which DCFS, a parent or other interested person may petition the court to change or modify a court order. It is commonly used by a parent to petition the court to change custody or modify custody or a visitation plan after a case is in the permanency planning stage. The petition must state a change of circumstances or new evidence that would warrant the modification of the current court order. If the court can make this preliminary finding, it will order a hearing within thirty days. The burden is on the petitioning party to prove by a preponderance of the evidence that it is in the best interests of the child to make the proposed change of order. This statute was recently amended to add a provision which allows a child who is a dependent to petition the court to request court orders for visitation, placement or other related orders regarding the establishment or maintenance of sibling relationships. (WIC 388(b))

As of January 2009, a party including the child, may petition the court to terminate reunification services prior to the date of the six month hearing if there is a child under the age of three at the time of removal or the prior to the twelve month date for a child over three years old. The party must allege:

1. A change of circumstances exists that would qualify for a termination of services under the disposition statute (WIC 361.5(b) or (e) or
2. The action or inaction of the parent including, but limited to the failure to visit the child, or participate regularly and make substantial progress in a court-ordered treatment plan which creates a substantial likelihood that reunification will not occur.

Factors to be considered is whether the parent is not visiting as a result of incarceration, institutionalization or participation in a substance abuse program. The court shall grant the petition only if it finds by a preponderance of evidence that reasonable services have been offered and by clear and convincing evidence that one of the two above conditions exist and it would be in the child's best interest to terminate reunification services. (WIC 388 (c)).

As of January 2010, a motion is not required at the 366.21(e) hearing (the 6 month hearing) if the court can find by clear and convincing evidence once of the following:

a) the child was initially removed under section 300(g) which in general specifies that the child has been left without any provision for support and the whereabouts of the parent are still unknown;
b) the parent has failed to contact and visit the child; or
c) the parent has been convicted of felony indicating parental unfitness.

4. MISCELLANEOUS TERMS AND PROGRAMS

Adoption Assistance Program

The Adoption Assistance Plan (AAP) is a financial aid packet for parents adopting dependent children. It is designed to help remove economic barriers to adoption and meet the financial needs of dependent children. All dependent children are eligible for these benefits and there is no means test or income eligibility requirement for prospective adoptive parents. AAP continues until the child reaches age 18. However, if the child has a physical or mental handicap, the age limit can be extended until 21. Additionally, all AAP eligible children remain eligible for Medi-Cal.

Court Appointed Special Advocates (CASA)

This is a program that operates out of the Courthouse whose members are all specially trained volunteers. CASAs assist the children when they come to court from shelter care and are assigned to specific children who have been referred by the Court. Usually the child's attorney has asked for the referral. Any child within Los Angeles County can be referred to a CASA but many of the cases involve children with little or no parental support and/or children with special needs.

Comfort for Court Kids, Inc.®

This publicly supported charity provides free teddy bears to every child who attends a court hearing at Children's court. The Comfort for Court Kids organization believes that "the teddy bear is a universal symbol of love and affection"™ and as such, assists children to cope with very difficult situations.

Clerk's Office

The Clerk's Office is located on the second floor of the courthouse. If you need the next court date or access to a file or legal forms, you can obtain that information there.

Court Interpreters

Certified Court Interpreters are highly skilled professionals who assist non-English speaking parties. There are a number of Spanish speaking interpreters readily available in every courtroom; if other languages are needed, the court makes an order for an interpreter. There are also a number of sign language interpreters who translate for the deaf and hard-of-hearing parties. There are certain courtrooms which have been designated Deaf Courtrooms where the Judicial Officer and the attorneys have received special training.

Court Mental Health Unit

This unit in the courthouse is available to review the psychotropic medication requests for children and provide assistance with placement options for children with mental health problems. If you have questions about the latest drugs or medications for children or adults, you should consult with the mental health unit.

Free Arts For Abused Children

This is a non-profit organization that recruits volunteers to do creative arts activities with the children and their families while they are waiting for their cases to be heard in court. The program operates on the third, fourth and fifth floors of the courthouse.

Free Legal Services for Children

The Alliance for Children's Rights, Public Counsel, Protection and Advocacy, Mental Health Advocacy, and the Legal Aid Foundation of Los Angeles are all organizations that provide free legal assistance to children in foster care. Some of the issues these organizations specialize in are: health care, social security income and disability benefits, special immigrant status, Regional Center, special education, foster care benefits, and agency adoptions.

Independent Living Program (ILP)

The Independent Living Programs are designed for children sixteen years and older who are not in their parents' custody. These programs help transition children to adulthood by assisting with college applications and scholarships, how to find and keep a job and other important life skills. Most of the children find this program to be valuable and one that should be court ordered unless DCFS has already made the referral.

Indian Child Welfare Act

The Indian Child Welfare Act of 1978 ("ICWA") was enacted to establish minimum Federal standards when American Indian children are removed from their families and placed in foster or adoptive homes. ICWA was intended to redress past practices of placing children in non-Indian homes that resulted in the further deterioration of the American Indian culture. Since ICWA is federal law it supersedes Californian dependency law. ICWA, among other things, requires higher levels of proof for the placement of children in foster care and the termination of parental rights.

When the Application for Detention is filed, DCFS is supposed to make an initial investigation of whether the child and/or a parent is eligible to be enrolled in a tribe or is currently enrolled in a tribe. If there is a possibility of tribal membership or eligibility, the hearing officer at the arraignment will order that DCFS obtain verification. Once tribal membership or eligibility has been verified, the case is transferred to a special courtroom that handles all the American Indian cases. Once the tribe has been notified, the tribe or the Indian parent can request that the case be transferred to the tribal court for all further proceedings. If the case is not transferred, the tribe may still intervene at any point in the proceedings and thereby become a party to the hearings.

211/Info Line

This organization is located in the lobby of the courthouse and acts as an information center that helps to locate appropriate treatment programs for families and parents. There are forms in each courtroom that attorneys can fill out for their clients to bring to INFO LINE and get immediate referrals, or individuals can simply walk in and ask for referrals. Individuals can also dial "211" and they will automatically be connected to INFO LINE.

Interstate Compact For The Placement of Children (ICPC)

The ICPC was created in 1960 to provide for the supervision and protection of children who are taken into custody in one state but then placed (usually) with a relative in a different state. Generally, it is a contract between two different states and establishes procedures and responsibilities among those participating. All of the 50 states plus the District of Columbia and the Virgin Islands are members.

Dependent children may not visit out of state for longer than 30 days without ICPC approval. The court can release children to non-offending parents living out of state but some receiving states will not provide courtesy supervision without ICPC. Placement from one Member State into another requires the cooperation and agreement of agencies in both states. This applies to children being sent to live with parents or relatives, as well as out of home placements. The sending state retains jurisdiction over the child to determine all matters of the custody, supervision, care, treatment, and disposition of the child which it would have had if the child had remained in the sending state, until the child is adopted, reaches the age of majority, becomes self-supporting, or dependency is dismissed.

L.A. Unified School District Liaison

Assistance has historically been available in the courthouse to help attorneys and their clients with issues involving enrolling children in the proper schools. These services can also be helpful in obtaining school records and transferring between schools. Due to budget considerations, this program is not currently available..

Mediation

The courthouse has a mediation program staffed with professional mediators. The mediation process affords the parties a confidential and informal setting where, at any stage of the proceedings, issues of the case can be discussed. For example, at the PRC, petition language can be amended and an appropriate case plan can be agreed upon. During mediation, the parties, with or without their attorneys, have the opportunity to express their feelings in total confidence. Each mediator is assisted by a DCFS worker who acts as a liaison between the field and the Court. Parents, County Counsel, parent's and children's attorneys, as well as DCFS must all consent before an Agreement is sent to the Court for court approval.

Special Education

School districts must provide each disabled student between the ages of three and twenty-two who qualify for special education services a free appropriate public education (FAPE) in the least restrictive environment. In addition, the school district must provide whatever supplemental services (often referred to as related services) the child requires in order to benefit from his or her education. A child can qualify for special education services under thirteen criteria. If a child is having serious school problems that affect his/her achievement, either the School District or caregiver (holder of educational rights) can request an evaluation to determine whether special education services are appropriate. If the child qualifies for special education, the School District must develop an Individual Education Plan ("IEP") for the child.

SSI

Supplemental Security Income is a program that provides income to needy children who are under 18 and students under 22. Benefits include a check from the federal government, a check from the state government and Medi-Cal. To be eligible, a child must meet all four conditions:

- U.S. citizen,
- U.S. resident,
- Disabled or blind, and
- Financially needy

Social Security Survivor Benefits

If a parent dies, a child may be eligible for “Survivor” benefits. The social security office determines eligibility.

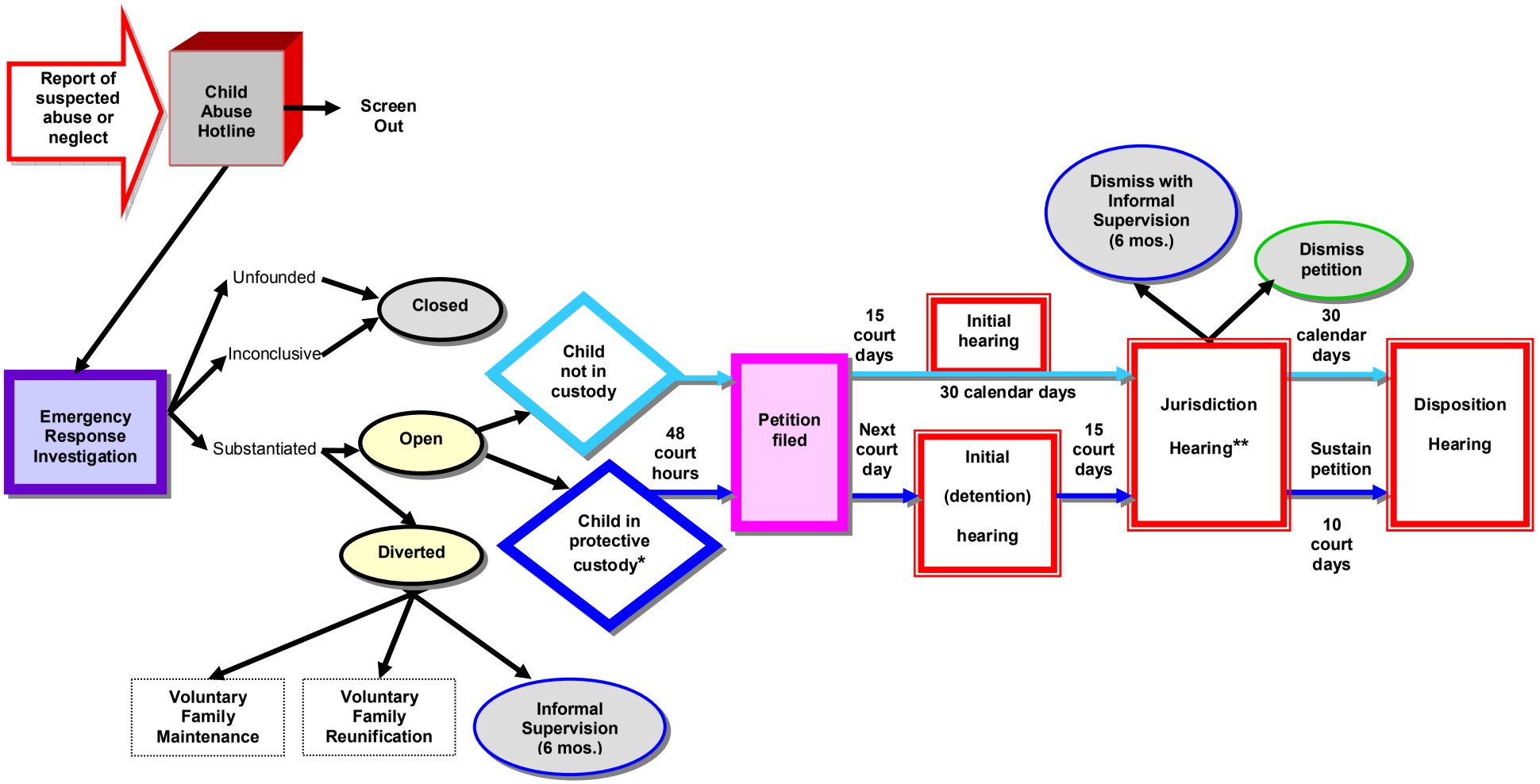
Regional Centers

Regional Centers provides services to individuals of all ages who have developmental disabilities. The Regional Center serves adults, children, infants, toddlers and anyone at risk of having a developmental disability and is also responsible for the education of disabled children from birth until the age of three. Once a child turns three, the local school district becomes responsible for all special education programs and related services. Individuals who are clients of the Regional Center gain access to resources for education, health, welfare, rehabilitation, therapy, social services and recreation.

Undocumented Children

Undocumented foster children are eligible for GRI (General Relief Ineligible) which is equivalent to the foster care rate. These children are also eligible for most Medi-Cal benefits. If an undocumented child does not reunite with his or her parents and the court orders him or her into a permanent plan of long term foster care or legal guardianship, he or she is eligible to apply for "Special Immigrant Juvenile Status" (SIJS) which, if granted, allows the child to obtain resident card also known as a “green” card. These cases should be referred to the DCFS Immigration Unit.

The Juvenile Dependency Court Process

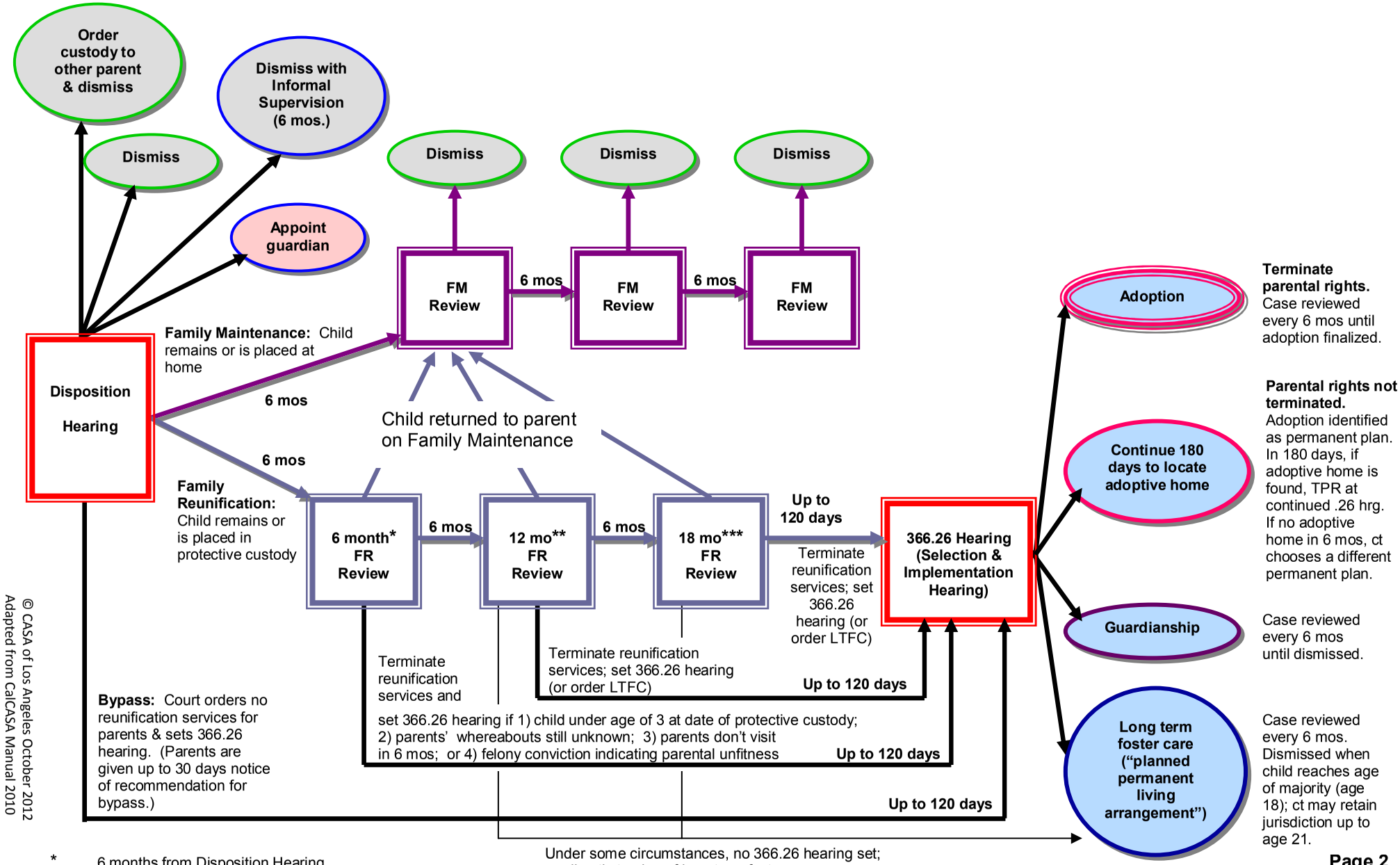


Judge Shawna Schwarz, sschwarz@scscourt.org
Santa Clara County Superior Court
April 2009 v.1.9

* **"Date of protective custody"** is the date child is physically removed from parent(s)

** **"Date entered foster care"** is a court finding, defined as the date of jurisdiction or 60 days after the date of protective custody, whichever is first

Dependency Court Process



Terminate parental rights. Case reviewed every 6 mos until adoption finalized.

Parental rights not terminated. Adoption identified as permanent plan. In 180 days, if adoptive home is found, TPR at continued .26 hrg. If no adoptive home in 6 mos, ct chooses a different permanent plan.

Case reviewed every 6 mos until dismissed.

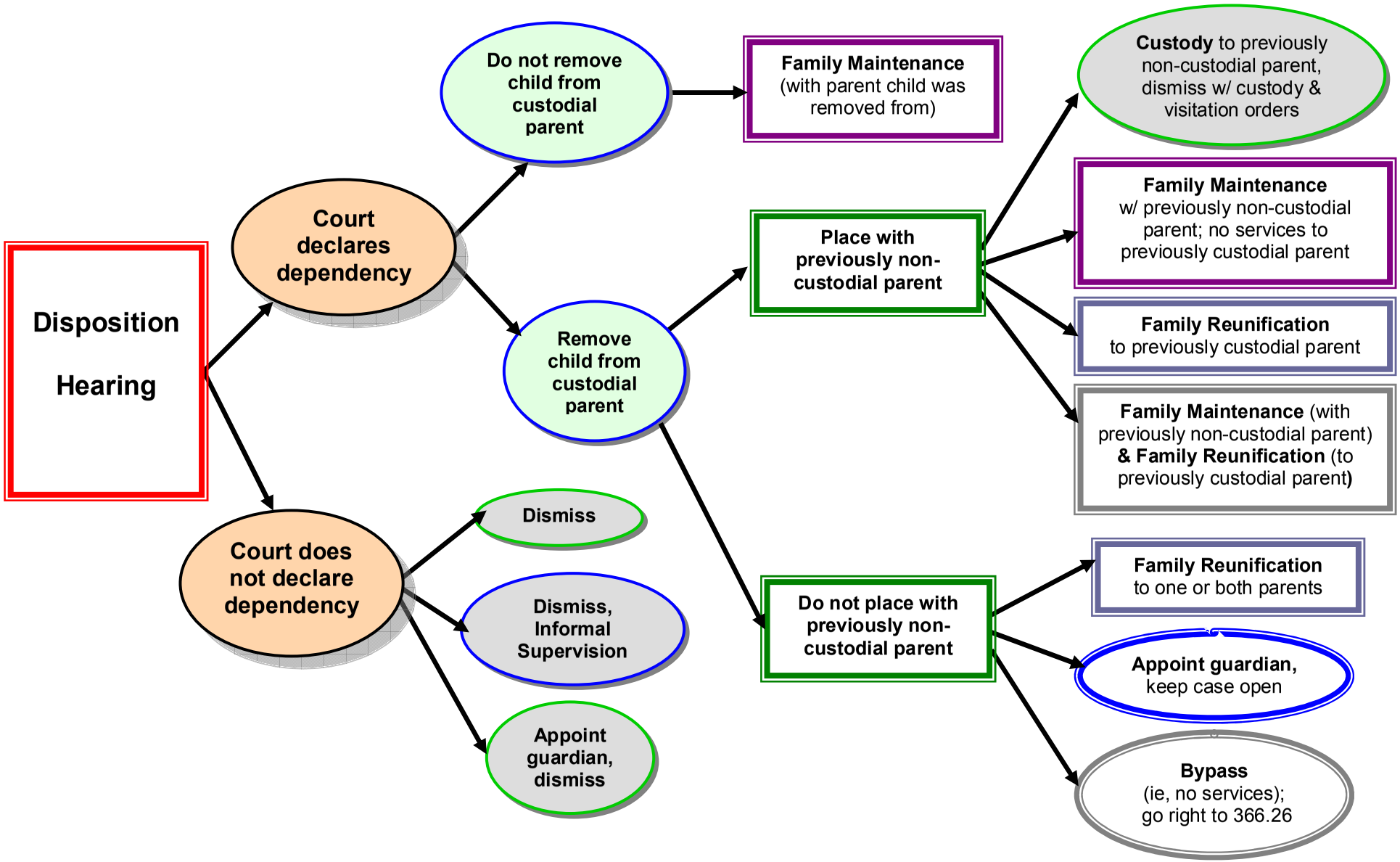
Case reviewed every 6 mos. Dismissed when child reaches age of majority (age 18); ct may retain jurisdiction up to age 21.

* 6 months from Disposition Hearing

** 12 months from "date child entered foster care"

*** 18 months from "date of protective custody"; see §366.22(b) for circumstances under which Court can extend reunification services to 24 months

Disposition: A closer look



CHAPTER 3
The Challenges and Opportunities of Difference

PURPOSE: *Learn about the "culture of foster care" and explore your perspectives on how people who are different interact.*

TABLE OF CONTENTS

Objectives

By the end of this chapter, I will be able to…

- ✓ Begin to understand how a child experiences the child welfare system
- ✓ Understand that difference is valuable, but often challenging
- ✓ Begin to distinguish between facts, beliefs, and assumptions
- ✓ Discern whether the difference is based on personality, culture, or one's position in society
- ✓ Develop an action plan to understand that you don't always understand

UNIT 1: Experiencing the System

Activity 3A: Reflection

Stop and think about *your own* childhood for a moment, perhaps when you were 9 years old. Did your parents raise you, or was it someone else? What school where you attending in the third grade? Did you have a bicycle? Did you have enough to eat? What happened when you misbehaved? Was childhood fun? Was it difficult? Was it painful?

Now, imagine a stranger coming to your school and taking you away from your home, perhaps leaving you in an office for hours, quizzing you about how your mother treats you, and then saying you can't go home. You soon find yourself in a strange home where everything is different – the food is different, the house smells different, and the bed is not your own. You only have the clothes on your back, and nothing else is familiar.

You're meeting many new people for the first time: two or more different social workers, an attorney, a judge, two foster parents and their other children. You don't know why, but everyone is acting oddly sweet and kind, except for the other children. You ask, but no one will tell you what is going to happen.

Discuss how you might feel with the group.

The Experience of Foster Care

Entering Foster Care

Generally, everyone can agree that having a child removed from home is a very big deal to family, and especially the child. The experience of being taken away from one's family will surely be remembered for the rest of the child's life. It is for this reason that professionals work so diligently to ensure that removing the child is a last resort – in fact, before a judge allows the child to be detained, he or she must find that reasonable efforts were made to prevent the need for removal.

As a CASA volunteer, you will certainly be appointed *after* a child has been declared a dependent of the court, and almost always after a child has been removed from the home. Therefore, you will not be dealing with the child during the removal process – however, your appointment could be very close in time. Therefore, keep in mind that the child may be going through some very stressful times.

How Children Cope with Stress
Clearly, being removed from one's family is a huge stressor, even if it results in increased safety. This stress, combined with the perpetrated abuse or neglect is often overwhelming for a child. Further, children often blame themselves for coming into the system, *and* they lose any support network that might have been in place. In all likelihood, entering the child welfare system is an earth shattering experience for the child.

Children understand things differently, and their comprehension depends on factors like their age, emotional and intellectual development, and how they were previously supported. They have so many thoughts and questions, and yet have limited experiences and tools with which to cope. It is essential to understand the value that you have to be a support to that child – but more importantly, the priceless opportunity you have to engage the youth, gain understanding, and advocate in a way that has everyone contributing to the needs of the child.

What Can I Do?
As a CASA volunteer, you are in a prime position to help a child in need. You will be able to listen, investigate, talk directly to the child and confirm their feelings and needs – and then follow up with a targeted advocacy that can bring results.

Living in Long-Term Foster Care

Once a child is in foster care, then different stressors can overwhelm them. This is especially true when the youth has been permanently planned into long-term foster care. There are so many things that a foster child has to deal with, like:

- Do they really want me here?
- Why didn't my parent work harder to get me back
- Will I ever get to go home? (or, what if they make me go home…)
- Why doesn't my family want me
- It's my fault
- I don't fit in here
- No one really cares about me
- The only people who spend time with me are those who are paid to do so
- I don't have the clothes and resources necessary to fit in
- No one cares what I do

These feelings, and thousands of others, all come together and sit on top of the normal childhood issues and feelings of insecurity and inadequacy. If a child or youth in a "normal" family has a difficult time adjusting, then imagine how difficult it can be to *also* be living in foster care.

Culture of Foster Care

When foster youth have been in foster care for a while, they become used to it, and used to the feelings associated with it. Therefore, there can be what one might describe as the "culture" of foster care. While each child may describe it differently, the culture of foster care centers on some basic, common threads.

First, it is not unusual for a foster child to feel as though no one really cares about them. One reason, from a foster child's perspective, is that all the people who choose to be involved in their lives are "paid to." If you think about it, they have a point. Teachers, therapists, social workers, doctors, attorneys, judges, foster parents, coaches, pastors, you name it – are "paid" to work with the youth. But not the CASA, you are a volunteer – here only because you choose to be.

Second, life as a foster child never feels "normal," and can begin to take on a bureaucratic quality. Do you want to go on a trip? Then, you need the social worker's okay. Do you want to see you mother? Well, then you have to wait until the scheduled visitation. Would you like to play a sport? Well, let's see if we can apply for some funds to get you the needed equipment. As a CASA you can help cut through the red tape.

Third, living is fraught with instability and uncertainty. While it's possible to be in long-term foster care and be with a loving family that will have you until you are 18 years old, the vast majority of youth in long-term foster care move placements often. Also, if you are an older youth, you are likely living in a group home. In group homes children come and go all the time, and if you misbehave, there is always the threat that you will get a "7-day notice," with means that the Agency will have 7 days to find you a new home. As a CASA, you can help stabilize the situation, be a friend and you can work to find them a permanent connection.

Fourth, foster youth often feel as though they are completely alone. When children undergo such immeasurable pain, they can begin to feel incredibly isolated. It is as if no one understands them unless they have been in a similar situation. "You don't know what I've been through," and "you don't know me." As a CASA, you can listen.

The Challenges of Leading a Normal Life

As alluded to earlier, foster youth face many challenges and it can be difficult to be "normal." This also extends to the one thing that is most important to adolescent youth: their social life. Of course, having a "social life," sounds minor when referred to as such. However, think about the value that these social interactions can have for foster youth.

The ability to have friends – and therefore identify people who care about you; the ability to play a musical instrument – and therefore grow one's soul and mind; the ability to go to a school dance – and just feel normal. What these youth want is a chance to have a childhood, and it is every professional's responsibility to ensure that the youth can.

- A child was not allowed to attend a Thanksgiving dinner with her father because the other diners had not been fingerprinted.

- A child whose "only joy," was playing the Saxophone, missed his second concert because transportation could not be arranged – the Agency had several week's notice.

- Group home staff told the 16-year-old youth that his friend could not come over to play video games because he did not have a criminal records check.

- A 17-year-old client missed her junior prom because her social worker said that her escort had to show proof of auto insurance. She was too embarrassed to ask him and therefore did not make the prom.

- A 16-year-old client was told she could not attend a high-school level "Battle of the Bands" event at her church because adults would be present who had not been subjected to a criminal records check. The youth's attorney had to take the matter to court, here the judge gave approval.

- The foster family agency originally denied a 17-year-old girl permission to attend a school-sponsored trip to Disneyland. Her attorney took the matter to the judge, who of course, gave permission.

- Unlike the biological children of the foster parent, this child was not allowed to go outside to play, participate in sports, or go over to friends' houses. Apparently, the private foster family agency had enacted rules preventing foster children from going anywhere on their own, "for fear of liability." The court remedied this as soon as it was brought to its attention.

- A 10-year-old boy was living in a foster family agency-licensed foster home. The foster mother wanted to place him in softball and karate classes during the summer. The foster family agency refused permission citing a "blanket policy" against foster children participating in martial arts. By the time the issue was brought up in court, signups were closed and the child could not participate in either activity.

UNIT 2: Cultural Competence

In the context of the CASA volunteer role, cultural competence is the ability to work effectively with people from different backgrounds. It 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. Developing cultural competence is a lifelong process through which you'll make some mistakes, get to know some wonderful people in deeper ways, and become a more effective CASA volunteer.

There are two primary means for acquiring cultural competence:

- Sources External to the Community (Internet, movies, books, classes)
- Community Engagement, Immersion & Assimilation

There are benefits and risks associated with both. To ask people to teach you their culture when you are not willing to use external sources is often perceived as selfish and rude. To think that one can learn about a people solely through external sources is often perceived to be arrogant and can lead one to ignore that culture is always tied to living people who cannot be fully captured through studies, movies, stories, and reports.

What Is Cultural Competency?
Cultural competency is the ability to work with people from a culture or community that differs from your own. It requires a commitment to engage, study, and practice. While there are often quick tips that can be provided to avoid the worst gaffs, there is no shortcut to spending the time required to increase one's skills and knowledge. Remember that members of the culture may not have a clear sense of what skills and knowledge are required. Much of it may seem simply normal or natural. Think about the challenge involved in writing a complete handbook on how to navigate one of your cultures or communities? We all carry an enormous amount of knowledge, so integrated into our daily lives that we barely know it is there.

Areas of cultural competency include:

- Language, Dialect & Slang
- Institutions & Social Structures
- Demographics & Subcultures
- Leaders, Heroes & Icons
- Cultural and Political History & Expression
- Observances & Celebrations
- Value, Belief & Etiquette Systems

Culturally Competent Child Advocacy

Read "Ten Benefits of Practicing Culturally Competent Child Advocacy." Consider which reason you view as most critical in the work of a CASA volunteer.

Ten Benefits of Practicing Culturally Aware Child Advocacy

1. Ensures that case issues are viewed from the cultural perspective of the child and/or family:
2. Takes into account norms, practices, traditions, intrafamilial relationships, roles, kinship ties, and other culturally appropriate values within that family.
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 an appropriate perspective:
5. Takes into account the child's need to develop and maintain a positive self-image and allow for them to stay connected to their family practices and traditions.
6. Takes into account the child's need to positively identify and interact with others from his/her family and/or cultural background.
7. Prevents cultural practices that do no harm from being mistaken for child maltreatment or family dysfunction.
8. Assists with identifying when parents are willfully refusing to comply with a court order versus when the order is culturally inappropriate.
9. Contributes to more accurate assessment of child's welfare, family system, available support systems, placement needs, services needed, and delivery.
10. Decreases cross-cultural communication clashes and opportunities for misunderstandings.
11. Allows the family to utilize culturally appropriate solutions in problem solving.
12. Encourages participation of family members in seeking assistance or support.
13. Recognizes, appreciates, and incorporates family cultural practices in ways that promote cooperation.
14. Allows all participants to be heard objectively.

Adapted from a document created by the CASA Program of Portland, OR.

UNIT 3: Different People, Different Backgrounds

Diversity

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

The United States is becoming increasingly multicultural. According to the 2000 US Census, approximately 30% of the population currently belongs to a racial or ethnic minority group. The Census Bureau projects that by the year 2100, non-Hispanic whites will make up only 40% of the US population. The facilitator will tell you about the demographics in your state and local area. As you work through this chapter, keep in mind the particular cultural groups with whom you will work as a CASA/GAL volunteer.

Understanding issues related to diversity and culturally competent child advocacy is critical to your work as a CASA/GAL volunteer. It can enhance your ability to see things from new and different perspectives and to respond to each child's unique needs. Developing cultural competence is a lifelong process. This chapter offers a starting point for understanding key issues, and the case studies and examples throughout this manual encourage continued exploration.

Activity 3B: Respecting Perspectives

Choose one of the family members in the Harris-Price case study. Try to see things from their perspective. What would their answers be to the following questions?

- How do you feel about the system's response?
- What do you think about the other family members?
- What do you think about the Social Worker and the CASA volunteer?
- Why do you think this happened?
- Has anyone tried to explain what has happened to you?
- What would you like to have happen?

The Value of Diversity

People are not the same. Everyone comes from a different culture, and yet brings something different to the table. Of course it is easy to see the value in fine Japanese silk, a Spanish meal, or a South African safari experience. It might prove a little more difficult to see the value in other types of culture and experience like: poverty for example.

Yet, the culture of poverty has immensely valuable components. For example, growing up poor can inspire people to great heights, it can create a camaraderie with others who are poor, it can create empathy for human suffering. Poverty has value. However, while few strive to be poor, the key is recognizing its value.

This example merely illustrates the difference that some people have – some are wealthy, some are middle class, and others are poor – and yet there is value to all of these differences. Your task, as a CASA, is to understand the value of the cultures of your CASA child and their family – whether it is a culture of class, neighborhood, race, etc.

Perceptions & Perspectives

Difference is most apparent when it results in conflicting opinions or clashing personalities. When these tensions involve deciding what is in the best interests of a child or implementing actions that are intended to advance the well-being of a child, the conflict can quickly become heated and it can become difficult not to make judgments about the other person. Of course, that person might very well be wrong, untrustworthy, or difficult. But what if that person is still important to the child's life? Indeed, what if that person is the child or youth?

One must ask two primary questions. First, whose perspective can help to build an accurate assessment of what is in the child's best interest? In interviewing people to determine what is in the best interest of the child, you must decide whose viewpoint is skewed, who might be lying, who is well informed, and who is seeing something you just might be missing. That can be difficult, particularly when your view is distorted by assumptions and stereotypes or when their reactions to you are skewed by their attitude toward your race, gender, or other characteristics. Second, what role can each person play in advancing the best interests of the child? For example, is a teacher's view of the child based on ignorance or misunderstanding? How can you still work with a person who you have come to dislike but is important to the child?

Activity 3C: Gut Reactions

Kathy Price's (A Birth Mother's) Story

Every day I wake up at 5 a.m. so I can get Rose, my baby, dressed and fed and get Ben and Robert up and ready for school. I take Rose to daycare and make sure the boys leave for school. Ben's a big help—sometimes he has dinner ready when I get home. I work long days. I clean at a motel and I also wash dishes at the restaurant around the corner. I get minimum wage. My jobs aren't so great, but I need every penny and can't miss a day. Sometimes after the kids go to sleep, I have a drink or two. It helps me sleep and is the only thing that helps my aching back—cleaning is hard work. My sister nags me about it, but it's not like alcohol is illegal or anything.

The day CPS took my kids was awful. The night before, I had run out of formula for Rose, so after I put her to bed I went to get some. The boys were watching TV and Ben was in charge. That formula is really expensive. I was out of vodka, too, and so I stopped to buy some. After that, I didn't have enough money for the formula. So I took a can—no big deal. But the lady saw me and they called the cops. They arrested me—for a can of formula! Worst of all, I was already on probation, so I'm really afraid they're going to throw the book at me.

1. What are the first thoughts and emotions that you have when reading this story?
2. How helpful do you think Kathy will be in helping you to understand what is in the best interests of her child?
3. How helpful do you think Kathy will be in helping to advance the best interests of her child?

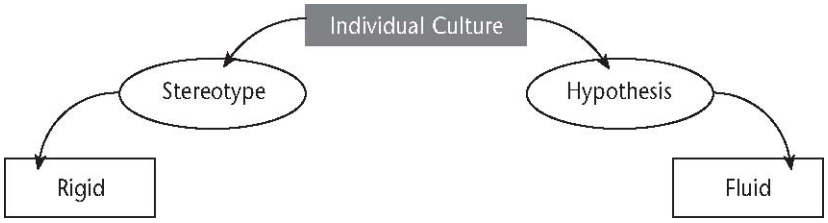
Stereotyping

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. Teenagers wear large, baggy jackets; therefore, teenagers shoplift. Such stereotypes can adversely affect your interactions with children and others in your 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 with whom you work. 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 still are closely tied to their Jewish faith or heritage. Another example might be that some African American families celebrate Kwanzaa, while others do not.

As an advocate, you need to examine your biases and recognize they are based on your own life and do not usually reflect what is true for the stereotyped groups. Everyone has certain biases.



Everyone stereotypes from time to time. Developing cultural competence is an ongoing process of recognizing and overcoming these biases by thinking flexibly and finding sources of information about those who are different from you.

Activity 3D: Identities & Labels

1. List all the identities you claim. (*e.g.*, father, Asian, Christian)
2. How would you feel if (or do you feel when) people ignore some of these identities?
3. Are there some that you keep to yourself to avoid stereotypes or assumptions?
4. List the labels that people have put on you.
5. Which of these do you accept? Which do you reject? Why?

Intersections

Intersections are important. They are often the ways in which people truly begin to understand just how different or how similar they are to other people. In talking with people, even those that are very different, you may find that you have been in similar situations, had similar events happen in your lives, have similar beliefs, or have similar perspectives on an issue. But while it is important to recognize these similarities, it is also important to recognize that they do not mean you are any less different. Just because you had a similar experience does not mean that the context was the same. For example, maybe losing a parent for you meant that you had to work instead of going to school, while for another person it only meant dealing with the grief associated with that loss.

In another example, you may share the fact you are both fathers that believe in strict discipline, but your understanding of "strict" may be completely different. Rather than use intersections to convince the person that you are really "all just people" or are "more alike than you thought," use intersections to learn more about just how similar and how different you are. Intersections may be the basis for improved understanding, but if unexamined, they can also lead to even greater assumptions and bigger mistakes.

Resisting Assumptions

1. Question your cultural assumptions.
2. Learn to assess whether differences of opinion are based on style (communication, learning, or conflict) or substance (issue).
3. Do not rely on your perceptions of what is being said.
4. Continue to seek experiences with people different from yourself.
5. Look for intersections, but do not impose similarity.
6. Understand that any change or new learning experience can be challenging, unsettling, and tiresome; allow for mistakes.
7. At the same time, understand that people may be tired of your mistakes.

Activity 3E: Intersections with Kathy Price

1. Reread Kathy Price's story on page 9.
2. How different do you think you are from her?
3. Do you have points of intersection with her?
4. Draw a "map" showing the parts of you that intersect and the parts that do not.
5. Do those intersections make you feel closer or more distant from her?

Activity 3F: Recognizing Your Values

Exploring the meaning and place of values in your work on behalf of children can assist you in seeing the range of values that people hold and the variety of reasons people have for their beliefs. It also increases your understanding that people can hold values very different from yours and be equally thoughtful and caring in their reasoning. Even when individuals appear to have similar values, they may actually have very different perspectives and reasons for having them.

Your work as a CASA/GAL volunteer cannot be free of values. You model your own and your community's values every day through your actions (and inaction). Almost all interactions transmit values in some way—for instance, through how you dress, move, relate to others, and communicate. As a CASA/GAL volunteer, you need to examine how values may affect your interactions with the children and families with whom you work. You need to acknowledge the plurality of values in your community and demonstrate respect for this diversity.

There are essentially two types of values: those that are universal and those that are not. Universal values are shared by an overwhelming majority of the community. Laws are often related to these values, but they are not the same things. The following exercise is an opportunity to explore your values and how they are similar to or different from the values of others.

Part 1: Complete the Values Statement Exercise. ***Do not*** put your name on the handout. This is an anonymous/confidential activity. After completing this form, give it to the facilitator, who will redistribute all the forms as part of an activity to clarify values and build empathy. When you receive a completed Values Statement Exercise, ***do not*** identify whether you received your form or someone else's. Spend a moment noticing if the answers in front of you are similar to or different from your own.

Part 2: Around the room are posted signs representing four possible responses to the values statements: strongly disagree, disagree, agree, and strongly agree. As the facilitator reads each statement, go to the sign that represents the answer on the sheet you have been given. With others in the group at your sign, think of the three most rational or respectful reasons a person might hold this belief. It may be especially difficult to come up with respectful reasons a person might hold a belief that is very different from your own, but remember that someone else in the room holds this belief. Show respect. This activity is an opportunity to gain insight into why people have beliefs that differ from your own.

As a group, share your three best reasons with the large group using the following format, "I believe [*read the statement*] because [*give your three best reasons*]."

After going through some of the statements, share any remaining concerns or questions.

Values Statement Exercise…

Circle the answer that best reflects your feelings and/or beliefs (e.g. the beliefs you would want to impart to your own children or family members).

1. I believe a family that prays together, stays together. strongly disagree disagree agree strongly agree	**8. I believe a parent's use of corporal punishment reflects his/her inability to communicate with children.** strongly disagree disagree agree strongly agree
2. I believe every child should be able to sleep in his/her own bed. strongly disagree disagree agree strongly agree	**9. I believe that mothers who stay in abusive relationships are guilty of child abuse.** strongly disagree disagree agree strongly agree
3. I believe a safe home is a happy home. strongly disagree disagree agree strongly agree	**10. I believe people who use or abuse drugs should be incarcerated.** strongly disagree disagree agree strongly agree
4. I believe that judges can resolve problems in families. strongly disagree disagree agree strongly agree	**11. I believe that cultural practices that violate the law should be prosecuted.** strongly disagree disagree agree strongly agree
5. I believe a gay or lesbian couple should be able to adopt children. strongly disagree disagree agree strongly agree	**12. I believe teen parents cannot do an adequate job of parenting.** strongly disagree disagree agree strongly agree
6. I believe that it is important to place a child with a family from a similar culture to their own. strongly disagree disagree agree strongly agree	**13. I believe drinking alcohol during pregnancy is child abuse.** strongly disagree disagree agree strongly agree
7. I believe illegal immigrants should not be entitled to government services. strongly disagree disagree agree strongly agree	**14. I believe that all children deserve safe and permanent homes.** strongly disagree disagree agree strongly agree

Exercise taken from National CASA Association 2007 Volunteer Manual

UNIT 4: Personality, Culture & Experience

When negotiating difference, it is often helpful to understand what the basis is for that difference. Do they have a different personality type? Do they come from a different cultural background? Have they been shaped by a different set of experiences? The answer is usually a complex blend of all three.

Personality Types

There have been many attempts to categorize people into personality types. Some of the more popular ones include Myers-Briggs, the Enneagram, and astrological signs. At root, all of these are attempts to understand why people, even within the same cultural group that have similar experiences, react differently. Most systems also provide suggestions on how to work with those that have personality types other than your own. These systems are as useful and as accurate as you find them to be. In general, it is helpful to have some framework for understanding and negotiating personality differences while understanding that people do not usually fit neatly into predefined boxes and that it is the actual people that must take precedence over a belief in any particular system.

Defining Culture

Most people agree that culture shapes people. But it is often hard to find a clear definition of what culture is. What do we mean when we say culture? Consider the following definition:

> **Culture:** The collective experiences, structures, and expressions of a people.

- What additional terms would you add to this definition?
- Do you disagree with any of the words used in the definition?
- How will exploring the meaning of culture help you in your role as a CASA volunteer?
- Are there differences between race, culture, and ethnicity? If so, what are they?
- Is there a CASA culture?

One challenge with defining culture is that it is never static. While culture helps to define a group of people, there are some people within that group that are always resisting and pushing the boundaries of culture. And because no group of people is monolithic and all people have some intersections groups, are constantly shifting and interacting, sometimes breaking up and merging. The debate of who and what is outside or inside a culture, what the culture is, and whether the culture should change is always active. Becoming culturally competent is not like learning a script and somewhat like learning how to play jazz: improvisation within a certain set of negotiable rules.

As a foundation for expanding your understanding of other cultures, it may be important to be acquainted with your own.

Activity 3G: What's in a Name?

Names are an important element of identity. Perhaps your first or last name has family or cultural significance, or maybe you have changed your name to better reflect who you are. In pairs, tell each other about your name. You may want to include the answers to the following questions:

- Who gave you your name?
- Do you like your name?
- Have you been called names?
- Do you have a nickname?
- Have you changed your name?

Most people belong to many communities, are influenced by many cultures, and have complex roles in different group. It can often be helpful to get an understanding of the different identities and communities held by people.

Experience

Although we are shaped by innumerable types of experiences, the type of experience we are going to explore in this manual are those based on status characteristics. Status characteristics are those traits a society uses to distribute privilege and access to resources. Just how large a role status characteristics play in the distribution of resources, which status characteristics play the biggest role and whether the society is becoming less focused on status characteristics is often a matter of heated debate. The premise underlying this manual is that status characteristics shape, to some degree, the experiences of people within California at this time.

Activity 3H: Exploring Status Characteristics

Part 1: Think about how your characteristics have influenced your experience.

- Age
- Sexual Orientation
- Religion or Spirituality
- Marital Status
- Language
- Disability
- Economic Status
- Race
- Family Form
- Ethnicity
- Nationality
- Gender
- Geographic Identity

Part 2: Then think about the following questions:

- Which categories would you consider to be a part of your private and truest identity? Are they listed here? Can one ever wholly describe you? Even so, would you like that part of your identity taken away?
- Which make you more vulnerable? Which give you strength? Can a characteristic do both at the same time?

As a CASA volunteer, you will have influence in the lives of the children and families in your cases. In the large group, discuss the following questions:

- How might your status characteristics and the experiences you have had create distance between you and those you will come in contact with as a CASA volunteer?
- How might they create connections?

Disproportionality in Child Advocacy

Disproportionality is overrepresentation or underrepresentation of various groups in different social, political, or economic institutions when compared to other groups. For example, women have a higher incidence of being single heads of household than men, and African Americans and Latinos have a higher incidence of imprisonments than European Americans.

There is no difference between races in the likelihood that a parent will abuse or neglect a child, but there is a great difference between races in the likelihood that a child will be removed from home and placed in foster care. Compared to white children, African American children are four times more likely to be placed in care, American Indian and Native Alaskan children are three times more likely, and Hispanic children are twice as likely.

Casey Family Programs on Disproportionality, www.casey.org/OurWork/Disproportionality/

✓ Children of color make up almost two thirds of the 540,000 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/Pubs/YouthED/Kids_00252_03783.pdf

✓ 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.

The AFCARS Report, www.acf.hhs.gov/programs/cb/publications/afcars/report9.htm

✓ The percentage of Hispanic children in foster care doubled from seven percent in 1982 to seventeen percent in 2002.

The Families for Kids Project and the AFCARS Report.

✓ 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 on Disproportionality, www.casey.org/MediaCenter/MediaKit/FactSheet.htm

What do you think causes disproportionality in the child welfare system? How might stereotyping or bias result in disproportionality? How can culturally competent child advocacy help eliminate disproportionality in the system? What changes in the society as a whole might help?

The Impact of Poverty

> *In 2004 a three-person family was considered "poor" if they earned less than $15,670, but the average income for poor families with children was less than $9,000 per year. This equals $747 a month, $172 a week, or less than $25 a day to meet all basic needs: food, clothing, shelter, health care, etc.*
>
> From *The State of America's Children: Yearbook 2000*, Children's Defense Fund, Boston: Beacon Press, 2000.

Consider the above information about the federal poverty level. Think about what strengths or abilities a person needs in order to live on $15,000 a year.

Socioeconomic status, or class, is a major factor that greatly defines how people live in the world. There are many myths and stereotypes associated with being poor. To separate myths from reality, it is important to look at what we do know about children and poverty in the United States.

Activity 3I: $25 a Day

Think about how much you spend, on average, per day, especially when a cup of coffee can cost $4. What if you had only $25 to spend each day, what would you spend it on?

Key Facts about American Children

1 in 2…

- Never completes a single year of college.

1 in 3…

- Will be poor at some point during childhood.
- Is behind a year or more in school.

1 in 4…

- Lives in a family where no parent has full-time, year-round employment.

1 in 5…

- Is born poor.
- Is born to a mother who did not graduate from high school.
- Children under age three is poor now.

1 in 6…

- Is poor now.
- Is born to a mother who did not receive prenatal care in the first three months of pregnancy.

1 in 7…

- Never graduates from high school.
- Children eligible for federal child care assistance through the Child Care and Development Block Grant receives it.

1 in 8…

- Does not have health insurance.
- Has an employed person in the family but is still poor.
- Lives in a family receiving food stamps.

1 in 9…

- Is born to a teenage mother.

1 in 12…

- Has a disability.

1 in 13…

- Was born with low birth weight.
- Will be arrested at least once before age 17.

From *The State of America's Children: Yearbook 2004*, Children's Defense Fund, Boston: Beacon Press, 2004, and the Anna E. Casey Foundation Kids Count Data Book, 2001 and 2003.

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

The majority of children you will encounter as a CASA 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.* However, knowing their socioeconomic status does help you better understand their life experience, specifically some of the hardships they face.

While abuse and neglect occur in families at all socioeconomic levels, poor children are more likely to come to the attention of the child protection system. This happens for a variety of reasons. One reason is that middle- and upper-income families have access to many more resources within their families than poor people do. Even though family crisis, including abuse, happens at all income levels, it is poor people who often ***have to*** turn to the system for support. For people living in poverty, initial contact with "the system" is usually for reasons other than abuse. The contact may be about accessing medical care, food stamps, housing, etc. Once this contact is initiated, these families are communicating with many "mandated reporters," increasing the likelihood that issues of child maltreatment 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. However, poverty is not a causal agent of abuse. Most poor parents do not abuse their children.

Children living in families in poverty are more likely:

- ✓ To have difficulty in school.
- ✓ To become teen parents.
- ✓ As adults, to earn less and be unemployed more.

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 a number of other risk factors. These risk factors include:

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

Children who live in poverty are far more likely to have both reports of abuse and substantiated incidents of abuse in their lives. While poverty is not the causal agent of the abuse, it is a risk factor.

Activity 3J: Thinking It Over

Consider the following questions:

- What effect might living in poverty have on access to education, health care, and daycare?
- What effect might current poverty have on the likelihood of future poverty?
- Is poverty viewed differently in different communities, geographic regions, neighborhoods, and/or religions? Why or why not?
- Are the experiences of poor families of color distinct from those of poor white families? What about Native American families? Are race and income level interconnected issues?

The facilitator will ask a few volunteers to share in the large group. The next unit examines these issues in more depth.

The Hidden Rules of Socioeconomic Class

"Hidden rules" are the unspoken understandings between individuals within one socioeconomic group (class) that help them recognize if others fit in or are a member of that socioeconomic class.

No matter the class, the rules of socioeconomic class are often so invisible that they are taken for granted by class members. People assume that everyone knows what they know. Hidden rules govern much of a person's first impression of an individual and his/her capabilities. People typically judge others from their own worldview. This is often a factor that keeps an individual from moving upward in a career—or even getting a job in the first place.

How a person approaches school or work may be more an expression of hidden rules than a true measure of ability. Middle-class solutions, typical of the child welfare system, should not necessarily be imposed when other appropriate and workable solutions can be found that better suit a particular family's worldview. Consider how the child must adjust to the expectations of a family each time their placement changes.

Think about the rules that existed in the home that you grew up in, or in the home you provide for your family. How would someone new fit into your family's dynamic?

Generational vs. Situational Poverty

Many of the families that come to the attention of the child protection system live in generational rather than situational poverty. The term "generational poverty" means that a person has been in poverty for at least two generations, while "situational poverty" is defined as a lack of resources due to a particular event such as divorce, death, or chronic illness. As with all descriptions of groups, this description is generalized and does not necessarily apply to any one individual. Families in generational poverty are often stereotyped as not working hard enough. However, most people who are living at or below the poverty level are working families. They work for minimum wage or less without access to health care or other benefits.

Most people living in generational poverty have functioning families. They have demonstrated the ability to parent appropriately and to meet their own and their children's basic needs. They fully utilize the nonfinancial resources at their disposal.

Some families with generational poverty have fewer resources and are more despondent and hopeless. A lack of autonomy and an inability to make choices have become the "norm" in their lives. They may feel left out of a society that places so much emphasis on material possessions. They may feel angry, frustrated, or cheated by the circumstances of their lives.

For most people, moving out of poverty is not possible without some type of support. If none is available, people become frustrated and hopeless. This hopelessness is sometimes expressed by an attitude that says, "Society owes me something." If you become frustrated by how the family of the child you represent thinks, consider their perspective for a moment. *Most people are doing the very best they can, with the resources they have, in the difficult situations they encounter.*

Activity 3K: Stereotyping vs. Cultural Competence

Read the home-visit summary written by a CASA volunteer below:

> During the home visitation, I observed that Billy's grandmother seemed to play an overly important role in Billy's life, and in fact, it was she who did the majority of parenting while I was there. When talking with his grandmother, Billy never looked at her directly and always spoke with a bowed head. It appeared that he was afraid of her and did not want to get within arm's reach. I observed in Billy's family some signs of disrupted attachment in that Billy did not kiss or hug his grandmother even though he had not seen her for several weeks. I also observed that the living quarters did not adequately provide for Billy's need to have a space of his own. He shared a room with several other people. I would therefore recommend that Billy's stay in foster care continues and that supervised visitations continue until the family can get more settled and provide for Billy's emotional and physical needs.

Divide into two groups: One group assumes that Billy's family is Native American, and the other group assumes that the family is Irish American. In small groups, answer the following questions:

- What additional information does this CASA volunteer need?
- How might this information change the CASA volunteer's interpretation of Billy's family situation?
- How might it change the CASA volunteer's recommendations?

Notes

CHAPTER 4

Child Development

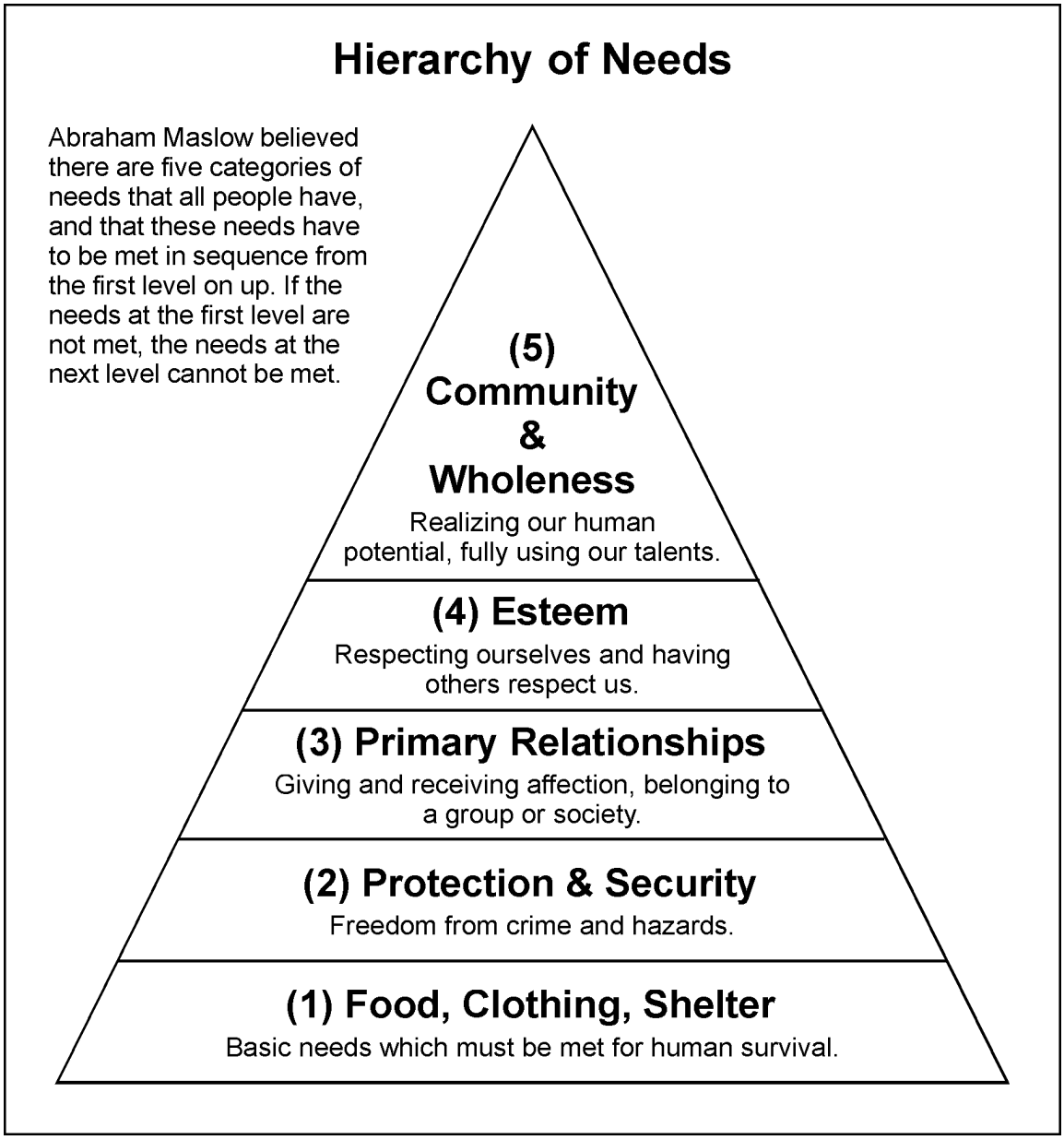
Purpose: *Learn about child development, attachment, separation, and other issues for children.*

TABLE OF CONTENTS

Objectives

By the end of this chapter, I will be able to…

- ✓ Analyze a child's needs using Maslow's hierarchy of human needs as a framework.
- ✓ Identify age-appropriate behavior for children from birth through adolescence.
- ✓ Name behavioral signs of attachment and lack of attachment in children.
- ✓ Understand a child's need for permanence.



UNIT 1: Hierarchy of Needs

Motivation and Personality, Abraham Maslow, New York: Harper & Row, 1960.

The first two categories of needs are self-explanatory. In the third level, primary relationships, Maslow stated that people need to experience love and a feeling of belonging. They need to give and receive affection and belong to a group or to a society.

Sound primary relationships make it possible for people's need for esteem—the fourth of Maslow's categories of need—to arise. Self-esteem and esteem from others allow people to feel self-confident and self-worthy. Without such respect in their lives, people feel inferior and worthless. When the need for esteem is met, the need for self-actualization surfaces. Maslow called this level "community and wholeness." At this level, people strive to realize their potential and exercise their talents to the fullest. Maslow noted that most people do not reach self-actualization because they never fully satisfy their needs for love and esteem.

UNIT 2: How Children Grow & Develop

When children's needs are being met appropriately, they are able to grow and develop optimally. It is important in your work as a CASA volunteer to be able to assess age-appropriate behavior for children from birth through adolescence. This unit examines materials on growth and development that will be a resource to you in your work.

How Children Grow & Develop

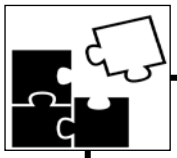
1. No two children are alike. Each one is different. Each child is a growing, changing person.
2. Children are not small adults. They do not think, feel, or react as grown-up people do.
3. Children cannot be made to grow. On the other hand, they cannot be stopped from growing.
4. Even though children will grow in some way no matter what care is provided for them, *they cannot reach their best growth possibilities unless they receive care and attention appropriate for their stage of development.*
5. Most children roughly follow a similar sequence of growth and development. For example, children scribble before they draw. But no two children will grow through the sequence in exactly the same way. Some will grow slowly while others grow much faster. Children will also grow faster or slower in different areas of development. For example, a child may be very advanced in language development but less advanced, or even delayed, in motor coordination.
6. During the formative years, the more successful a child is at mastering the tasks of a particular stage of growth, the more prepared he/she will be for managing the tasks of the next stage. For example, the better a child is able to control behavior impulses that he/she has as a two-year-old, the more skilled he/she will be at controlling behavior impulses he/she has as a three-year-old.
7. Growth is continuous, but it is not always steady and does not always move smoothly forward. You can expect children to slip back or regress occasionally.

8. Behavior is influenced by needs. For example, the active fifteen-month-old baby touches, feels, and puts everything into his/her mouth. His/her whole person is responding to a growth need; he/she is not intentionally being a nuisance who gets into everything.

9. Children need to feel that they are loved, that they belong, that they are wanted. They also need the self-confidence that comes from being able to meet situations adequately.

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

Resources for Child Caring, Inc., Minnesota Child Care Training Project, Minnesota Department of Human Services, 1986.



Activity: Ages & Stages

Divide into small groups. Each small group will be assigned one of the following children's age groups:

- birth to one year,
- one to three years,
- three to five years,
- six to nine years,
- ten to fifteen years,
- sixteen to twenty-one years.

The facilitator has placed cards with behaviors written on them on a table at the front of the room. Several different age groups' behaviors are represented on the cards. Collect cards that you think are descriptive of the age group you have been assigned. (Don't peek at the chart on the next page during this part of the activity!)

In the large group, we will share what you discovered and answer any questions

Child Development...	0 to 6 Months	6 to 12 Months	12 to 18 Months
COGNITIVE	Recognition of mother; 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 two to three words besides "mama" and "dada"; imitates familiar words.	Experiments with physical environment; understands the word "no"; comes when called to; 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 his/her toes, eyes, and nose; brings objects from another room when asked.
PSYCHOLOGICAL	Attachment to mother/ caretaker; totally dependent; totally trusting; learns intimacy.	Separation from mother; 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.
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 two or three 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 shoes, socks, pants, sweater.

Child Development...		18 to 36 Months	3 to 5 Years	6 to 9 Years
	COGNITIVE	Can conduct experiments inside head but limited to experience; rapid language growth; copies adult chores in play; carries on conver-sation 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.	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 1000 words; names at least one color; understands "tonight," "summer," "lunchtime," "yesterday"; begins to obey requests like "put the block under the chair"; knows his/her last name, name of street on which he/she lives and several nursery rhymes; uses past tense correctly; can speak of imaginary conditions "I hope"; identifies shapes.	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 penny, nickel, dime; knows common opposites like "big/ little"; asks questions for information; distinguishes left from right.
	PSYCHOLOGICAL	Autonomy struggles; learns system of meeting needs; social development increases; points to things he/she wants; joins in play with other children; shares toys; takes turns with assistance.	Can cooperate; self-perceptions develop; cannot separate fantasy from reality; has nightmares; models on same-sexed parent; experiences and copes with feel-ings (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.	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 coopera-tive play with other children involving group decisions, role assignments, fair play.
	MORAL	Knowledge of preferences of authority figures.	Self-esteem dependent on authority figures; follows peers' fads; negotiates to get needs met.	Has a conscience; refinements in moral development.

Child Development...		18 to 36 Months	3 to 5 Years	6 to 9 Years
	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...		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 his/her 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 his/her 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.
Child Development...	SEXUAL	Puberty; sex organs mature; males ejaculate and have wet dreams; both sexes able to masturbate to orgasm with fantasies; girls develop physically sooner than boys; may display shyness, blushing, and modesty.	Feelings of love and passion; development of more serious relationships; sense of sexual identity established[1]; increased capacity for tender and sensual love.
	MOTOR	Greater body competence (e.g., physical coordination); manual dexterity; growth patterns vary.	Heightened physical power, strength, coordination.

Chart compiled by Katie Thompson, Elon College student intern, NC Guardian ad Litem Program. Sources include: "Infant and Toddler Development," Dr. Maureen Vandermaas-Peeler, Elon College; "Child Development," Ray Newnam, Ph.D.; "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.

In using tools such as the preceding child development chart, keep in mind that:

- ✓ There is a wide range of typical behavior, and at any particular age twenty-five percent of children will not have reached the behavior or skill, fifty percent will be showing it, and twenty-five percent will already have mastered it;
- ✓ Some behaviors may be typical—in the sense of 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; and
- ✓ A CASA volunteer needs to become aware of his/her own values, attitudes, and perceptions about what is typical in order to be more objective and culturally sensitive when assessing a child's needs.

UNIT 3: Ten Strategies for Encouraging Teens

1. **Give responsibility.** Take the attitude that the teenager is a responsible person. Expect that he or she will take responsibility for his or her actions.
2. **Show appreciation for contributions at home.** Be sure to recognize teens' positive efforts. Show that you appreciate these efforts.

3. **Ask teens for their opinions and suggestions.** Teens probably know things that you don't, especially in the areas of fashion, computers, and music. Find out what teens have to offer...you'll learn something!

4. **Encourage participation in decision-making.** Show your respect for teens' opinions by getting them involved in making decisions about such things as their plans after high school, which electives they will take in school, career choices, household chores, etc.

5. **Accept mistakes.** Without mistakes, there would be no learning. Mistakes can occur anywhere, and can be made by anyone. Don't catastrophize when they occur.

6. **Emphasize the process, not just the product.** Focus on the effort, progress, or movement (process), not just on the goal, achievement, or accomplishment (product). Remember, it takes time to accomplish any goal; by encouraging efforts and progress, you can help increase teens' self confidence.

7. **Turn liabilities into assets.** Become an expert at scouting for positive potential. Accentuate the positive. By focusing on the positive, you will provide a safe environment for teens in which they can openly discuss their fears and perceived shortcomings.

8. **Show confidence in teens' judgment.** Start by showing confidence in teens' decisions about clothing, friends, and use of leisure time.

9. **Have positive expectations.** If you expect the worst, chances are you'll get it. However, expecting the "best" can set teens up for failure if they feel they have to be perfect. Instead, expect positive things and increasing effort.

10. **Develop alternative ways of viewing situations.** Use creativity and sense of humor to discover ways of seeing the same situation (e.g. a teen who is discouraged about not being hired for a job could be encouraged to look at all the things he or she learned from the application process and how to go through an interview).

UNIT 4: Attachment

What Is Attachment?

Attachment can be defined as:

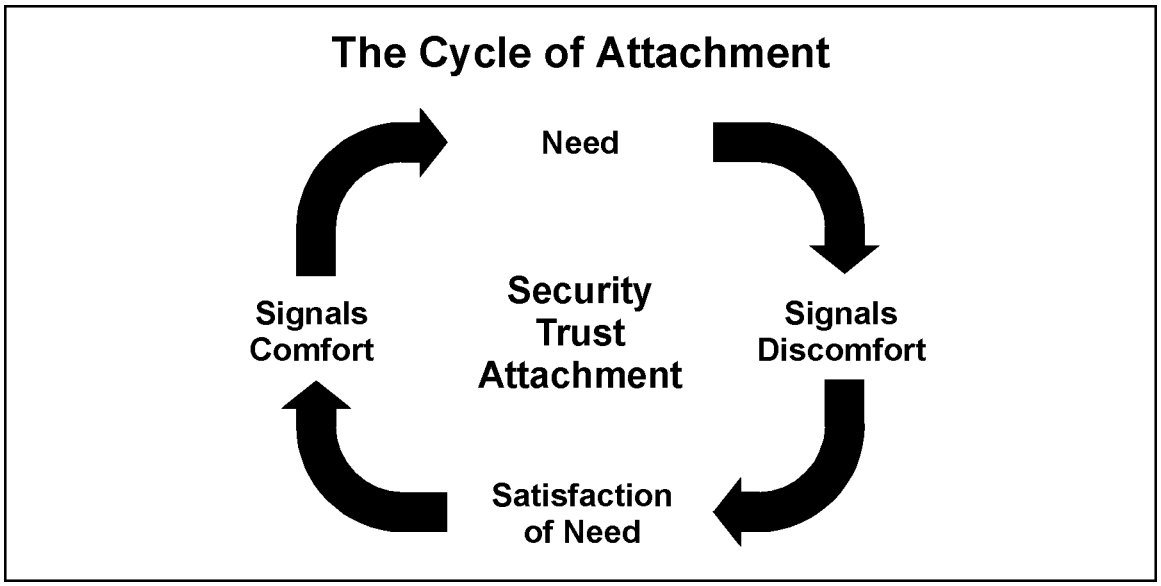
- The psychological connection between people that permits them to have relational significance to each other.
- An affectionate bond between two individuals that endures through space and time and serves to join them emotionally.
- A strong and enduring bond of trust that develops between the child and the person(s) he/she interacts with most frequently.

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

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

1. The child's genetic predisposition;
2. The conditions under which the child is taught; and
3. The child's "teachers" (the parents or caretakers).

Healthy attachments <u>are not</u> based on genetic ties to or the gender or culture of the caretaker. They <u>are</u> based on the nature of the relationship between the child and the caretaker.



When a baby cries, the caretaker responds by picking up the child. The caretaker continues to stroke, talk to, and hold the baby while the child is fed. After several days of this routine the child learns that to get needs met, all he/she has 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 having needs consistently met creates a secure attachment between the infant and caretaker. It is referred to as the "cycle of attachment" or the "trust cycle."

The basic needs of many of the children in the CASA program have not been met. Some children may cry for hours at a time, or may get hit when they do cry. This could result in a child who does not cry when hungry and does not trust adults. This child might turn away from the caregiver, refuse to make eye contact, push away or fight to avoid being close with another individual. When this type of child is distressed, he/she may not seek out a caregiver for soothing or comfort, or may be indiscriminate—seeking satisfaction from any potential caregiver, including a total stranger.

It is very important to understand the normal process of attachment because the experiences of most of the children in the child protection system increase the likelihood that they will have attachment problems, which may or may not rise to the level of a reactive attachment disorder.

Think about what you have observed in a healthy relationship between a child and parent. There is a distinct cycle of infant attachment development: (1) expressing a need (by crying); (2) having that need met (feeding, diapering, holding); (3) growing familiar with the person who meets the need; and (4) trusting that the caretaker will be there every time. This leads to "bonding" with that person, the trusted caretaker. This is the healthy attachment cycle.

Observation Checklist:

What to Look for in Assessing Attachment

Birth to One Year	
Does the child...?	**Does the parent(s)...?**
• appear alert • respond to people • show interest in the human face • track with the eyes • vocalize frequently • exhibit expected motor development • enjoy close physical contact • exhibit discomfort • appear to be easily comforted • exhibit normal or excessive fussiness • appear outgoing or is he/she passive and withdrawn • have good muscle tone	• respond to the infant's vocalizations • change voice tone when talking to the infant or about the infant • show interest in face to face contact with the infant • exhibit interest in and encourage age appropriate development • respond to the child's indications of discomfort • show the ability to comfort the child • initiate positive interactions with the child • identify positive or negative qualities in the child that remind the parent of another family member

One to Five Years	
Does the child...?	**Does the parent(s)...?**
• explore the environment in a normal way • respond to parent(s) • keep him/herself occupied in a positive way • seem relaxed and happy • have the ability to express emotions • react to pain and pleasure • engage in age appropriate activity • use speech appropriately • express frustration • respond to parental limit setting • exhibit observable fears • react positively to physical closeness • respond appropriately to separation from parent • respond appropriately to parent's return • exhibit body rigidity or relaxation	• use appropriate disciplinary measures • show interest in child's development • respond to child's overtures • encourage physical closeness with the child • comfort the child in a positive way • initiate positive interactions with the child • accept expressions of autonomy • see the child as "taking after" someone, is this positive or negative

Grade School Children	
Does the child...?	**Does the parent(s)...?**
• behave as though he likes himself • appear proud of accomplishments • share • perform well academically • always test limits • try new tasks • react realistically to making a mistake • show fear, anger, or acceptance • have the ability to express emotions • establish eye contact • exhibit confidence in his abilities or does he/she frequently say "I don't know" • appear to be developing a conscience • move in relaxed way or is their body rigid • feel comfortable speaking to adults • smile easily • react to parent(s) being physically close • have positive interactions with siblings and/or peers • appear comfortable with sexual identification	• show interest in child's school performance • accept expression of negative feelings • respond to child's overtures • give support for child in terms of developing healthy peer relationships • handle problems between siblings equitably • initiate affectionate overtures • use appropriate disciplinary measures • assign age appropriate responsibilities to the child
Adolescents	
Is the child...?	**Does the parent(s)...?**
• aware of his/her strong points • aware of weak points • comfortable with sexuality • engaging in positive peer interactions • performing satisfactorily in school • exhibiting signs of conscience development • free from severe problems with the law • accepting and/or rejecting parents' value system • keeping occupied in appropriate ways • comfortable with reasonable limits or is he/she constantly involved in control issues • developing interests outside the home	• set appropriate limits • encourage appropriate autonomy • trust the adolescent • show interest in and acceptance of adolescent's friends • display interest in adolescent's school performance • exhibit interest in adolescent's extracurricular activities • have reasonable expectations of chores and/or responsibilities the adolescent should assume • stand by the adolescent if he/she gets into trouble • show affection • thing this child will "turn out O.K"

UNIT 5: Separation and Loss

Most children who enter foster care, or move on from one foster home to another, or move into an adoptive home, experience separation from the person or persons to whom they are attached.

Reactions to Separation

Children differ in the way they respond to being separated from their parents. This response varies from severe depression in children who are well-attached to their parents and then abruptly separated from them to almost no reaction in children who have been emotionally neglected and have virtually no attachment to their parents. The reactions of most children who enter the child welfare system fall between those two extremes.

The child's reaction to separation from his parents can provide the court with valuable information about the attachment between them. There are several important influences on the child's reaction to separation. These include:

- **the nature of the child's attachment to his primary caretakers**
- **the nature of the primary caretaker's bonding to the child**
- **the experiences the child has had with separation in the past**

Does the child view the separation as his fault? Children whose parents have been hostile or irritable and have threatened the child with separation seem to be particularly affected by it.

- **the circumstances of the move itself**

Whether the child has been prepared for the move or not, the attitudes of the people around him and his ability to express his feelings and have them accepted all influence the child's reaction to separation.

- **the environment from which he is being moved**

Despite shortcomings that others may see in the child's environment, from the child's viewpoint the known is always better than the unknown. However if the child is actually fearful of his living environment he may not react to the separation as much.

All these factors influence a child's reaction to separation. In helping a child handle separation it is useful to know what a "normal" reaction to separation is.

Bowlby (1970) describes three stages that well-attached children go through when they are separated from the person to whom they are attached. These stages are most evident in the younger child. They are:

1. the child protests vigorously and makes attempts to recover his mother, such as going to the door and trying to find her;
2. the child despairs of recovering his mother, but he continues to be watchful. He appears to be preoccupied constantly and depressed. When a car drives up or when there is a noise at the door, he becomes alert, hoping that his mother is returning; and
3. the child becomes emotionally detached and appears to lose interest in mother.

Case Example

At the time we saw John, he was four and had been in foster care for about three months. During his first six weeks in care, he was placed in a foster care receiving home. During his stay in the receiving home John was fussy and cried constantly.

In his second foster placement he was not so much fussy as withdrawn. He played for hours by himself, talking to himself in baby voices and making peculiar sounds. He had good eye contact when we examined him, but he seemed to respond equally warmly to all adults. He was at his age level on developmental tests and was in good contact with reality.

The history revealed that John had lost his mother when he was eighteen months old. His father became his primary caretaker. The father planned a major move across the country. While he was moving and getting settled, he left John with an aunt. John had almost no contact with the aunt before he was left there. With the aunt he became very fussy. He regressed in toileting and smeared feces. He alternated between being very depressed and having temper tantrums. The aunt had placed John in foster care.

When John was in the second foster placement, his father came for his first visit with the child. John's face "lit up" when he first saw his father. He then looked apprehensive and acted ambivalent about getting close to his father. His father initiated many positive interactions with John. Eventually, John was able to say "Don't ever leave me again, Daddy."

John's history illustrates the stages that Bowlby describes as common in well-attached children who are separated. Because history of strong attachment is rare in the child welfare system or because workers fail to recognize this sort of behavior for what it is, there is a danger that children who have this kind of reaction may be classified as "severely disturbed."

Fears, anxieties, nightmares, or night terrors are very common for children who are separated from their parents. Some children will withdraw more and won't want to talk. In these cases, foster parents can be physically close without insisting on talking. When a child is angry, foster parents can accept the anger and at the same time teach the child appropriate ways of expressing it. Some children initially overeat when they are placed in foster care, as though they were trying to fill a void in their lives. Others are too depressed or anxious to eat at all.

It is not unusual for a child to act aggressively during separations from his parents and be very ambivalent toward them when he visits them or returns home. The child does not plan to act this way but does so in response to unconscious stimuli. The function of this behavior is to assist in the reunion process and to discourage his parents from leaving again. Hence, this behavior promotes rather than discourages bonding.

Symptoms of Lack of Attachment

Withdrawal

Many children with attachment problems withdraw from interactions with others. This withdrawal takes different forms. Some children withdraw physically. Others seem to put up a shield around themselves; they may be physically near but not close emotionally.

A third type of withdrawal resembles fear. As the parent reaches out to the child, he cringes. If the parent hugs the child, he pulls away or tightens up. All children who withdraw from physical closeness this way have not been abused. Some may have simply learned about the effect their behavior has on adults. Adults don't want to scare children. Thus, eventually the child learns that cringing, fearful behavior works to keep adults at a distance.

Chronic Anxiety

When a child is confident that his parent will be available when needed, he is less prone to anxiety that is intense or chronic. The most frightening situation for the child is one in which he needs his parent and that parent is not available. This kind of anxiety is greater in children who have been moved without preparation or who have other major changes in their lives occur abruptly. Children who experience chronic anxiety are also often very possessive and clinging.

Aggressive Behavior

Some children keep adults at a distance by behaving aggressively. If an adult is hit, kicked, scratched, or bitten every time he approaches a child, he is likely to learn to

keep his distance. If children have tantrums whenever a demand is placed on them, many parents find it easier to stop making demands. Hyperactive behavior also keeps adults away. It is difficult to get close to a child who is always on the move and easily distractible.

Indiscriminate Affection

Although a normal child may be very talkative and sociable with strangers, the talk is rarely accompanied by physical overtures. On the other hand, the child who is indiscriminately physically affectionate may go up, hug a virtual stranger, and say "I love you." He, or more commonly, she, will immediately climb up on the lap of the visitors to their home and start to hug and kiss them. These interactions frequently have a seductive quality about them.

If the child behaves in this way toward many adults—or virtually all adults—the child is really saying, "No one is more important to me than others." Since attachment means that a few people are more important than others, indiscriminate affection is a sign of attachment problems. It is difficult for foster or adoptive parents to feel close to a child who is acting close to everyone else. In addition, children who are willing to go with strangers pose real supervision problems for their parents.

Over-competency

Some children with attachment problems seem to be over-competent. They don't appear to need parents. They frequently insist on doing everything for themselves. These are the preschoolers who never seem to need help with dressing or undressing. Some little girls who are excessively competent are, at age five, getting up, making their own beds, and picking up their rooms without being asked. This may sound like desirable behavior, but as anyone who has had a child will recognize, it is certainly unusual behavior. When such children do need help,they may grant the adult permission to help them, as in "You may tie my shoes for me."

Lack of self-awareness

Some abused children seem very aware of their environment but nearly unaware of their own bodies. They may overeat until their stomachs are distended and they are at the point of vomiting. They may not react to pain and seem unaware of extremes of temperature. Many of these children are bedwetters. It is as if they never learned to pay attention to the signals from their own bodies or to what alleviates their own discomfort.

These behaviors may develop in children whose parents were unresponsive to them in infancy. Some abusive parents take care of the child when they feel like it, rather than when the child needs it. Thus, the child does not learn to associate certain kinds of discomfort with certain kinds of relief.

Control Battles

Both the lack of trust for others that poorly attached children have and the family power struggles that many abused children have witnessed contribute to problems such children have with control issues. Such children have trouble staying within clearly defined limits of behavior. They appear to be constantly testing. Reasonable requests from parents lead to major confrontations.

Though outwardly these children seem to need to be in control of all situations, they actually feel that they have little control over their lives. This may come from being moved abruptly, or from experiencing other sudden major life changes.

The Two or Twenty Syndrome

There are certain poorly attached children that appear "too old for their ages" part of the time and immature at other times. They seem to receive little gratification for acting their chronological age.

Such children try to engage in activities usually preferred by older children. When they play with children their own age, they want to be in charge. They want few restrictions placed on their behavior. In some ways, they act like an independent, twenty-year old.

However, if someone sets limits on their behavior or if they are frustrated, they revert to temper tantrums typical of two-year olds. Teachers usually describe these children as immature because in a structured school situation their "babyish" resistance to controls is more evident.

Delayed conscience development

Children with a delayed conscience development tend to lie and steal. They may lie about very unimportant things even when there would be no negative consequences for telling the truth. It may also be difficult to tell when such children are lying. The stealing they do may take the form of "finding" things frequently at school, of taking money or things from their family, or of stealing from stores. They often do not show signs of anxiety when they are caught. In fact, they may continue to deny their actions in the face of evidence of their misbehavior.

Lack of Attachment and Its Relationship to Cognitive and Developmental Problems

Some of the symptoms exhibited by children who have had poor attachments are the same symptoms that are exhibited by children with what is called "minimal brain dysfunction." Children with minimal brain dysfunction may be hyperactive, easily distractible, impulsive, subject to extremes of emotions and have learning

disabilities. They may, in other words, be children who seem to have a very short attention span, or who seem to "always act before they think."

They may also overreact to what is going on around them. For example, if a child gently brushes by a hyperactive child, the hyperactive child may perceive this as an open invitation to fight. Such children may have a very low tolerance for frustration. They may have difficulty moving from one task to another if they view the first task as incomplete.

CHAPTER 5
Dynamics of Child Abuse and Neglect

TABLE OF CONTENTS

Goal

In this chapter, I will learn about child abuse and neglect—definitions, indicators, and risk factors. I will increase my understanding of and my ability to assess the families and family situations of the children with whom I will work as a CASA volunteer. In particular, I will consider the issues of substance abuse, domestic violence, poverty and mental illness and how these issues impact families.

Objectives

By the end of this chapter, I will be able to…

- ✓ Describe why the "minimum sufficient level of care" standard is in the best interest of the child.
- ✓ Specify risk factors associated with child abuse and neglect.
- ✓ Recognize how substance abuse and domestic violence impact families and children.
- ✓ Better understand the reality of poverty for children and families in the United States and understand why poverty is a risk factor for children.
- ✓ Recognize how mental illness impacts families and children.

UNIT 1: The Importance of Family to a Child

Why the "Minimum Sufficient Level of Care" Standard Is Important

Children grow up best in families. To develop into functional, emotionally stable adults, they need that unique sense of belonging that comes from being part of a family. Children need that safety net that only the unconditional acceptance of family can provide. They need that knowledge of and connection to their cultural/ethnic heritage that is learned within the family.

Based on information from *Beyond Rhetoric: A New American Agenda for Children and Families*, National Commission on Children, Washington, D.C.: Government Printing Office, 1991.

When a child's biological family is unable to meet these needs, what then? What is in the child's best interest? These are not easy questions to answer. The CASA volunteer starts with the assumption that a child's own family is usually the best setting for raising and nurturing that child. This is true even if the family's lifestyle, beliefs, resources, and actions are radically different from the volunteer's. *As long as the child's family meets or can be helped to meet the minimum sufficient level of care required for the safety of that child,* the child belongs with his/her family.

A minimum sufficient level of care (MSL) means that all basic needs are met and the child is not harmed physically, sexually, or emotionally. On the other hand, the optimum level of care means that the child has considerably more than the minimum: things like a library card, tutoring, tennis lessons, a community of faith, Little League, Scouts, college, a loving extended family. The state intervenes when basic needs are not met—not when a family is unable or unwilling to provide an optimal level of care.

In considering what the minimum sufficient level of care is for any one child, it is important to remember the key parameters of this standard.

1. It relates to a particular child.
2. It is a set of minimum conditions, not an ideal situation.
3. 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.
4. It remains the same when considering removal as when considering reunification.

The idea that a minimum sufficient level of care should be the standard for families is often difficult for CASA volunteers to embrace. It feels counterintuitive, almost like it defies common sense. Volunteers are tempted to ask, "Wouldn't any child be better off in a family without the limitations that are present in this situation?" The truth is that most would not. The overwhelming sense of loss that children suffer when removed from their home—loss of love, of security, of the familiar, of their heritage, of control in their lives; feelings of worthlessness; and the almost unendurable pain of separation—is far worse for most children. Despite the bad things that have happened in their lives, most children in the system love their families and want desperately to be reunited with them. In some ways, that is not strange at all. Take a moment to think back to your own childhood. Whatever it was like, how would you have felt if a stranger came one day to take you away to live with a "better" family?

If parenting hovers at the minimum sufficient level of care, the child protective services system and the court likely will not get involved. If parental care drops below the minimum sufficient level of care (meaning the child's basic needs are not being met and/or the child is being abused), the child protective services system steps in. Once the system has intervened, the responsibilities of the parent (e.g., seek substance abuse treatment, learn parenting skills) and those of the child protective services agency (e.g., provide visitation, financial aid, etc.) are spelled out in agreements that are enforced by court orders.

Ideally, these agreements will help the parent move at least to a minimum sufficient level of care, and hopefully beyond. The steps in these agreements with parents need to be in small, manageable segments. Appropriate resources need to be available to support changes that the parent makes. If the steps are too big or complex, the parent may give up, causing the family situation to deteriorate and the child to lose the chance to ever return home. It is also helpful if these agreements are written in a way that allows success to be measured.

It is important to acknowledge the resources that do exist within a family and tap into them. While the CASA volunteer may impact the financial status of a family through advocating for a referral to a program such as job training, it is far more likely that the volunteer's influence will be exerted to access other resources. Some examples of this are identifying a tutor for the child, advocating for medical care, assisting the family in locating culturally appropriate support systems, and connecting them with role models in their community.

Unit 2: Assessing the Care of Children

Assessing for abuse and neglect takes experience, careful observation, and collaboration. It is easy to jump to conclusions in either direction.

Parameters used in assessing child abuse and neglect

- ✓ Age of the child
- ✓ Frequency of the abuse or neglect
- ✓ Severity of the abuse or neglect
- ✓ Location of injury
- ✓ Intent
- ✓ Caregiver's awareness
- ✓ Concurrent stressors in the home
- ✓ Presence of surrogate parent in the home
- ✓ Several risk factors in the home
- ✓ History of known or suspected child abuse or neglect
- ✓ Cultural and regional differences in child-rearing
- ✓ Local laws on child abuse and neglect

Common signs and patterns of child abuse and neglect:

Physical Abuse:

Signs: Bruises, swelling, lacerations, abrasions, fractures, burns, bleeding

Patterns: Shape, location, stages of healing, erratic medical visits

Sexual Abuse:

Signs: Bleeding, bruising, swelling, infections, STDs, pregnancy

Patterns: In genital area, on upper thighs or buttocks

Neglect:

Signs: Off age height/weight charts, hunger, poor hygiene, skin disorders

Patterns: Erratic medical/ dental care, clingy or avoidant of contact

Abused or neglected children often (but not always) exhibit similar negative behaviors:

- ✓ Regression (immaturity) or pseudo-maturity
- ✓ Fearfulness or lack of fearfulness
- ✓ Age-inappropriate or excessive sexualized play or exploration
- ✓ Extreme aggressiveness or timidity
- ✓ Poor sleeping patterns
- ✓ Poor eating patterns
- ✓ Excessively good or poor hygiene habits
- ✓ Under-achieving or over-achieving in school
- ✓ Excessively prone to accidents (including self-inflicted injuries)
- ✓ Increase in somatic complaints
- ✓ Cruelty to smaller children or animals
- ✓ Disorganized attachment patterns

Please note: Children with certain medical and psycho/neurological conditions or children who are experiencing other stresses at home (e.g., a death in family, new baby, move to a new home or divorce) can also exhibit some of these same behaviors.

Mary Nichols, MFT, Supervising Children's Social Worker, Department of Children and Family Services, West Los Angeles, Emergency Response.

UNIT 3: Risk Factors Associated with Child Abuse & Neglect

The source of child maltreatment is typically some combination of people, environment, opportunity, and needs. Risk factors for child abuse and neglect include child-related factors, parent/caretaker-related factors, social-situational factors, family factors, and triggering situations. These factors frequently co-exist. Poverty is often a complicating issue, creating problems in a family and reducing the resources they have for addressing problems. Poverty in and of itself is not child neglect.

Conditions That May Lead to Abuse & Neglect

Child-Related Factors

- **Chronological age of child:** Fifty percent of abused children are under the age of three; ninety percent of deaths are under one year of age; first-born children are most vulnerable;
- **Mismatch** between child's temperament or behavior and parent's relating style and 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:** Financial stress, inability to bond, parental feelings of guilt, failure, or inadequacy; and/or
- **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 tend to 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 faulty brain chemistry and/or a result of having major problems and limited emotional resources to deal with them. Abusive and neglectful parents are often seen and considered by themselves and others to be terribly depressed people;
- **Impulsive:** Abusive parents often have a marked inability to channel anger or sexual feelings;
- **Substance abuse:** The "high" resulting from drugs and/or alcohol serves as a temporary relief from insurmountable problems but, in fact, creates new and bigger problems;
- **Character disorder or psychiatric illness**;
- **Ignorance of child care and child development and unrealistic expectations**;
- **Isolation:** Abusive and neglectful families may tend to avoid community contact and have few family ties to provide support. Distance from, or disintegration of, an extended family that traditionally played a significant role in child rearing may increase isolation;

- **Sense of entitlement:** Belief that it's acceptable to use violence to ensure child's or partner's compliance;
- **Mental retardation or borderline mental functioning**.

Social-Situational Factors

Abuse occurs in the family context. It is important therefore to understand the factors that may affect the family unit as a whole.

- **Structural/economic factors:** The stress of poverty, unemployment, little mobility, and poor housing can be instrumental in a parent's ability to adequately care for a child. The child needs to be protected from separation from his/her family solely because of stressed economic conditions. Middle- and upper-income abusive parents may use the excuse of job or financial stress as well—abuse is not limited to families in poverty;
- **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;
- **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 between men**, with intolerance of perceived disrespect ("dissing");
- **Abnormal child-rearing practices** (e.g., genital mutilation of female children, father sexually initiates 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"); and/or
- **Institutional manifestations of all of the above** in law, health care, education, welfare system, sports, entertainment, etc.

Family Factors

- **Domestic violence** can indicate an inability of one parent to protect the child from another's abuse because the parent is also being abused;
- **Stepparent, or blended, families are at greater risk:** There is some indication that an adult partner who is not the parent of a child is more likely to maltreat. Changes in family structure can also create stress in the family;
- **Single parents are highly represented in abuse and neglect cases:** Economic status is typically lower in single-parent families, and the single parent is at a disadvantage in trying to perform the functions of two parents;
- **Adolescent parents are at high risk because their own developmental growth has been disrupted:** They are ill-prepared to respond to the needs of the child because their own needs have not been met;
- **Child-rearing styles** that are punishment-centered 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; and/or
- **Adoptions:** Late in childhood, special needs, or with a temperamental mismatch; Indian children not culturally matched or given a culturally responsive placement.

Triggering Situations

Any of the factors above can contribute to a situation in which an abusive event occurs. Following are some examples that may trigger the abusive event:

- **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 who will not stop crying;
  - Frustration with toilet training;
  - An alcoholic who is fired from a job;
  - A mother who, after being beaten by her partner, cannot make contact with her own family;
  - Being served an eviction notice;
  - The cessation of prescription drug used to control mental health problem;
  - Law enforcement is called to the home in a domestic violence situation, whether by the victim or a neighbor; and
  - A parent who was disrespected in the adult world later takes it out on the child.

UNIT 4: The Impact of Substance Abuse/Chemical Dependency on Children & Families

Substance abuse is one of the factors that contribute to abuse and neglect. Psychoactive substances, including alcohol, whether legal or illegal, impact and alter moods, emotions, thought processes, and behavior. These substances are classified as stimulants, depressants, narcotics, cannabis, or hallucinogens based on the effects they have on the people who take them.

Impact on Children

Some estimates indicate that as many as fifty to eighty percent of substantiated child abuse and neglect cases involve some degree of substance abuse by the child's parents. It is helpful to remember that the child of a parent with abuse/addiction problems still loves his/her parent, even though the parent may have abused or neglected the child.

Adapted from materials by Stephen Bogan, M.A., Department of Social and Health Services, Olympia, WA.

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 his/her ability to parent effectively, a child may suffer in a number of ways:

- A parent's overriding involvement with alcohol and other drugs may leave the parent 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.
- 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 (churches, 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.
- A child may be placed at increased risk for sexual abuse with the parent's substance-abusing friends coming in and out of the home.
- Eventually, a parent's substance abuse may lead to criminal behavior and periods of incarceration, depriving the child of parental care.
- Consistent 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 own substance abuse.

What the Child Experiences

From a child's perspective, a parent's substance abuse is usually characterized by the following:

- ✓ **Broken Promises**
  To go somewhere with the family, do something with the children, not drink that day, not get high on some occasion. The children grow up thinking they are not loved or important enough for their parents to keep their promises.

- ✓ **Inconsistency & Unpredictability**
  With rules and limits that seem to change with the occasion, and parents who can be loving one moment and abusive the next.

- ✓ **Shame & Humiliation**
  As alcohol or drugs take over and suddenly turn an otherwise lovely parent into a loathsome embarrassment.

- ✓ **Tension & Fear**
  Because the children never know what will happen next. Children of substance-abusing parents typically feel unsafe at home, the environment in which they should feel most protected.

- ✓ **Paralyzing Guilt & an Unwarranted Sense of Responsibility**
  Many children think they cause their parents' behavior. Part of the disease is to blame someone else for it, and the children grow up thinking that if they were better students, more obedient, neater, more reliable, or nicer to their siblings, the problem would disappear.

- ✓ **Anger & Hurt**
  About being neglected, mistreated, and deemed less important than the alcohol or drugs. The children grow up with a profound sense of abandonment.

- ✓ **Loneliness & Isolation**
  Because the family tries desperately to deny or hide the problem and often will not even discuss it among them. The children, with no one to talk to about the most important thing in their lives, think they are the only ones with this problem.

- ✓ **Lying as a Way of Life**
  To constantly cover for the failure of the parent, or account for his/her deviant behavior.

- ✓ **Feeling Responsible**
  To organize and run the home and care for younger siblings.

- ✓ **Feeling Obliged**
  To hide the problem from authorities in order to protect the parent.

Adapted from *When Your Parent Drinks Too Much: A Book for Teenagers*, Eric Ryerson, New York: Facts on File, Inc. 1985

Children in substance-abusing families need significant treatment to address these issues and begin to heal their wounds. The CASA volunteer can advocate for counseling from a provider who has expertise in working with substance abuse issues.

Key Points a CASA Volunteer Should Consider

In deciding whether a child can return home to a family where substance abuse occurs, a number of 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; and
- Treatment prognosis and/or length of sobriety.

A dilemma that often arises is the conflict between the legal mandate for permanence (ASFA), as well as the child's need for permanence, and the long-term treatment (including inpatient treatment) that may be needed by substance-abusing parents. If a parent is in treatment, consideration should be given to placing the child with the parent rather than in foster care. Although it is often the only available option, the child may feel punished when he/she is placed in foster care or away from the parent. The focus should be to support success in treatment, not punish the parent by withholding the child.

What Can a CASA Volunteer Do?

Educate yourself about the power of addiction and about resources such as Alcoholics Anonymous, Narcotics Anonymous, Rational Recovery, Al-Anon, and Alateen. 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:

- 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, and child support;
- When a child is in foster care, frequent visitation in a homelike atmosphere; and/or
- Assistance for the parent seeking to flee a domestic violence perpetrator, such as obtaining a protective order, alternative housing, and other necessary steps. Substance-abusing domestic violence victims are more likely to remain sober away from the abuser.

Information on Drugs & Their Effects

	DRUGS	POPULAR NAMES	METHODS OF USE	POSSIBLE EFFECTS	EFFECTS OF OVERDOSE
Depressants	Alcohol	Booze, Liquor, Spirits	Oral	▪ slurred speech ▪ disorientation ▪ loss of memory ▪ loss of inhibitions ▪ impaired judgment	▪ shallow respiration ▪ cold and clammy skin ▪ weak and rapid pulse ▪ coma ▪ possible death
	Methaqualone	Quaalude, Sopor, Ludes, 714s	Oral, Injected		
	Benzodiazepines	Diazepam, Dalmane, Librium, Valium, Tranks	Oral, Injected		
	Barbiturates	Seconal, Nembutat, Stumblers, Downers, Goofballs	Oral, Injected		
Cannabis	Marijuana	Weed, Pot, Grass, Acapulco Gold, Sinsemilla, THC	Oral, Smoked	▪ difficulty concentrating ▪ euphoria ▪ short-term memory loss ▪ loss of depth perception ▪ increased appetite ▪ disoriented behavior ▪ lack of motivation ▪ lowered productivity	▪ fatigue ▪ paranoia ▪ possible psychosis
	Hashish	Hash, Hash Oil	Oral, Smoked		
Stimulants	Cocaine	Coke, Flake, Snow, Crack	Snorted, Injected, Smoked (freebased)	▪ increased alertness ▪ excitation ▪ euphoria ▪ increased pulse rate ▪ increased blood pressure ▪ loss of appetite ▪ insomnia ▪ dilated pupils	▪ agitation ▪ increased body temperature ▪ hallucinations ▪ convulsions ▪ possible death
	Amphetamines	Dexedrine, Desoxyn, Biphetamine, Crystal, Meth, Speed, Crank, Uppers	Oral, Injected, Snorted		
	Nicotine	Cigarettes, Snuff, Smokes, Chew	Oral, Smoked		
Hallucinogens	LSD	Mickey Mouse, Acid, Microdot, Blotter Acid, Paper Acid	Oral	▪ illusions ▪ hallucinations ▪ poor perception of time and distance	▪ longer and more intense “trip” episodes ▪ “awake” coma ▪ bizarre behavior ▪ violence ▪ psychosis ▪ possible death
	Mescaline & Peyote	Mesc, Buttons, Cactus	Oral, Injected		
	Amphetamine variants	2, 5-OMA, PMA, STP, MDA, Ecstasy, Adam & Eve	Oral, Injected		
	PCP	Angel Dust, Hog	Oral, Injected, Sniffed, Smoked (usually w/Marijuana)		
	Other	Psilacybin, DMT, DET	Oral, Injected, Smoked, Sniffed		
Narcotics	Opium	Paragoric, Dover’s Powder, Parepectolin	Oral, Smoked	▪ euphoria ▪ drowsiness ▪ respiratory depression ▪ constricted pupils ▪ nausea	▪ slow and shallow breathing ▪ clammy skin ▪ convulsions ▪ coma ▪ possible death
	Morphine	Big M, Drugstore Dope	Oral, Injected, Smoked		
	Codeine	Robitussin A-C, Empirin Compound w/Codeine	Oral, Injected		
	Heroin	Smack, Stuff, Horse, Dope, Boy	Injected, Sniffed, Smoked		
	Methadone	Dolophine, Methadose, Dome, Medicine	Oral, Injected		

UNIT 5: The Impact of Domestic Violence on Children & Families

Domestic Violence Statistics

- A woman is beaten every 15 seconds: between three to four million women are battered each year in the United States of America.
- Every day approximately 10 women are killed by their batterer.
- Women of all races are about equally vulnerable to violence by an intimate.
- The health-related costs of rape, physical assault, stalking and homicide committed by intimate partners exceed $5.8 billion each year. Of that amount, nearly $4.1 billion are for direct medical and mental health care services, and nearly $1.8 billion are for the indirect costs of lost productivity or wages.
- In a national survey of more than 6,000 American families, 50 percent of the men who frequently assaulted their wives also frequently abused their children.

Domestic violence stems from one person's need to dominate and control another. Domestic violence is not caused by illness, genetics or gender, alcohol or other drugs, anger, stress, the victim's behavior, or relationship problems. However, such factors may play a role in the complex of factors that result in domestic violence.

What Are the Basic Dynamics of Domestic Violence?

- ✓ It is more that the conflict between a man and a woman (or one partner and another).
- ✓ It should not be characterized solely by physical assaults.
- ✓ It is not about "hotheadedness," but about repetitive deliberate forceful exertion of control.
- ✓ It is a profile of chronic abusive and controlling behaviors only punctuated by physical assault.
- ✓ These behaviors include:
  - Verbal put-downs
  - Threats of violence—verbal and symbolic (brandishing weapons, destruction of property, mistreatment of pets)
  - Unrealistic expectations
  - Rigid limitations of the victim's actions
  - Control of household decisions, especially control of finances
- ✓ It is a relationship problem.
- ✓ It is a family problem.
- ✓ It is a community problem.

Mary Nichols, MFT, Supervising Children's Social Worker, Department of Children and Family Services, West Los Angeles, Emergency Response.

Insert Domestic Violence Fact Sheet

What is the Effect of the Family Violence on the Children?

Not all survivors have the same physiological or psychological responses to the same trauma. No two children necessarily have the same response to family violence. It depends on the child's developmental age at the onset, the severity and frequency of the violent relationship they experience; the individual child's own personality and resilience; previous trauma they might have suffered; the availability of social supports.

Physical/Medical risks for children:

- They can get injured "accidentally."
- They are also more likely to be the target of physical or sexual abuse.
- Often they are at risk for neglect, especially medical neglect
- Early drug and alcohol abuse
- Stress-related ailments: asthma, headaches, stomachaches, etc.

Social Developmental risks for children:

- They view violence as a normal feature of "love" relationships.
- They minimize the dangerousness
- They learn it is "expected" behavior—a problem-solving tool.
- Identify with the batterer/power—increase aggressiveness
- Identify with the victim—overly cooperative and compliant
- Running away and/or early marriage

Psychological Developmental risks for children:

- Learned helplessness
- Excessive need for control
- Mood disorders
- Anxiety complaints
- Attachment disruptions (too dependent or lacking empathy)

Neurological/Post Traumatic Stress symptoms for children:

- Flashbacks, nightmares
- Dissociative states—numbing out
- Hyperarousal: easily startled, easily agitated
- Elevated basal, resting, heart rates.
- Sleep disturbances

Cognitive and Academic Developmental risks:

- Short-term memory impairment
- Poor attention skills
- Impaired ability to present information in a narrative
- Overly conscientious at school

Mary Nichols, MFT, Supervising Children's Social Worker, Department of Children and Family Services, West Los Angeles, Emergency Response.

In the Words of Their Mothers…

Annette

The kids were carrying a dreadful secret. If they talked, they would lose their dad, and they would be responsible for "breaking up" the family. If they didn't talk, they felt like they were taking part in my abuse. The kids were torn to pieces by the time we left him. And even that didn't end it. Every time he had visitation, he'd grill them about me, and he was always trying to make them choose between him and me. He'd coach them on things he wanted them to say to me and then they'd have to decide: "Should I say it or not?" He tried to turn them into weapons in his war on me.

Jocelyn

*One morning after my husband left for work, my sons were in their room and as I cleaned the kitchen, I realized that they were role-playing one of our fights. My youngest called his brother a "rotten *#@*" and I wanted to die. Over the years the imitation continued. The older one wanted to beat up his dad for me and tried on a few occasions. But the younger one walked around the house calling me a fat pig. Eventually he started to hit me. That was too much. It opened my eyes. I wouldn't tolerate this behavior from an eight-year-old, so why was I tolerating it from my husband? I realized that my kids were growing up with a totally distorted image of what a family is, what a normal mom is, what a normal dad is, what love is. They'd already learned to disrespect women—to disrespect me.*

Cheryl

One day my husband laid into me because I was delayed at the church and I wasn't home with dinner on the table when he came in from work. He cursed me out and carried on, and afterwards my son said to me, "I'd be mad too if I came home and my wife wasn't there." He was only nine years old. I hated the way he thought about women and the way he talked to me, and I realized that if we stayed there he was going to wind up thinking and acting just like his father.

What Can a CASA Volunteer Do?

Child advocates have reason to 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 1995 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 U.S."

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

The CASA volunteer's task is even more complex than usual when partner abuse is a factor in family relationships. The history and severity of family violence will figure into 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 caretaker/ victim (usually the mother). As part of that perspective, these professionals advocate for placement of the child with the mother regardless of other factors, saying that to do otherwise further victimizes the mother at the hands of the system.

However, the CASA volunteer must take a broader view. It may be that, with proper safeguards in place, the victim can make a safe home for the child while the threat from the batterer 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. The CASA volunteer should assess the situation with a clear understanding of domestic violence dynamics but, in the end, must make a recommendation based solely on the best interest of the child.

As a CASA volunteer, you should seek resources that are relevant for children exposed to domestic violence. They need positive role models and supportive environments that will help them develop social skills and address feelings about the violence in a constructive manner. They also need opportunities to learn that there are nonviolent ways to address conflict. Specialized domestic violence counseling programs, individual therapy, peer support groups, youth conflict resolution training, and relationships with supportive mentors can help children adopt alternative, nonviolent ways to resolve conflicts.

A CASA should recommend parenting classes for a battered parent focused on empowering them to become more effective parents and teaching them how to help children cope with the consequences of witnessing domestic violence. Advocate for treatment programs for batterers followed by parenting classes focused on how to parent in a non-coercive, nonintrusive manner.

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

UNIT 6: Poverty—The Facts for Children

Poverty data recently released by the U.S. Census Bureau for 2010 showed that over one in five children in America lived in poverty. The number of children in poverty increased by 950,000 between 2009 and 2010, rising from 15.5 million to 16.4 million. Overwhelmingly, children have suffered more than any other age group during this recession and slow recovery. The child poverty rate is the highest it has been since1993, when 22.7 percent of children were poor. A family of four living in poverty with an annual income of under $22,314 lives on less than: $1,860 a month; $429 a week; $60 a day.

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Moments in America for Children

- Every 17 seconds a child is arrested.
- Every 19 seconds a baby is born to an unmarried mother.
- Every 29 seconds a baby is born into poverty.
- Every 47 seconds a child is abused or neglected.
- Every 67 seconds a baby is born without health insurance.
- Every 85 seconds a baby is born to a teen mother.
- Every 2 minutes a baby is born at low birth weight.
- Every 3 minutes a child is arrested for a drug offense.
- Every 6 minutes a child is arrested for a violent offense.
- Every 21 minutes a baby dies before his or her first birthday.
- Every hour and a half a child or teen dies from an accident.
- Every 3 hours a child or teen is killed by a firearm.
- Every 5-and-a-half hours a child is killed by abuse or neglect.
- Every 8 hours a child or teen commits suicide.
- Every 10 hours a baby's mother dies due to complications from pregnancy or childbirth.

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

The majority of children the CASA volunteer works with 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.* However, knowing their socioeconomic status does help to better understand their life experience, specifically some of the hardships they face.

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

Poverty, which can be defined as a lack of resources, 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. However, poverty is not a causal agent of abuse. Most poor families do not abuse their children.

Children living in families in poverty are more likely:

- ✓ To have difficulty in school;
- ✓ To become teen parents; and
- ✓ As adults, to earn less and be unemployed more.

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 a number of 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); and
- ✓ Poor quality daycare.

Children who live in poverty are far more likely to have both reports of abuse and substantiated incidents of abuse in their lives. While poverty is not the causal agent of the abuse, it is a risk factor that cannot be ignored or overlooked in its importance.

Leaving Poverty: Roadblocks to Change

Research shows that individuals leave poverty for one of four reasons:

1. They have a clear goal or vision of something they want to be or have;
2. Their personal situation is so painful that they are willing to take big risks;
3. They have a role model who builds their confidence, teaches them that they have choices, and shows them a more complete range of life's possibilities; or
4. They have a specific recognized talent or ability that provides an opportunity for them.

Being in poverty is rarely about a lack of intelligence or ability. Many individuals stay in poverty because they don't know there is a choice or have no access to the resources that they need.

Adapted from *A Framework for Understanding Poverty*, Ruby K. Payne, Ph.D., Baytown, TX: RFT Publishing Co., 1998.

UNIT 7: The Impact of Mental Illness on Children & Families

Issues of Mental Illness in Families

The Facts

- ✓ One in five adults—approximately 45.9 million Americans—experience a mental health disorder in a given year. About one in 12 children live with a serious mental or emotional disorder.
- ✓ Fewer than one-third of adults and one-half of children with a diagnosable mental disorder receive mental health services in a given year.
- ✓ Racial and ethnic minorities are less likely to have access to mental health services and often receive a poorer quality of care.
- ✓ Suicide is the third-leading cause of death for people ages 10-24 years.
- ✓ Seventy percent of youth in juvenile justice systems have at least one mental disorder with at least 20 percent experiencing significant functional impairment from a serious mental illness.
- ✓ Over 50 percent of students with a mental disorder age 14 and older drop out of high school—the highest dropout rate of any disability group.

Statistics from the 2010 National Survey on Drug Use and Health: Mental Health Findings

Definitions of mental illness have changed over time, across cultures, across national—and even state—boundaries. Mental illness is diagnosed based on the nature and severity of an individual's symptoms. If a person meets the diagnostic criteria as set forth in the *Diagnostic and Statistical Manual of Mental Disorders (DSM),* currently in its fourth edition, he/she may be diagnosed with a particular disorder such as depression, anxiety, post-traumatic stress disorder, schizophrenia, alcohol dependence, and so on. The term "dual diagnosis" indicates that an individual has two sets of problems, such as a substance abuse problem and a psychiatric disorder.

Ethnic & Cultural Considerations

There is increasing recognition that the standards for research and definitions of health and illness (and treatment) are biased because they are derived from a white, middle-class perspective. Although special efforts were made in the development of the *DSM-IV* (the standard medical diagnostic resource) to incorporate cultural information to try to reduce bias, it is important to remember that the assessment and treatment of mental illness are ethnically and culturally biased.

Causes

There is no single model or perspective that accounts for all instances of mental illness. Some disorders have a predominately biological or neurological basis; others seem to be more related to life experiences and trauma, or difficulties in communication. Many see the genesis of a mental illness as a complex interaction between innate or inherited traits and stressors. The most helpful stance for a CASA volunteer to take is to accept that mental illness affects the whole person—mentally, physically, psychologically, socially, emotionally, and spiritually.

Impact on Children & Families

The biggest obstacle facing those suffering from mental illness is the lack of appropriate, effective treatment. This lack may be a result of misunderstanding the need for treatment or being afraid to seek it due to the stigma associated with mental illness in U.S. culture. Untreated mental illness can lead to isolation and despair for individuals and families. A parent may be so incapacitated by anxiety or depression that he/she is unable to care for his/her child. Or a parent may have hallucinations or delusions, which make him/her a danger to himself/herself, or his/her children. Regardless of the type of disorder, people suffering from mental illness have a diminished ability to cope with the normal demands of life. The degree to which their functioning is impaired varies from mild to severe. It is important to note that with medication and/or therapy, most people with mental illness can function normally.

In addition to understanding mental illness, it is critical to have some idea of the parent's level of functioning in order to make recommendations that address the likelihood that parents can remedy the problems that initiated their involvement with the child protective services system. A person's level of functioning can be affected by many factors; some, 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 (the term formerly used was mentally retarded) or specific learning disabilities. These limitations, just like physical ones, have a range of severity. At the mild end, parents with diminished intellectual capacity may not be able to understand the court system with its complex language or the many written documents presented to them by the child protective services agency. At the severe end of the scale, parents with grave intellectual limitations may not be able to provide basic daily care for themselves, much less for a child. The CASA volunteer must look beyond IQ or any other diagnostic term to assess how a parent functions on a day-to-day basis.

What Can a CASA Volunteer Do?

It is not your task to diagnose mental illness. However, it is important to be aware of warning signs or indicators so that you can alert the caseworker about your concerns. How will you know mental illness when you see it? Your own internal cues are your best initial indicators that something is "off" or "not right" about a person.

Following are some indicators that may point to the need for professional assessment:

Social Withdrawal

Characterized by "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

Includes 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 (such as perceiving the world as "dead"); thinking or talking about suicide; a growing inability to cope with problems and daily activities.

Thought Disorders
Evidenced by 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 Feelings
Such as hostility from a person formerly passive and compliant; 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
Such as 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/school.

(Note: As part of the assessment, it is important to determine if domestic violence and/or substance abuse are contributing or causal factors. This is a task for professionals.)

In your capacity as a CASA volunteer:

- ✓ You can recommend a mental health assessment of a parent or child; and
- ✓ You may request consultations with a parent's mental health care providers.

Although the parent's mental health providers are ethically and legally required to maintain their client's confidentiality, they may be willing—with their client's permission—to talk with you about their perspective on the situation and any concerns you have. Your CASA volunteer supervisor will be able to answer your questions about gaining access to this confidential information.

CHAPTER 6
Core Responsibilities for Effective CASA Advocacy

PURPOSE: *To better understand the central activities of a CASA volunteer*

TABLE OF CONTENTS

Additional information:
Every Child, Every Hearing

Objectives

By the end of this chapter, I will be able to…

- ✓ Know where to find information regarding my child's case.
- ✓ Introduce myself as a CASA volunteer.
- ✓ Utilize case notes to document information.
- ✓ Understand the structure and purpose of the CASA Court Report.

UNIT 1: Best Interests Focus

Tools of the Trade

Once you have been assigned to a case, you will have access to information, some of which will be yours to take home. You will need to keep track of the contact information for the child and service providers as well as important dates (such as when your first court report is due to your CASA Senior program coordinator, the date and time of the next hearing, and your CASA child's birth date).

You will also need to manage your "tools of the trade"—such as the copies of your order of appointment and your CASA identification badge. We will provide you with specialized CASA volunteer business cards with your individualized contact information. It is helpful to have contact information for your Senior Program Coordinator.

The Case File

Your first resource for information is the case file. Your senior program coordinator will explain to you how the file works. It is not uncommon for there to be different sections of the file for different kinds of information, and for information to be in the order of most current information on top. This means that if you want to start at the beginning, you may have to start at the back. When reviewing case files it is helpful to start with the **petition**. This will provide you with a sense of where the child was living at the time the DCFS (Department of Children and Family Services) intervened in his/her life, and what were the reasons for the intervention. As you read the file, it can be helpful to note dates of events and names of individuals and especially to note each time a child has moved. As you review the file, questions will begin to come to you. Be sure to jot those down and review them with your senior program coordinator.

One particularly helpful tool for a CASA volunteer is to construct a **time line** that begins when DCFS first encountered the family and highlights all the significant events in the case. This will help you visualize the progress being made—and keep the child's sense of time in the forefront of your thinking about the case. In addition, sketching out the family/relationship tree is frequently very helpful for you to have a sense of relationships, and may assist in family finding. It is recommended to note within the family diagram any contact information that you might come across (e.g. phone numbers, addresses, etc.).

Reviewing the case file should also help you in identifying individuals and agencies that may be useful sources of information regarding your CASA child's needs, experiences, and strengths. Your CASA Senior program coordinator will help you set priorities regarding what information is most necessary and pertinent.

Identify Key Issues and Sources

The number of people to contact and the types of information available can be overwhelming. You simply cannot do it all at once. Work with your senior program coordinator and get his/her perspective on the most important issues in the case and who might be a good source of general information about the child. Once you have this information, work with your case supervisor to develop a plan outlining what information you need to get first and, in turn, which people are most important to interview and which records are most important to gather and review. Also, as you are getting to know the young person, give the youth an opportunity to share with you what he or she sees to be the most important issue(s) for them.

Keep in mind two important concepts: collaboration and communication. People may not trust you and, therefore, may not share all the information they have or may even try to hide or distort what they know. **Use information gathering** as a way to start building relationships. Think about whether the benefits of getting information quickly outweigh the costs of trying to force someone to give it to you before he/she trusts you.

An important strategy for building relationships with the social worker and with attorneys is to call or email updates on the child's wellbeing, letting them know they do not need to return your call. This establishes you as a resource and will go a long way to ensure they will get back in touch when you need them to.

Best Interests

If you were the judge, what is the information you would want in order to advance the best interests of the child or youth? Think beyond the immediate problems or looming decisions. What might improve the child's immediate well-being? Who are potential connections that might expand the child's support network?

Remember that your duty is to help advance the best interests of the child. Compare this to the duty of the child's lawyer, which is to advance the stated interests of their client. However, you should, of course, not only listen to what the child wants, but also assist them whenever possible in achieving what they need and involve them in what you are doing.

UNIT 2: Finding and Gathering Information

As a CASA you must investigate, and to do that, you need access to information. When you are appointed, the judge will make an order granting you access to confidential information about the child and his or her circumstance. Remember that you are an "officer of the court," and have an obligation to safeguard the confidentiality of the information you receive.

However, the practical reality is that people and even professionals may be unaware of this court order and they might seek to hide or protect information (often with the best of intentions). Be prepared to explain who you are, your role as a CASA volunteer, and have your appointment/court order handy.

Gathering information can require a great deal of patience and determination, but you must ensure that you get the best, most complete information possible.

This is also true when gathering information from the child. Remember that foster children often feel as though their life is on display for all to see. You will be one more person who knows everything about their situation. Getting information from the child will be your primary task. It is not unusual for children to suffer in silence simply because they felt they had no one who would listen.

When talking with professionals, teachers, school administration, etc. you may be asked questions about your CASA child and his or her family. You must maintain confidentiality and not share information. Refer them to the child's social worker who is the "holder" of confidentiality.

Introducing Yourself as a CASA:

One of the first tests of your communication skills as a CASA volunteer will occur when you introduce yourself and describe your role. The following is a sample of how you might introduce yourself to a Parent.

Introducing Yourself to a Parent

I am your child's Court Appointed Special Advocate (CASA). I am an unpaid volunteer and do this work because I care about children and families, and I want to help.

I am not a DCFS (Department of Children and Family Services) social worker and the CASA program is not part of DCFS. However, I will talk to your child's social worker to get background information about your child's situation. I will also talk to you, other family members, teachers, and anyone else who is important to your child. After I have gathered information, I will write a report for the hearing officer, recommending what I believe is in your child's best interest. Nothing in my report will be kept secret from you. Your attorney will receive a copy of my report at the next hearing.

Interviewing

1) The Child

- Don't try to go too fast, even if a child seems like he or she is telling you everything, children need to trust you before they will reveal deeper issues.
- Don't be surprised if the child is very open with you about the particulars of the case, often they have had the chance to tell the story to many, many professionals before you. You want more than just what you've already read in the file.
- Even though the child tells you his/her story, he/she may be doing it without emotion, or in a robotic way. Observe how the child reacts to you.
- You should try to get down on the child's level. For example, just play with the child, and often he/she will reveal more and more than was revealed previously.
- Know your limits. You are not a therapist (and if you are by training, then this child is not your client) so realize when wounds are opening, and listen. You can then redirect the child to their therapist and follow up with the child later.
- Be honest with the child. If you don't know, say so. If you do know an answer but don't want to say, tell the child that you don't want to tell him or her at this point. Children, especially foster children, often have an ability to see through thin white lies "professionals" often tell. You want to avoid falling into that category.
- Be upfront with the child about your need to tell someone if the child tells you any new issues of abuse or neglect. Stress to the child how he or she can trust you to help get the needed help and keep them safe.

Introducing Yourself to a Young Child

Hi, my name is Jane. I am your CASA sent especially by your Judge because he/she wants to know how you are doing and if there is anything that you need. Do you know what a Judge is?

CASA stands for Court Appointed Special Advocate. I am a volunteer. Do you know what volunteer means? It means I do not get paid to be your CASA. I want to be your CASA and get to know you.

I will talk to your social worker, parents, teachers, attorney and anyone else involved in your life. I will write a report for the judge and I will always ask you if there is anything you want to tell the Judge. I will try my best to be at Court when you have a hearing. Have you been to Court?

2) Service Providers and Professionals

- It is always best to make an appointment and set a time to talk in-person or by phone
- When leaving messages for professionals, be specific about information you are requesting. Do not be surprised or frustrated if the call back time from professionals takes a few days or longer. Remember that they all have tremendous case loads. Be patient and professional, but tenacious.
- When you speak with professionals, be prepared to maintain confidentiality regarding what information they will ask from you. You may need to present your order of appointment and clarify your role as a CASA volunteer.
- It is a good idea to prepare your questions for professionals ahead of time. Be clear with them that the information you are gathering may be part of your court report. Take notes on the conversation and summarize the information in your notes to them to verify that it is accurate. Always verify the spelling of a person's name and title. Always thank the other person for their participation and time.

Gathering Information

Your duty is to gather the best information possible and, from that information, interpret what is in the best interests of the child. When you share with others the conclusions you have reached, you should also share the information and sources that led you to that conclusion. Exchanging information and the research process is as important, if not more important, than sharing your conclusions.

Activity: Your Contact Information

Discuss with your group what contact information you would give to each of the following individuals:

- Your CASA child
- The child's caregiver
- The child's parents
- The child's family members/siblings
- The social worker
- The child's teacher

What affects your decision? Might that decision change over time? In special circumstances? Who might each of these people share your information with? Reflect on the fact that it is almost impossible to take back your information once it has been shared. We will hear samples of your responses in the larger group.

You should be cautious regarding sharing personal information about yourself or your family.

DO NOT GIVE ANYONE YOUR ADDRESS. You are not obligated to give anyone your address. There are rules against taking a CASA child to your home and therefore there is no reason to share this information.

YOU MAY GIVE OUT YOUR PHONE NUMBER. It is up to you whether you want to give out your telephone number. However, it may be best to wait until you have developed some trust and boundaries. Discuss this with your case manager – he or she has experience and knowledge that can inform your decision.

UNIT 3: Concurrent Planning

One thing to think about when you are collecting information and investigating your case is that the law calls for "concurrent planning." Concurrent planning is basically planning two things at the same time. Therefore, for every child who is trying to reunify with his or her parent, the professionals must plan for 1) reunification, or in the alternative 2) a different permanent plan.

For example, baby Samantha is taken from her mother because her mother is using methamphetamine. The Agency will set the mother on the path to reunification and provide services – let's say drug treatment, counseling, and referrals to other helpful resources. Samantha is placed in a foster home.

The concurrent plan will be to have Samantha placed in a foster home that is willing to adopt her – her concurrent plan will be adoption. This is basically an insurance policy. The overriding goal is to reunify with the mother, but if the mother does not get clean and have a safe home for Samantha, then no time is lost. Samantha has been bonding and being loved by her prospective adoptive parents the entire time.

Concurrent planning often sets people at odds, and can be confusing. It can also break the hearts of well-intentioned foster parents when the child is returned home. However, the main concern is always the child. It is better for a parent to feel threatened, or foster parents to feel a great loss, than to hurt a child.

Concurrent Planning: What the Evidence Shows

Excerpts from "Concurrent Planning: What the Evidence Shows" from the Child Welfare Information Gateway.

Concurrent planning is an approach that seeks to eliminate delays in attaining permanent family placements for children in the foster care system. Concurrent planning involves considering all reasonable options for permanency at the earliest possible point following a child's entry into foster care and concurrently pursuing those that will best serve the child's needs. Typically, the primary plan is reunification with the child's family of origin. In concurrent planning, an alternative permanency goal is pursued at the same time (Katz, 1999; Lutz, 2000). Evaluations of some early concurrent planning efforts suggested that they led to earlier permanence for children. The practice did not gain general acceptance, however, due primarily to opposition in the courts and among parents' attorneys, who saw the early development of an alternative permanency plan as being in conflict with agencies' genuine pursuit of family reunification (Katz, 1999; Munroe, 1997).

The Federal Adoption and Safe Families Act of 1997 paved the way for the legal sanction of concurrent planning in states and the formalization of the practice in child welfare agencies (Schene, 2001).

UNIT 4: Documenting, Organizing and Reporting

Before you start finding and gathering information, you should work with your senior program coordinator to discuss how you will 1) document the information so that it is preserved, 2) organize the information so that it is accessible, and 3) communicate the information so that it is useful.

As a CASA volunteer, you will gather information from many different sources during the course of your understanding and monitoring of a case. People and their stories run together. Facts can become cloudy, especially if the case is not scheduled for court for some time. It is vital that you keep accurate and thorough notes about the date and content of each case contact, whether it is a planned interview, an impromptu visit to a school, a phone call, or a review of a record. Your records can also be a valuable tool in documenting dates of contacts.

Activity: Your Case Notes

Review the list below of important factors to include in your note taking. In the large group, we'll answer the following questions: What would you add? Why is the information relevant?

Important Elements to Include in Note Taking

- Person interviewed and contact information
- Date/time
- Place (parent's home, job, jail, etc.)
- Observations
- Feelings expressed
- Facts
- Summary of what happened
- Plan of action by the other person
- Plan of action by you
- Decisions

Ultimately, the information you gather will be used to formulate recommendations about what is in the child's best interest. Your written court report is the vehicle by which these recommendations are presented to the court. Clear, fact-based reports and recommendations will enhance the judge's ability to make good decisions about the child you represent.

CAUTION! CASA case notes may be subpoenaed. The case notes in your file should not include:

- Conclusions and interpretations
- Unsupported statements of fact
- Statements that diminish professional credibility
- Personal feelings about the case or individuals involved in the case

Why Document, Organize and Report?

We need to take notes on the facts of the case and where we got that information so that we can keep asking whether we need to expand or verify the information that we have. We need to document how we chose the goals, objectives, and strategies for the child. We need to record signs that those strategies are working or are failing. And then we need to make careful decisions about what to do next.

Why document, keep organized records, and report on our work? For many reasons:
1) Because taking careful notes encourages us to be careful about what we are hearing and gives us a chance to re-examine it outside of a situation that might have led us to make quick judgments. 2) Because we need to be able to share the basis of our conclusions so that others might give their insights. 3) Because if something were to happen to us so that we could not continue with the case, the work we accomplished would not be lost.

Documenting and reporting is not distracting paperwork, but central to your role and effectiveness. By finding, gathering, documenting, organizing, sharing, and interpreting information in a disciplined manner, and by doing so in a way that builds connections and leads to action, you earn the right to be heard. Your process should always be open, and you should always be open to hearing critique and suggestions about how to improve. No one should ever simply have to "take your word for it."

The keys to good report writing and to holding your readers' attention are:

ACCURACY (to be exact, free from errors and misstatements)

BREVITY (to be concise and complete)

CLARITY (to be easily understood)

Keep in mind that the judge will likely be reading between 25 and 40 reports each day. There is no page limit for CASA reports however, if you can present your information concisely, there is a better chance that all parties will take the time to read your report in its entirety.
Keep statements and opinions under their appropriate section headings.
Do not use the term "the minor". Refer to the child by name or as "the child". While the term "minor" is used frequently in the courtroom for legal purposes, CASA reports can help make everyone mindful of the fact that the subject of the case is a child.

UNIT 5: Communication and Collaboration

CASA volunteers play a critical role in helping to foster effective communication between stakeholders and in promoting collaboration. Collaboration can take the form of team decision-making meetings. But it does not have to require acting in agreement with one another. As long as stakeholders can agree about certain goals and objectives for a child, each person can use his or her role and their own strategies to advance that objective. Of course, talking through those strategies will often be helpful to avoid duplication and promote synergy whenever possible.

Be sure to ask about existing teams, methods of communication, and decision-making processes as you conduct your research. It is best if you can join or build from an existing resource rather than trying to establish lines of communication yourself.

As a group, you will have to carefully think through what information can safely be shared with whom and who can share it. You may be the only person who has access to all of the information. Professional and ethical responsibilities must be respected. Do not assume that you can share information with someone just because the person seems to share the same vision you have or seem to have the best interests of the child at heart. Boundaries are in place for a reason.

At the very least, the key stakeholders should know about each other, share contact information, and understand the key goals, objectives, and strategies developed for the child. In general, the more people communicate in implementing a shared vision of what is best for the child, the better the results will be.

As you conduct your research, make sure to keep a contact roster with room for notes on each person. As you talk with people, make sure to ask who else they know that is working with or is important to the child or youth. As this list grows, it can be illuminating to create a connections map.

UNIT 6: Developing a Plan

A basic plan has goals, objectives, and strategies. The following may help you to create goals objectives, and strategies for your case. In general, you should have at least one goal, objective, and strategy for the three most important issues within a case.

Goals

Definition: A goal is the end result towards which you direct your effort

Elements of a Goal

- A direction to go in → action word or verb
- The area of concern

Sample: Improve the child's attendance at school OR
Decrease the number of absences from school

Objectives

Definition: An objective states how much progress one will make in fulfilling a goal. It is a specific and measurable accomplishment to be achieved within a specified time and under specific resource constraints.

Sample: The child will go from twenty (in the last marking period) to five absences in the next marking period.

Who sets goals and objectives?
Everyone involved should help set them.

1. Decide what is most important for the well-being and resilience of the child. Be as specific as possible.
2. Decide how much is realistic in a given time period given the resource the child has and the challenges he or she faces.

The S.M.A.R.T. method of writing objectives, provided on the following page, can help you further refine your objectives.

Writing Objectives

Specific:	detailed, focused, everyone knows what is to be accomplished
Measurable:	quantifiable, provides a standard for comparison, indicates when the goal is reached
Action-oriented:	indicates an activity, a performance, or task to be done to fulfill the goal
Realistic:	practical, achievable, and possible goals must motivate people to improve and to reach for attainable ends.
Time limited:	scheduled; regulated by time and resources to be expended.

Strategies

Definition: The way you plan to meet your objective.

Sample: The child's school attendance will be increased by getting better treatment for her asthma.

It is helpful to get as many perspectives as possible when establishing your strategies. It may be that many people can have a positive effect, especially if they work together. Sometimes this is necessary to have any impact at all on a problem.

UNIT 7: Court Reports and Hearings

Your court report is the culmination of your information-gathering work as a CASA volunteer. It is the vehicle through which you present the information you have gathered about a child's situation and your recommendations about what services will meet the child's needs. Judges rely on the information in CASA volunteer court reports as they make their decisions. The court report becomes part of the official court record and may be introduced and considered as evidence.

CASA volunteer court reports are shared with all parties and the other individuals who are authorized by law to receive them; this includes the attorneys for the parents and the child, who may choose to show them to their clients; this also includes the child's social worker. As a CASA volunteer, developing a court report is a critical part of your role. Keeping the court informed and providing recommendations is a part of your work in achieving the goals and objectives you have for the child.

Look to the "Every Child Every Hearing," resource to determine what the court must be considering at the hearing you will be attending. You have a duty to ensure that the court and other players address each element that benefits the child.

Procedure for Submitting Court Reports:

1. Your report will be due no later than two weeks in advance of the next court hearing date.
2. Enough time must be allowed for staff to review the report and talk to you about any questions or concerns. Staff must have enough time to make any formatting corrections needed and make copies for all parties involved.
3. Your finalized report is delivered to the courtroom by staff two days before the hearing. The original report goes to the judge and copies of it go to the attorneys on the case, as well as the Court Officer. The judges need time to read the reports a day in advance of the hearing, so it's important to submit them to the office in a timely manner. A copy of your report will be waiting for you to pick up from your senior program coordinator on the morning of the hearing.

Court Hearings

Before your first court date, your Senior Program Coordinator will review what is expected of you and the court process. He or she will also discuss any potential areas of concern you may have about going to court (*e.g.*, meeting birth parents, understanding legal jargon, planning sufficient time). You are strongly encouraged to attend all case-related hearings. Your senior program coordinator can attend court with you, facilitate networking and introductions to parties, and remind you of protocol. You will typically be responsible for taking thorough notes

during the hearings and understanding what was ordered by the judge. If you are unable to attend court, your senior program coordinator may be able to attend in your place and will inform you of the outcomes afterward.

In California, all juvenile court hearings are confidential matters. This means that only people involved with each particular case will be allowed into the court room during the hearings.

Show respect for everyone in the courtroom. This rule applies regardless of whether you disagree with them, do not personally care for them, or actually dislike them. Finally, be especially respectful of the judge and mind the bailiff, who will tell you when to sit, when to stand, and when to be quiet.

"Where Do I Sit?" You will sit at the table with your CASA child, the child's attorney, County Counsel, and parents' attorneys

"What Do I say?" At the beginning of the proceedings you may be expected to state your name for the record, as will all others present in the room. In many cases, the report that you have written will serve as your voice in the courtroom. In some circumstances, the judge may ask you clarifying questions regarding the information in your report. In California, it is usually very rare that a CASA volunteer is called upon or subpoenaed to testify. Anyone who is testifying may be sworn in under oath prior to taking the stand. In less formal settings—such as an uncontested review hearing—some judges do not require that witnesses be sworn in or that they take the stand. In this case, the witness remains seated next to his/her attorney to testify or share his/her recommendations.

"What will happen?" Your senior program coordinator will review with you before you begin writing your court report what kind of hearing is scheduled to take place, what questions the judge will be seeking to resolve and what are some expected outcomes. Don't be surprised if a hearing is continued at least once; this usually occurs if one of the parties was not prepared for the hearing, or an attorney was unable to attend. The judge has the power to continue a hearing, make findings and rulings, and set orders for things that are to occur before the next court date. The judge will also make the determination if it is appropriate to close the case if all matters have been resolved.

Follow Up

1. Conduct follow-up investigations to ensure that the orders of the court are being properly executed by:
    - Reviewing the court order;
    - Visiting the child regularly and maintaining sufficient contact with parents, relatives, foster parents, and agency personnel to determine if the orders of the court are being properly executed;

- Verifying the accuracy of information gained during follow-up investigation;
- Notifying staff and attorney for the child if the orders of the court are not being properly executed; and
- Contacting those who are responsible for carrying out the orders of the court to address issues surrounding noncompliance.

2. Report to the court when the needs of the child or youth are not being met by:
   - Identifying facts and changes that might necessitate the case's return to court.
3. Protect and promote the best interests of the child or youth until formally relieved of the responsibility by the court by:
   - Regularly monitoring the child in his or her home setting, evaluating appropriateness of placement and whether the child is receiving court-ordered services, and identifying any unmet needs;

Understanding and Being an Effective Participant in Case Meetings

Preparation:

Who initiated or convened the meeting?

1. Parent or caregiver
2. Social worker
3. Staff person (typically social worker) whose role is to facilitate this meeting
4. CASA volunteer

What triggered the meeting to happen?

1. Imminent placement changes or disruption
2. Unmet needs of the child, youth or family
3. Social worker's need to prepare a case plan for family

What kind of a meeting is it?

1. Is it a formal or informal meeting?
2. What is the philosophy or value system framing it?
3. Are the agreements or plans made in this meeting binding?
4. Who carries the responsibility to arrange the meeting?
5. Who carries the responsibility to follow up after the meeting?

Who are the primary or target participants? (If they weren't there the meeting wouldn't happen)

What is the goal or expected outcome of the meeting?

What is the role of the CASA child or youth?

1. They are the subject or topic of the meeting.
2. They are invited to give suggestions or ideas to participants.
3. They are active participants in the decision-making process.
4. Their buy-in is necessary for the decisions to move forward.

What is the expected role of the CASA volunteer?

Every Child, Every Hearing

HOW TO ENSURE THE DAILY WELL-BEING OF CHILDREN IN FOSTER CARE BY ENFORCING THEIR RIGHTS

ADMINISTRATIVE OFFICE OF THE COURTS

CENTER FOR FAMILIES, CHILDREN & THE COURTS

Every Child, Every Hearing

HOW TO ENSURE THE DAILY WELL-BEING OF CHILDREN IN FOSTER CARE BY ENFORCING THEIR RIGHTS

Transitioning a child into adulthood requires constant attention to all aspects of the child, including the child's physical and mental health, social and cognitive development, and education. It is the responsibility of all court participants to help children who come before the juvenile court with their development and ultimately with their transition into adulthood. Whether you are a parent or guardian, a relative, a foster parent, an Indian custodian, a tribal member, a social worker, a probation officer, a Court Appointed Special Advocate, a mentor, an important individual in the child's life, an attorney, a teacher, an educational representative, an employer, a doctor, a nurse, a therapist, or a judicial officer—whatever your role, our shared responsibilities are great.

This booklet will assist the court and other interested persons who have this responsibility. It offers key questions (with accompanying citations) that must be asked and followed up on for every child. For children served by the juvenile court, consistent inquiry into these questions is necessary to help transition them back to their home of origin or to another permanent plan when reunification is not possible.

ADMINISTRATIVE OFFICE OF THE COURTS

CENTER FOR FAMILIES, CHILDREN & THE COURTS

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Administrative Office of the Courts

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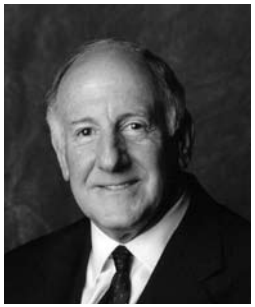

A MESSAGE FROM CHIEF JUSTICE RONALD M. GEORGE

Approximately 88,000 children are in foster care at any given time in California. Courts play an important role in the life of a child in foster care. No child enters or leaves care without a judge's decision. When a child comes before juvenile court, the many responsibilities of caring for and assisting the child become shared by the family, the court, court participants, and the child's home placement and service providers. It is therefore critical that the court and others who share this responsibility have vital information concerning the child's mental, physical, and emotional health and education and development.

This booklet offers a comprehensive set of questions that will help us gather information and share responsibility for ensuring that every child's rights are enforced at every hearing. I hope you find this booklet useful as you work to help California's children in foster care.

Ronald M. George
Chief Justice of California

HOW TO USE THE CITATIONS

The information and questions contained in this checklist are based on federal and state laws, rules, regulations, forms, and manuals and on general information relating to children. The following information will help you find the referenced citations:

Federal and state laws are contained in code books:

- U.S.C. = United States Code
- Ed. Code = California Education Code
- Fam. Code = California Family Code
- Gov. Code = California Government Code
- Health & Saf. Code = California Health and Safety Code
- Welf. & Inst. Code = California Welfare and Institutions Code

Laws are often further explained in regulations and rules of court:

- C.F.R. = Code of Federal Regulations
- FR = Federal Register
- Cal. Code Regs. = California Code of Regulations
- Cal. Rules of Court = California Rules of Court

Forms are often used to help comply with laws. The *Health and Education Questionnaire* (Form JV-225), *Order Limiting Parent's Right to Make Educational Decisions for the Child and Appointing Responsible Adult as Educational Representative—Juvenile* (Form JV-535), and *Local Educational Agency Response to JV-535—Appointment of Surrogate* (Form JV-536) may be found at this Web site: *www.courtinfo.ca.gov.*

Other references:

- MPP = California Manual of Policies and Procedures, Child Welfare Services
- *Ibid.* means the statement is based on the previous citation.
- Citations beginning with *www* are Web site addresses that require Internet access.

These questions are of a sensitive and private nature. Juvenile court judges should encourage all persons to respect the child's privacy and emotions when addressing the child's needs.

GENERAL COURT-RELATED QUESTIONS FOR THE INITIAL OR DETENTION HEARING

Physical Health

- **Child's history.** At the initial hearing, did the court direct each parent to provide the child's complete medical, dental, mental health, and educational information to the child welfare agency? Welf. & Inst. Code, § 16010(f)
  - Did the parents submit a completed *Health and Education Questionnaire* (form JV-225)? Welf. & Inst. Code, § 16010(f)
  - At the dispositional hearing, did the court ensure that the parents provided this information? Welf. & Inst. Code, § 16010(f)
  - Has an assessment of the child's mental health, physical health, and educational needs begun? Has an assessment of any identified substance abuse concerns begun?
  - Did the child arrive at the temporary placement with required medication, if any?

Education

- **Educational rights.** Are there reasons for the court to consider temporarily limiting the parent's or guardian's educational rights concerning the child and appointing a responsible adult to make educational decisions? Welf. & Inst. Code, § 319(g); see Welf. & Inst. Code, §§ 361, 726; Gov. Code, § 7579.5
- **School of origin.** Has the parent or other person with educational rights determined that remaining in the school of origin is in the child's best interest? Ed. Code, § 48853.5(d)
  - If yes, is the child's local educational agency allowing the child to continue attending the school of origin for the duration of the academic year? Ed. Code, § 48853.5(d)(1)
  - If no, see **Change of School**, section 4b.

Mental Health

- How is the child responding emotionally to separation from the family of origin?
- Was the child receiving emotional or mental health supportive services before removal?
- Does it appear that mental health services are necessary to assist the child's adjustment to foster care?
- If the child was detained from his or her parent or legal guardian as a result of the child's severe mental health needs, did the child's Individual Education Plan (IEP) team refer the child for AB 3632 and AB 2726 mental health services, and was residential placement considered? If not, why not? Cal. Code Regs., tit. 2, § 60040, 60100
- Does the child have a current IEP that identifies the child as "emotionally disturbed" and makes the child eligible for residential treatment? *Note: Jurisdiction may not be necessary if the only reason for the child welfare agency's involvement is the need for residential services. AB 3632 and AB 2726 services are available to all eligible children and are not limited to children placed in foster care.*

Procedural and Substantive Due Process Rights Under the Indian Child Welfare Act (ICWA)

- Have the court, social worker, and probation officer asked the parents and all adults appearing at the hearing whether the child may have Indian ancestry? Welf. & Inst. Code § 224.3; Cal. Rules of Court, rule 5.664
  - If yes, have the court and the social worker or probation officer complied with applicable ICWA requirements such as notice, active efforts, and placement requirements? 25 U.S.C. § 1900 et seq.; Welf. & Inst. Code, §§ 224-224.6; Cal. Rules of Court, rule 5.664

Relatives

- Has the court conducted a parentage inquiry? Welf. & Inst. Code §316.2
- Has the court ordered the parent to disclose to the social worker the contact information for any known relatives of the child? Welf. & Inst. Code § 319(f)
- Has the social worker investigated placement with an appropriate relative? Welf. & Inst. Code §§ 309(d), 319(f), 361.3, 361.4

These questions are of a sensitive and private nature. Juvenile court judges should encourage all persons to respect the child's privacy and emotions when addressing the child's needs.

For the following questions, consider:

- What has been done to address any obstacles to respecting these rights?
- What more needs to be done to ensure that these rights are protected?

Ask these of the child (if the child is of cognitive age), the child's advocate, the placing agency, and any other interested person.

RIGHTS OF FOSTER YOUTH

For additional rights of foster youth, review Welf. & Inst. Code, § 16001.9; Cal. Code Regs., tit. 22, §§ 83072, 84072, 89226, 89372.

- **Searches.** Is the child protected from unreasonable searches of personal belongings? *Ibid.*
  - Does the child have storage space to safeguard his or her personal belongings? Are the child's valuables safeguarded? *Ibid.*
- **Religion.** Is the child given the opportunity to attend religious activities of his or her choice and not forced to attend other religious activities? *Ibid.*
- **Discrimination and harassment.** Is the child protected—at the placement, at all activities, and in the delivery and determination of need of all services—from discrimination or harassment on the basis of actual or perceived ethnic group identification, race, ancestry, national origin, color, religion, sex, sexual orientation, gender identity, mental or physical disability, or HIV status? *Ibid.*
  - Is personal information kept confidential and disclosed only when appropriate? *Note: Inappropriately disclosing a young person's foster-care status, gender identity, sexual orientation, political affiliation, religion, race, or disability could subject the young person to rejection, ridicule, and even violence.*
- **Placement.** Is the child's placement safe, comfortable, and healthy? *Ibid.*
- **Protection from abuse.** Is the child protected from physical, sexual, emotional, or other abuse and protected from corporal punishment in his or her placement? *Ibid.*
- **Respect.** Is the child being treated with respect? *Ibid.*
- **Rights and needs.** Are the child's needs being met and his or her rights being respected?
- **Equal access.** Is the child receiving fair and equal access to all available services, placements, care, treatment, and benefits? *Ibid.*
- **Daily needs.** Is the child receiving adequate clothing and sufficient and healthy food? Is the child receiving an allowance, if placed in a group home? *Ibid.*
- **Prevention or treatment of pregnancy.** Is the child's right to consent to medical care related to the prevention or treatment of pregnancy respected and ensured? Fam. Code, § 6925; Health & Saf. Code, § 123450 *Note: Parental consent is not required for abortions.* American Academy of Pediatrics v. Lungren *(1997) 16 Cal.4th 307*

RIGHTS IN JUVENILE COURT PROCEEDINGS

- **Case plan.** Does the child give input into his or her own case plan, if appropriate? Welf. & Inst. Code, §§ 16001.9, 16501.1
- **Attendance.** Does the child attend court hearings and have an opportunity to speak to the judicial officer? Welf. & Inst. Code, § 16001.9
- **Informed of rights and complaint procedures.** Does the social worker review the child's rights with him or her at least every six months? Welf. & Inst. Code, § 16501.1(f)(4)
- **Contact information.** Does the child have contact information for the California Foster Care Ombudsman's Office (telephone 877-846-1602), the child's social worker or probation officer, and the child's attorney?
- **Indian Child Welfare Act.** Have the court and placing agency both complied with applicable ICWA requirements, including inquiry, case plan, expert witness, burden of proof, and placement requirements of the Indian Child Welfare Act? 25 U.S.C. § 1901 et seq.; Welf. & Inst. Code, §§ 224-224.6; Cal. Rules of Court, rule 5.664
- **Immigration.** If the child did not have legal residency when he or she became a dependent—and if the court has found that family reunification is no longer an option, that it is not in the child's best interest to return to his or her home country, and that the court will be ordering a permanent plan—has immigration counsel or specialized assistance been provided to the child to complete an application for Special Immigrant Juvenile Status? 8 U.S.C. § 1101(a)(27); 8 C.F.R. § 204.11 (1993); California Manual of Policies and Procedures, Child Welfare Services (MPP) 31-236(i)(4)(D)

These questions are of a sensitive and private nature. Juvenile Court judges should encourage all persons to respect the child's privacy and emotions when addressing the child's needs.

HEALTH CARE

Health and Education

- Did the child receive a medical and dental examination within 30 days of placement? MPP 31-405.1(n)(1)
- Does the child's current case plan include a summary of his or her health and education information? Welf. & Inst. Code, § 16010(a)
- Does the current court report include a copy of the child's current health and education summary? Welf. & Inst. Code, § 16010(b)
- Does the child have a complete and up-to-date health and education passport? Welf. & Inst. Code, § 16010

Insurance

- Does the child have Medi-Cal or other health insurance? 42 U.S.C. § 1396 et seq.

Appointments and Exams

- **Prevention.** Is the child receiving ongoing primary and preventive health-care services? Welf. & Inst. Code, § 16001.9(a)(4)
- If the child is less than three years old, is the child receiving preventive health-care examinations on the periodicity schedule required for his or her age group as recommended by the American Academy of Pediatrics? Cal. Code Regs, tit. 17, § 6847; *www.cispimmunize.org/IZSchedule_2006.pdf*
- If three years or older, is the child receiving annual preventive health-care examinations? If not, why not? Cal. Code Regs., tit. 17, § 6847; California Department of Social Services All County Information Notice No. 1-82-05
  - When was the child's last well-child exam? When should the next one be scheduled? Do such examinations meet Child Health Disability Prevention (CHDP) criteria? 42 U.S.C. § 1396 et seq.; MPP 31-405.1(n)
- When was the child's sight last evaluated? When should the next examination be scheduled?
  - Does the child have, or need, any glasses or contact lenses?
- When was the child's hearing last evaluated? When is the next examination due?
  - Does the child have, or need, any hearing aids?
- If appropriate, has the child been placed in a home that serves medically fragile children? Welf. & Inst. Code, §§ 17710, 17730–17733
- **Immunization.** Is the child up to date on his or her immunizations? Cal. Code Regs., tit. 17, § 6846(b)(9)
- **Dental.** If the child is at least one year old, is he or she receiving dental examinations every six months, as recommended by the American Academy of Pediatric Dentistry? CHDP Provider Information Notice 04-13; Welf. & Inst. Code, § 14132.88; *www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf*
  - When was the child last seen by a dentist? When is the next examination due?

Basic Health Care

- Does the child have a primary health-care physician?
- Does the child have any current medical problems?
- Is the child taking prescribed medications? If yes, does the child have these medications at the current placement?
- Have any substance abuse concerns been identified? If yes, how are these concerns being addressed? See Fam. Code §6929; Welf. & Inst. Code, § 359

Information Sharing and Follow-Up

- Has the placing agency provided the substitute care provider with the child's medical history? Welf. & Inst. Code, § 16010(c); MPP 31-405.1(s)(2)
- Who is taking the child to medical appointments?
  - Is this person aware of the child's health-care needs?
- Are all identified health-care needs being followed up with appropriate referrals and treatment? Cal. Code Regs., tit. 17, § 6850
- Has the substitute care provider received information about CHDP services? MPP 31-405.1(m)

Privilege and Consent to Medical Care

- Has the child invoked the physician-patient privilege? Welf. & Inst. Code, § 317(f)
- Has the child invoked the right to consent to medical care related to the prevention or treatment of pregnancy? Fam. Code, § 6925; Health & Saf. Code, § 123450 *Note: Parental consent is not required for abortions.* American Academy of Pediatrics v. Lungren *(1997) 16 Cal.4th 307*
- Has the child invoked the right to consent to medical care related to the diagnosis or treatment of sexual assault or, if the child is age 12 or older, of sexually transmitted diseases or drug- or alcohol-related problems? Fam. Code, §§ 6926, 6928–6929; Welf. & Inst. Code, §§ 220–222

Children Exiting the Juvenile Court System

- If the youth will soon be transitioning from the child welfare system, has he or she received:
  - A recent comprehensive health and dental examination? Welf. & Inst. Code, §§ 391, 16010
  - Assistance in understanding his or her health-care needs and in locating health-care providers that can meet those needs? *Ibid.* For further discussion, see **Transition From Juvenile Court Jurisdiction**, section 4c.

Additional Health Services

- Does the child have any physical, mental, or learning disabilities that may qualify for accommodations or services? 42 U.S.C. § 12101 et. seq.; 29 U.S.C. § 794; 20 U.S.C. § 1400 et seq.; 34 C.F.R. 104.1 (2000) et seq.
- If yes, see **Accommodations and Services**, section 6b.

These questions are of a sensitive and private nature. Juvenile court judges should encourage all persons to respect the child's privacy and emotions when addressing the child's needs.

Relationships, home life, daily activities, and the information necessary for a child to transition to adulthood are core personal rights of every child. Children in foster care often experience frustration and obstacles when trying to enjoy these basic, daily rights. Ensuring constant attention to these rights will strengthen the child's experience of self, permanency, community, and stability.

RELATIONSHIPS AND LIFELONG CONNECTIONS

- **Family.** Is the child always allowed to contact and visit with his or her family members with whom the court has not limited contact, and with his or her Tribe or Indian custodian, social worker or probation officer, authorized representative, attorney, CASA, Community Care Licensing Division of the State Department of Social Services, and the State Foster Care Ombudsman? Welf. & Inst. Code, §§ 16001.9, 16501.1
  - Has "Family Finding" been done to identify the youth's family and connections? See *www.aecf.org/initiatives/familytofamily/*
  - If yes, who was found and what actions have been taken to engage extended family and other connections (e.g. a family meeting/conference)? See *www.f2f.ca.gov/ and www.cpyp.org*
- What effort is the placing agency making to find or contact the child's extended family members?
- **Siblings.** Are siblings placed together? If not, has the social worker or probation officer made diligent efforts to place siblings together and to develop and maintain sibling relationships? Welf. & Inst. Code, § 16002(b), 306.5, 362.1
- For dependent children, does the social worker's report address the nature of the sibling relationship, the frequency and nature of sibling visitation, and the impact of the sibling relationships on the child's placement and permanency planning? Welf. & Inst. Code, § 366(a)(1)(D)
- **Important individuals.** If the child is more than 10 years old and has been in out-of-home placement for more than six months, does the social worker ask the child whether there are other individuals who are important to the child? Welf. & Inst. Code, § 366.1(g)
  - Who are the important individuals in the child's life? Has placement with these important individuals or a nonrelative, extended family member been considered? Welf. & Inst. Code, §§ 366.1, 362.7, 727
  - Does the social worker help to maintain those relationships if it is consistent with the child's best interest? Welf. & Inst. Code, § 366.1(g)
- **Contact.** Does the child have access to a telephone to make and receive confidential calls to and from anyone with whom the court has not limited contact? Welf. & Inst. Code, § 16001.9; Cal. Code Regs., tit. 22, §§ 83072, 84072, 89372

Note: If the court limits specific contacts, it is appropriate for a placing agency or caregiver to restrict a child's calls with those individuals, but they may not restrict calls beyond court limitations.

- Is the child receiving unopened mail (unless prohibited by court order)? Welf. & Inst. Code, § 16001.9; Cal. Code Regs., tit. 22, §§ 83072, 84072, 89372

STABILITY IN PLACEMENT

Home Placement

- Who is the child placed with? Is this caregiver committed to being in the child's life permanently? Is the caregiver committed to legalizing that commitment (i.e. reunification, adoption, guardianship)? 42 U.S.C. § 671 (a)(15)(F); Welf. & Inst. Code, §§ 358(b), 366.21, 727.2, 727.3, 727.4
  - If not, what characteristics of the relationship make it a viable, permanent lifelong connection?
- During the past six months, what specific steps have been taken by all court participants to finalize the child's permanent plan and give the child a permanent placement? Welf. & Inst. Code §§ 366.21, 366.3, 727.2, 727.3, 727.4, 16501.1
  - Is the child present in court to discuss permanency? If not, why not?
  - If the child is not returning home, what postpermanency support services are needed and planned?
- Was proximity to the child's school taken into consideration when determining placement? Welf. & Inst. Code, § 16501.1(c)(1)

School Placement

- Where is the child going to school and was placement based on the best interests of the child? Ed. Code, §§ 48850(a), 48853(g)
- Is the child now attending an alternative school (e.g. continuation, community, independent study) or a regular comprehensive school? If the placement is an alternative school, on what basis was this placement made? Ed. Code, § 48853(b)
- Has the child been placed in a nonpublic school onsite at the child's placement?
  - If yes, is this school placement based on an IEP and has the person who holds education rights consented? Ed. Code, § 48853(a)(2)

Note: Foster youth are entitled to be placed in the least restrictive educational placement. Regular comprehensive school placements must be considered first, before any alternative school placement. Ed. Code, § 48853(b)& (g)

Foster children with special needs may be placed in a nonpublic school only if the district has no public program that can meet the child's needs or the person who holds educational rights consents. Ed. Code, §§ 48853, 56157(a)

- Are the educator, advocates, court and emergency placement, group home or caregiver working together to maintain a stable school placement? Ed. Code, §§ 48850(a), 48853.5(d)(1), 48853.5(d)(6); if the child is awaiting foster-care placement, 42 U.S.C. §§ 11434a(2)(b)(I), 11432(e)(3)(c)(i) (III)(cc)
  - Was transportation to and from school provided? If not, did this affect the child's educational placement? If the child is awaiting foster-care placement, 42 U.S.C. §§ 11434a(2)(b)(I), 11432(e), (g)
- While in foster care, how many schools has the child attended before this one?
- Is the child safe in the school, surrounding community, and en route to and from school?

These questions are of a sensitive and private nature. Juvenile court judges should encourage all persons to respect the child's privacy and emotions when addressing the child's needs.

Change of Home Placement

- Is there a plan to change the child's placement?
  - If yes, how is the proposed change of placement in the child's best interest? Welf. & Inst. Code, §16501.1(c); see Welf. & Inst. Code, §§ 361, 726; Ed. Code §§ 48853, 48853.5
- Was the placement based on a selection of a safe setting that:
  - Actively involved the child?
  - Is the least restrictive or most family-like?
  - Is the most appropriate setting available?
  - Is near the parent's or guardian's home or Tribe?
  - Is consistent with the selection of the environment best suited to meet the child's special needs and best interest?
  - Promotes educational stability by taking into consideration nearness to the child's school and Tribe? Welf. & Inst. Code, § 16501.1(c); see Welf. & Inst. Code §§ 361, 726; Ed. Code, § 48853
- How many times has the child's placement changed during this stay in foster care?
- If the placement has changed, have all required medications been provided to the new caretaker?
- **School of Origin.** Is the child's local educational agency allowing the child to continue attending the school of origin for the rest of the academic year? Ed. Code, § 48853.5(d)(1)
  - If no, has this resulted in a change of school for the child?
  - If yes, see **Change of School** below.
- **Impact on Child.** What impact has this move had on the child and the child's educational progress? Welf. & Inst. Code, § 16501.1(c); Ed. Code, § 48853.5

Change of School

Note: Proper and timely transfer between schools is the responsibility of both the local educational agency and the county placing agency. Ed. Code, § 49069.5(b)

- Every school must have a Foster Youth Educational Liaison. Did he or she facilitate the enrollment of the child into the new educational placement? Ed. Code § 48853.5(b); *www.cde.ca.gov/ls/pf/fy/ab490contacts.asp*
- **Notice—county placing agency.** Did the county placing agency notify the Local Education Agency (LEA) as soon as possible of the date the child will be leaving the school and request that the child be transferred? Ed. Code, § 49069.5(c)
  - If the child has a disability or an IEP, at least 10 days before the placement change, did the county placing agency notify both the LEA providing the special education program for the child and the receiving LEA of the impending placement change? Gov. Code, § 7579.1(a)
- **Efforts—county placing agency.** What were the placing agency's efforts to maintain the child in the school of origin, despite the foster care placement change? Welf. & Inst. Code, § 16501.1(c); Ed. Code, § 48853.5(d); if the child is awaiting foster-care placement, 42 U.S.C. §§ 11434a(2)(b)(I), 11432(g)(3)(B)(i)
- **Waiver.** Was the child given the opportunity to continue at his or her school of origin for the duration of the academic school year before a placement change occurred? Did the child and the person holding educational rights agree to waive the child's right to attend the school of origin? Ed. Code, § 48853.5(d)
- **Transfer of records—LEA.** After receiving the transfer request, did the LEA transfer the child out of school and deliver the records, including any evaluations of a child with a disability, to the next educational placement within two business days? 20 U.S.C. §§ 1414(b)(3)(D), 1414(d)(2)(C), 1412; 34 C.F.R. §300.304(c)(5) (2006); Ed. Code, §§ 48853.5(d), 49069.5(d), (e)
  - Did the child's school records include a determination of seat time, full or partial credits earned, classes, grades, immunization, and (if applicable) special education or plans under section 504 of the Rehabilitation Act of 1973 (hereinafter "section 504")? Ed. Code, §§ 48645.5, 49069.5
- **Enrollment—new school.** Did the new school immediately enroll the child, even if the child's records, transcripts, and other documentation had not been transferred? Ed. Code, § 48853.5
  - If not, who should be directed to ensure that records are transferred?
- **Resulting absences.** Were the child's grades and credits calculated as of the date the child left school? Ed. Code, § 49069.5(g)

EXTRACURRICULAR ACTIVITIES

- Is the child encouraged and permitted to participate in extracurricular, enrichment, social, and recreational activities consistent with his or her interests and geared toward the community or communities with which he or she identifies? Welf. & Inst. Code, §§ 362.05, 16001.9

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TRANSITION INTO ADULTHOOD/TERMINATION OF JUVENILE COURT JURISDICTION

- **Preparation for adulthood.** For a child aged 15 to 17. 42 U.S.C. § 675(1)(D), 42 U.S.C. § 675(5)(C), 20 U.S.C. § 1414(d)(1)(A)(i)(VIII); 20 U.S.C. § 1414(d)(1)(B)(vii); Ed. Code, § 56345(a)(8); Welf. & Inst. Code, §§ 366.3(e)(10), 391, 10609.3, 10609.4, 11403.2, 16001.9; Cal. Code Regs., tit. 22, §§ 83072, 84072, 89372
  - Is the Transitional Independent Living Plan (TILP) current, and does it specify services that will assist the child's transition to adulthood?
  - Is everyone who is involved in the TILP fulfilling their responsibilities to ensure that the child receives appropriate transition services?
  - Is the child receiving independent living services? Are there any obstacles preventing the child from receiving these services that must be addressed?
  - Has the child achieved his or her TILP goals?
  - Has a child with a disability been invited to attend an IEP team meeting to discuss transition services and postsecondary goals? 20 U.S.C. § 1414 (d)(1); 34 C.F.R. §§ 300.320(b) (2006), 300.321(b) (2006); Ed. Code §§ 56043(g)(1), 56345.1
  - Does the child's IEP include transition services that are scheduled to begin no later than the child's 16th birthday or, if just determined eligible for an IEP, as soon as the IEP goes into effect? *Ibid*.
- **Transition from juvenile court jurisdiction.** For a child about to transition out of juvenile court jurisdiction, has the county provided him or her with:
  - Written information about his or her case, including family and placement history and the location of the child's siblings under juvenile court jurisdiction?
  - Documents, including a social security card, birth certificate, health and education summary, ID card, death certificate of parent(s), and proof of citizenship or residence?
  - Immigration counsel or specialized assistance to complete an application for Special Immigrant Juvenile Status if the child did not have legal residency at the time of becoming a dependent? MPP 31-236
  - Referral to available transitional housing or help getting other housing, a job, or financial support?
  - Help applying for financial aid for college or vocational training?
  - The necessary education and support to obtain a driver's license?
  - Assistance with obtaining health insurance?
  - A copy of his or her health and education summary? Welf. & Inst. Code, § 391
- **Employment and savings.** Does the child have a job, an "emancipation bank account," and the opportunity to manage his or her own resources? Welf. & Inst. Code, § 16001.9
- **Proof of dependency/wardship.** Did the placing agency give the youth a proof of dependency or wardship card that may assist him or her in receiving financial aid, grants, and scholarships to pursue educational goals? MPP 31-236(i)(4)(F)
- **Health care.** Has the child received a recent comprehensive health and dental examination? Has the child received assistance in understanding his or her health-care needs and in locating health-care providers who will be able to meet those needs? Welf. & Inst. Code, §§ 391, 16010
- **Medi-Cal and insurance.** Has the child received information regarding Medi-Cal eligibility and assistance in completing an application for Medi-Cal? Has the child received assistance in obtaining other health insurance? Welf. & Inst. Code, § 391
- **Social security.** Is the child eligible to receive social security?
  - Is the child receiving this benefit?
  - If yes, who is currently the payee, and who will be the payee in the future?

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EMOTIONAL HEALTH

- How is the child emotionally responding to the separation from the child's family of origin? To school? To placement?
- What else can be done to support the development of the child?

Screening/Medication

- Has the child received a mental health screening?
  - If yes, what screening tool or tools were used?
- Did the results of the screening indicate the need for further assessment?
  - If yes, has a further assessment been completed?
- Is there a primary diagnosis?
- Is the child taking any psychotropic medication? Welf. & Inst. Code, § 369.5
  - Is there a current authorization for the medication?
  - What treatment options were tried before medication?
  - What treatment options are being used now to decrease the child's need for medication?
  - Is the child willing to use the medication and is he or she taking it regularly?
  - Is the child experiencing any benefits or complications from the medication?
  - How is the child's response to the medication being monitored?
- Should the medication be reevaluated?

Mental Health Services

- If the child might benefit from mental health services, is the child receiving these services? Welf. & Inst. Code, § 370; Fam. Code, § 6924
  - If yes, how is the child participating in and responding to these services?
  - Should these services include family participation?
  - If the child is experiencing parental rejection due to the child's sexual orientation or gender identity, what is being done to support the family's acceptance and reconciliation?
- Do court reports contain sufficient information concerning the child's mental health status? Welf. & Inst. Code, § 16010
- Does the child have a history of psychiatric hospitalization?
  - Date of last hospitalization?

Service Provider

- Does the child's treating therapist have experience providing mental health services to children before the juvenile court?
- Is the therapist a licensed clinician?
- Is the therapist an appropriate match for the child?
- You may want to consider the relevance of the clinician's gender, language abilities, cultural competence, and location as well as experience working with children who have been removed from, or are at risk of being removed from, the parents or guardians.

Treatment Plan

- Do the child, family, and caretaker all have input into the treatment goals and therapeutic plan?
- Are the mental health services currently being provided adequate to meet the child's needs?
- Has the child invoked the psychotherapist-client privilege? Welf. & Inst. Code, § 317(f)
- If the child is 12 years of age or older, has the child invoked his or her right to consent to mental health treatment or counseling on an outpatient or residential shelter basis? Fam. Code, § 6924

Additional Mental Health Services and AB 3632 Residential Placement

- Is the child eligible or thought to be eligible for special education services?
- Does the child's current IEP show that mental health services are necessary for the child to benefit from education? Gov. Code, §§ 7572, 7576
  - If yes, has the child been referred for or is the child currently receiving AB 3632/AB 2726 mental health services? Gov. Code, §§ 7572, 7576; Cal. Code Regs., tit. 2, § 60100

Community Treatment Facilities and Secured Settings

- Has the child voluntarily applied for inpatient or outpatient mental health services in a secured setting, such as a community treatment facility? Welf. & Inst. Code, § 6552
- How have the child's due process rights been ensured, regarding placement in a secured setting? Welf. & Inst. Code, § 6552
- Is the court satisfied that the child suffers from a mental disorder that may reasonably be expected to be cured by residential treatment? Welf. & Inst. Code, §§ 4094, 6552; Health & Safety Code, § 1502(a)(8)

Conservatorship

- Does the child have or need a conservator? Welf. & Inst. Code, § 5350 et seq.
- When was the conservatorship granted?
  - What is the conservator's name?
  - What is the date of the next conservatorship hearing?

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GENERAL EDUCATION

Educational Rights

See 34 C.F.R. § 300.30 (2006); Welf. & Inst. Code, §§ 319, 361, 366.27, 726; Gov. Code, §§ 7579.5, 7579.6

- Has the court addressed or limited the parent's or guardian's educational rights? If yes, who holds the educational rights for the child?
- Are the child's educational needs being met?
- Does the educational rights holder need assistance in making educational decisions for the child?
- Is the educational rights holder unwilling or unable to meet the child's educational needs?
  - If yes, the court may consider limiting educational rights.

Limiting Educational Rights

- **Appointment of responsible adult.** If the educational rights holder is unable or unwilling to meet the child's educational needs, the educational rights should be limited and a responsible adult appointed as the child's educational representative. Welf. & Inst. Code, §§ 319, 358.1(e), 361, 366.27, 726
- If the court has appointed a responsible adult, did the social worker, probation officer, or clerk of the court forward to the school district a copy of form JV-535 (*Order Limiting Parent's Right to Make Educational Decisions for the Child and Appointing Responsible Adult as Educational Representative—Juvenile*), which identifies who holds the educational rights? Has the school been informed that the education representative now has the education rights, including notice of meetings, grades, and participation in the child's education, previously held by the parent? Ed. Code, § 51101
- **Appointment of surrogate.** This may occur if the court has limited education rights and cannot identify a responsible adult to make educational decisions, and the child is eligible or may be eligible for special education and related services. 20 U.S.C. § 1415 (b); 34 C.F.R. §§ 300.30(a)(5) (2006), 300.519 (2006); Welf. & Inst. Code §§ 361(a), 726(b); Gov. Code § 7579.5(a)(1)(A):
  - Did the court refer the child to the local educational agency for appointment of a surrogate? Welf. & Inst. Code §§ 361(a), 726(b); Gov. Code § 7579.5(a)(1)(A)
  - Did the court provide the agency with a copy of form JV-536 (*Local Educational Agency Response to JV-535—Appointment of Surrogate Parent*), which requests the appointment of a surrogate? 20 U.S.C. § 1415(b)(2)(B); Welf. & Inst. Code, § 361(a); Gov. Code, § 7579.5(a)
  - Did the local educational agency appoint a surrogate parent not more than 30 days after determining that the child needs a surrogate parent? 20 U.S.C. § 1415(b)(2)(B); Gov. Code, § 7579.5
  - If the court cannot identify a responsible adult and if appointing a surrogate parent is not legally warranted, the court may make educational decisions for the child. Welf. & Inst. Code, §§ 319(g), 361
  - Has the holder of educational rights been fully informed of, and provided consent in writing for, the activity for which consent is sought? 34 C.F.R. § 300.9 (2006); 71 FR 46540, 46551; Ed. Code, §§ 56321, 56341(h), 56346

Note: County social workers and probation officers do not have the authority to make decisions regarding the child's educational rights and may not be appointed to make educational decisions for the child. If a nonpublic agency is providing the child with education or care or has a conflict of interest, neither it nor any person employed by it may be appointed to make educational decisions for the child. See Gov. Code, § 7579.5(i)–(j); Welf. & Inst. Code, § 361(a)(5)

Achievement/Participation

- What is the child's attendance record this year? What are the reasons for any absences or truancies? Has the child been wrongfully penalized for any absences related to change of placement or any court appearances? Ed. Code, § 49069.5(g), (h)
- What are the child's grades?
- What grade level should the child be in? If needed, is there a specific plan to assist the child with reaching this grade level? Welf. & Inst. Code, § 16010(a)
- What educational services (e.g. tutoring, summer school, other supplemental services) is the child receiving? Ed. Code §§ 48070.5, 48850, 48853(g)
- Has the new school district accepted for full or partial credit all coursework satisfactorily completed at the prior school placement? Ed. Code, § 48645.5
- Is the child limited in his or her ability to speak English? If yes, is the child receiving appropriate programs to address his or her English language needs? 20 U.S.C. § 1703(f); Ed. Code, § 300 et seq.
- Does the child's background suggest that he or she might qualify as a migrant student? If yes, has he or she been assessed to determine migrancy and if identified as migrant, does the child have access to appropriate programs available for migrant students? 20 U.S.C. § 6399(2); 34 C.F.R. § 200.81(d) (2002); Ed. Code, §§ 54441, 54442(a)
- What is the child's experience in school (friends, social environment, interest, etc.)?
- Is the child experiencing isolation, rejection, or harassment at school? (Explore reasons: race or ethnicity, sexual orientation, other.)
- Is the child attending a school that has been identified as a program improvement school? If yes, is the student receiving supplemental services and/or has the child been given a school choice option? 20 U.S.C. § 6316
- Is the child participating in extracurricular activities and if not, why not? Ed. Code §48850(a); Welf. & Inst. Code, §§ 362.05, 16001.9(a)(13)

High School Students

- Has the child obtained any of the following?
  - High school diploma or GED
  - Certificate of Completion
  - Passing of high school exit exam. Ed. Code, § 60851
- If the child is not making sufficient progress toward passing the high school exit exam, is she or he being provided supplemental instruction designed to help him or her pass? Ed. Code, § 60851(f).
- How many more credits are needed for graduation and does the school district have an alternative means for students to earn the credits to graduate? Ed. Code § 51225.3(b)
- What are the child's plans for postsecondary education or vocational school? Welf. & Inst. Code, § 16001.9; if the child is awaiting foster-care placement, 42 U.S.C. §§ 11434a(2)(b)(I), 11432(g)(4)
- What assistance is the child receiving to achieve these goals and to apply for financial aid?
- Has the social worker or probation officer provided the child with information regarding educational options available, including required coursework for vocational and postsecondary educational programs, and financial aid information for postsecondary education? Welf. & Inst. Code, § 16001.9(a)(24)

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SCHOOL DISCIPLINE

- Has the child been expelled or suspended, or experienced any other school discipline? Ed. Code, § 48900 et seq.
- If so, what was the reason for the child's most recent exclusion from school? Ed. Code, §§ 48900, 48900.2–48900.4, 48900.7
  - How are these concerns being addressed? Ed. Code, § 48916(b)
  - Was the exclusion more than 5 consecutive days, or has the child been excluded for more than 20 total days of the school year? Ed. Code, §§ 48903(a), 48911(a) *Note: Longer exclusions are generally not permissible.*
  - Have proper due process procedures been followed for the exclusion? 20 U.S.C. § 1415; 34 C.F.R. §§ 300.504 (2006), 300.530(h) (2006); Ed. Code, §§ 48900 et seq., 48915.5
  - Did the public agency have a basis to know that the child had a disability before it disciplined the child? 20 U.S.C. § 1415(k)(5)(B); 34 C.F.R. § 300.534 (b) (2006); Ed. Code, § 48915.5
  - Did the person who holds educational rights receive a copy of the expulsion or any other discipline-related notices? Ed. Code, § 48918(b)
  - Has the child's rights to a due process hearing been waived? If yes, who agreed to the waiver, was it in writing, and what were the terms of the waiver?
  - Has the child been provided an educational placement during the period of the expulsion? Does the child have a rehabilitation plan and a set date when the child can apply for readmission to a regular school? Ed. Code, § 48916(b)
- If the child is eligible for special education services and the child's behavior appears to interfere with achieving the goals and objectives of the IEP:
  - Has an appropriate behavioral intervention plan been implemented? Cal. Code Regs., tit. 5, § 3052; Ed. Code, § 48916
  - Was an IEP meeting held before a change in placement was made as a result of behavior (including suspension totaling more than 10 days in a school year)? 34 C.F.R. § 300.530(e) (2006)
  - Was a Manifestation Determination IEP meeting held before expulsion proceedings were begun? 34 C.F.R. § 300.530(e) (2006); Ed. Code, § 48915.5

ACCOMMODATIONS AND SERVICES

Note: The state must have in effect polices and procedures to ensure that all children with disabilities are identified, located, and evaluated and that a practical method is developed and implemented to determine which children are currently receiving needed special education and related services. 20 U.S.C. § 1412(a)(3); 34 C.F.R. § 300.111 (2006); Gov. Code § 95022; Ed. Code, § 56300

- Is the child eligible for or receiving services or accommodations for a physical, mental, or learning disability as required by the Americans With Disabilities Act (ADA), the Individuals With Disabilities Education Act (IDEA), or section 504? 20 U.S.C. § 1400; Ed. Code, § 56000; 34 C.F.R. § 104.3(j) (2000)
  - If yes, are the services appropriate and meeting the child's needs?
- **Referrals: Children under 3, and 3 to 5 years old.** If the child is under age 3 and is developmentally delayed or meets eligibility criteria for being considered "at risk of developmental delay," has the child been referred to the Early Intervention Program to determine eligibility for an Individualized Family Service Plan (IFSP)? 20 U.S.C. § 1436; Ed. Code, §§ 56425-56426.9; Gov. Code, § 95000 et seq.; Cal. Code Regs., tit. 5, § 3031; Cal. Code Regs., tit. 17 §§ 52020, 52022; see 34 C.F.R. § 300.25 (2006) and Gov. Code, § 95014 for the definition of "infant" or "toddler."
  - If yes, has a written IFSP been developed in compliance with 20 U.S.C. § 1436(d)? 20 U.S.C. § 1436; Ed Code § 56426.8
- If the child is between 3 and 5 years old and has not met these developmental markers, has the child been referred to the district to be assessed for special education services? Ed. Code, § 56001
- If the child is receiving services, are they appropriate? Ed. Code, § 56001
- **Referrals: Children 5 to 22.** If the child or youth is between 5 and 22 years old and has not graduated from high school, has a learning deficit or other disability been suspected or identified?
  - If yes, has the child or youth been referred to the district for a special education assessment?
- The Secretary of the Interior is responsible for providing and coordinating special education and related services to children ages 5 through 21 with disabilities on reservations who are enrolled in elementary schools and secondary schools for Indian children operated or funded by the Secretary of the Interior. 20 U.S.C. § 1411(h); 34 C.F.R. § 300.713(a), (b) (2006)
- **IEP.** If the child has been assessed and found eligible for special education services, does the child have a current IEP? 20 U.S.C. § 1414(a); Ed. Code, §§ 56043(j), 56381
  - What is the child's qualifying disability?
  - Do the IEP goals correspond to the areas of need mentioned in the assessments?
  - Are the goals specific enough that the parties can easily recognize when they have been attained?
  - Does the IEP include an appropriate setting or classroom to meet the child's needs?
  - When was the most recent IEP made?
  - Who was present at the assessment?
  - Was the educational rights holder an effective representative?
  - Are the child's needs reviewed annually?
  - Is the public agency ensuring the child has the supplementary aids and services determined necessary by the child's IEP team for the child to participate in nonacademic and extracurricular services and activities to the maximum extent appropriate to the needs of that child? 20 U.S.C. § 1412(a)(5); 34 C.F.R. § 300.117 (2006); Ed. Code, §§ 56033.5, 56345
- Are any services necessary to help the child benefit from the special education program (e.g. transportation; psychological services; and physical, speech, and occupational therapy)? 20 U.S.C. § 1401(26); 34 C.F.R. §§ 300.34 (2006), § 104.3(j) (2000); Ed. Code, § 56363; Gov. Code, §§ 7573, 7575

Note: The Supplement to Asking the Right Questions: A Judicial Checklist *provides additional citations and details specific to California law. See* http://clcla.org/train_educat.htm

- **Development.** Does the child have a developmental disability (e.g. mental retardation, autistic spectrum disorder, cerebral palsy, epilepsy)? Welf. & Inst. Code, § 4512 (a)
  - If yes, is the child receiving appropriate developmental services from the regional center? Welf. & Inst. Code § 4512 (b)
  - If no, and if the child is suspected of having a developmental disability, has a referral been made? See Gov. Code, §§ 95014, 95016; Welf. & Inst. Code § 4642

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CHAPTER 7

Reference Guide to Psychological and Developmental Assessments and Diagnoses

TABLE OF CONTENTS

UNIT 1: Professional Assessment of Children

The issues explored in this section can impact any child, not just those who have come to the attention of the child protective services system as a result of abuse or neglect. It is not the purpose of this training to make you an expert in child development or psychology, but to help you recognize warning signs that might indicate the need for evaluation and treatment by an educational specialist or qualified mental health professional.

The children with whom you will be working may exhibit symptoms or behaviors that require professional assessment. A specific behavior may be a warning sign of a particular problem but may also be attributable to a variety of other causes. ***It is critical that the CASA volunteer not try to diagnose.*** A referral to a competent mental health professional is the best course of action if you learn about or observe red flags as you complete your initial investigation and as you continue to monitor the child's situation.

Psychological Assessment of Children

During a case, recommendations may be made for children to undergo psychological assessment. Assessment is a process, not just a series of tests. The reasons why assessment is recommended, the particular instruments (tests) used, the individual conducting and evaluating the instruments, the timing of the assessment in the context of the child's life, and the intended uses of the assessment are all important parts of this process. Following is a brief overview of reasons that children are referred for assessment.

Reasons for Assessment

1. Children are referred for psychological assessment for many reasons, including:
2. **Dysfunctional and negative behavior**, such as tantrums, a demanding personality, excessive crying and whining, delinquency, defiance of rules and limits.
3. **Developmental concerns**, such as perceptual and motor problems, speech and learning problems, delayed development, school readiness determination.
4. **Educational problems**, such as inadequate performance and progress, aggressive behavior, dislike or disinterest in school.
5. **Sleeping and eating problems**, such as infant feeding and nursing problems, excessive crying, bulimia, anorexia nervosa, over- and undereating, and any suspected nutritional deficiencies that may be contributing to learning problems, sleep and behavior problems, fatigue.
6. **Toilet training problems**, including any manifestations of encopresis (soiling), enuresis (bedwetting), or excessive fear of going into the bathroom.
7. **Behavioral issues**, such as poor self-control, lack of motivation, irresponsibility, lying, stealing, dependence/independence conflict, setting fires, "mean" behavior toward animals and others, self-inflicted injuries, sexuality issues.
8. **Family problems**, such as sibling conflict, dysfunctional communication, inadequate support system in social relationships and skills, attachment and separation problems, aggressiveness, and abuse. Problems of change prompted

by divorce, custody issues, separation, adoption, termination of parental rights, moving, visitation issues, grieving and death issues. Problems related to how the child learns and processes information that the family presents (the belief system within the family leading to attitude, temperament). Parents' negative feelings for the child, poor relationship indicators, conflict over discipline, family arguing.

9. **Medical considerations**, such as psychophysiological reactions to stress, adjustment to illness of a child or family member, terminal illness of the child or family member, physical or sexual abuse, neglect, drug and alcohol abuse by child or other family member.

10. **Psychiatric manifestations**, including personality disorder, cyclothymic mood disturbance (alternate periods of elation and depression), disassociation and psychic numbing (emotional shutting down and flat affect), excessive fears, harming others, and psychotic behavior such as hallucinations and thought disorder.

Professional Assessment of Children

Tools for Assessment

The selection of instruments (tests) to be administered to a child must be appropriate for the purpose of the evaluation and must take into consideration the child's age and any special handicaps such as sensory deficits, physical or motor impairments, or speech disorders. Tests should also be culturally appropriate or at least be free of cultural bias.

Other factors of importance in selecting tests for individual examination are determined by the attributes of the tests. Among those to be considered in choosing one test in preference to another are:

- **Validity**
  How well does the test measure what it is said to measure?

- **Reliability**
  How consistently are the test results reproduced when the same individual is re-tested? When the test is broken up via the split-half method and compared with itself, is it internally consistent?

- **Standardization**
  The test norms should be derived from a representative sample of the population to whom the test is to be applied.

- **Objectivity**
  An objective test involves specific responses to specific requests or situations. A standard set of directions is followed for administering and scoring the test. Any departures from these prescribed procedures must be reported.

(Note: No single test score is conclusive; professionals look for several sources of data to support conclusions they draw from the tests.)

UNIT 2: Brief Descriptions of Some Commonly Used Assessment Tools

The following list of assessment tools is in no way intended to be complete. It does, however, give some examples of the types of instruments that may be used. The CASA volunteer is not expected to have an expert's knowledge of the use of assessment instruments. However, some familiarity with the types of instruments being used may help guide research and further discovery on behalf of the child.

Developmental Scales

Denver Developmental Screening Test *(1 month–6 years)*
Quick assessment of personal, social, fine motor, adaptive, language, and gross motor development.

Gesell Developmental Schedules *(2 ½ years–6 years)*
Thirteen tests assessing wide range of developmental factors in preschoolers. Assesses behavior and emotional and physical development. Used for screening, early intervention, or diagnosis.

Bayley Scales of Infant Development *(2 months–30 months)*
Two-scale test for infant mental and motor development and a behavior rating. Assesses early mental and psychomotor development. Used in the diagnosis of normal versus retarded development.

Intelligence Tests

Wechsler Intelligence Scale for Children–Revised (WISC-III) *(5 years–15 years)*
Twelve subtests divided into two major divisions yielding a verbal IQ, performance IQ, and full scale IQ for children tested individually. Provides verbal and nonverbal scales.

Wechsler Preschool & Primary Scale of Intelligence (WPPSI-II) *(2 years–6 ½ years)*
Ten standardized subtests divided into verbal and nonverbal scales to assess cognitive and reasoning abilities. Scores converted to deviation quotient comparing subject to age peers.

Stanford-Binet Intelligence Scale (SB-IV) *(2 years–Adult)*
Measures overall cognitive abilities. Emphasis at lower ages on sensorimotor performance; at school age and above, highly dependent on verbal skills. Verbal and nonverbal tests assess verbal reasoning, abstract/visual reasoning, quantitative comprehension, and short-term memory. Can be used to substantiate scores from group tests, to provide more comprehensive assessment, and when a subject has physical, language, or personality disorders that prevent group testing. Results can help identify subjects who would benefit from specialized learning environments.

Leiter International Performance Scale *(2 years–18 years)*
Multiple-item nonverbal task assessment of intelligence. Individual performance scale. Covers range of functions, non-timed, nonverbal, assumed to be culture-free. Useful for children with speech or language difficulties.

Wechsler Adult Intelligence Scale–Revised (WAIS-R) *(16 years–Adult)*
Eleven subtests yielding verbal IQ, performance IQ, and full scale IQ. Verbal and nonverbal scales. Popular and well-standardized test but considered not useful for exceedingly superior or for retarded.

Vocabulary

PPVT
Point to response nonverbal multiple-choice selection of picture associated to word spoken by examiner. Measures receptive vocabulary for Standard American English, estimates verbal ability, and assesses academic aptitude. Also used with English as a Second Language (ESL) students, mentally retarded, and gifted students. Vulnerable to deficit in visual/perceptual functions. Scores converted to mental ages, deviation IQ.

Full Range PVT
Similar to Peabody. Assesses individual intelligence when scores are converted to mental age and tables are available for comparable Wechsler Verbal IQ. May be used in testing special populations such as physically handicapped, uncooperative, aphasic, or very young subjects.

Perceptual- or Visual-Motor Integration Tests

Bender Visual-Motor Gestalt Test *(3 years–Adult)*
A paper-pencil test, untimed. Assesses visual-motor functions. Evaluates developmental problems in children, learning disabilities, retardation, psychosis, and organic brain disorders. Visual-perception, visual-motor integration, motor skill, and organizational ability are tapped by copying figures. Also used as projective test.

Illinois Test of Psycholinguistic Abilities (ITPA) *(2 years–10 years)*
Ten subtests evaluate child's cognitive and perceptual abilities in communication, auditory, psycholinguistic process of visual reception, levels of organization, sequential memory, association of symbols, ordering recall, discrimination and conceptualization of similarity, and closure.

Frostig Developmental Test of Visual Perception *(pre-kindergarten)*
Forty-one-item paper-pencil test assessing eye-motor coordination, figure-ground, form constancy, discrimination of position in space, and reproduction of spatial relationships. Evaluates children referred for learning difficulties or neurological handicaps.

Goodenough-Harris Drawing Test *(3 years–15 years)*
Assesses mental ability through nonverbal technique and drawing tasks. Revisualization, ability to reproduce representation of human figures. Developmental age scores. Also used as projective device.

Benton Revised Visual Retention Test *(8 years–Adult)*
Measures visual memory. Utilizes ten cards depicting one or more geometric forms exposed ten seconds. Assesses revisualization, spatial perception, and perceptual-motor reproductions. Scored for number correct and number of errors. Used as supplement to visual mental examinations.

Memory for Designs (Graham-Kendall) Test *(8 ½ years–Adult)*
Assesses revisualization and visual-motor coordination. Fifteen cards with simple geometric figures, each exposed five seconds, to be reproduced. Used to differentiate between functional behavior disorders and those associated with brain injury.

Auditory Processing Tests

Illinois Test of Psycholinguistic Abilities (ITPA) *(2 years–10 years)*
Assesses specific psycholinguistic abilities and disabilities in children. Facilitates assessment of child's abilities for remediation. Ten subtests of auditory-reception, association, sequential recall, grammatic closure, sound-blending, and verbal expressiveness. Assess decoding, ordering, memory, ability to analyze and synthesize parts-to-whole.

Goldman-Friscoe-Woodcock Test of Auditory Discrimination *(4 years–Adult)*
Diagnoses an individual's ability to hear clearly under increasingly difficult listening conditions. Twelve subtests measure auditory election, attention, discrimination, memory, and sound-symbol skills. Intersensory integration is involved in multiple-choice response to pictures associated with recorded words. Used for instructional planning.

Kinesthesia & Tactile Perception

Southern California Sensory Integration Tests *(4 years–10 years)*
Measures an individual's ability to see, touch, and move in a coordinated manner. Seventeen-item paper-pencil and task assessment tests measuring visual, tactile, and kinesthetic perception, and different types of motor development. Used to identify the degree and type of disorder often associated with learning and emotional programs, minimal brain dysfunction, and cerebral palsy.

Reitan-Indiana Neuropsychological Battery for Children *(5 years–Adult)*
Assesses brain-behavior functioning in children. Includes subtests of sensory perception, intersensory manual form perception, tactile localization, tactile-kinesthetic perception, learning, and recall. Used for clinical evaluations.

Motor Tests

Southern California Sensory Integration Test *(4 years–10 years)*
Five of six subtests require imitation of patterned movements, body positions, or response to verbal requests.

Southern California Motor Accuracy Tests *(4 years–8 years)*
Measures degree of accuracy in drawing a pencil line over a printed line. Used in diagnosis of perceptual-motor dysfunction in atypical children. Used in clinical evaluations.

Lincoln Oseretsky Motor Development Scale *(6 years–14 years)*
Measures motor development. Tests fine and gross motor skills. Used to supplement information obtained from other techniques concerning intellectual, social, emotional, and physical development.

Purdue Perceptional Motor Survey *(6 years–10 years)*
Range of postural, motor, body image, and form perception measures.

Frostig Developmental Test of Visual Perception *(3 years–10 years)*
Eye-motor coordination subtests measure skill of visually guided movements.

Bayley Scales of Infant Development, Motor Scale *(2 months–30 months)*
Assesses developmental levels of motor patterns, including prehension and locomotion.

Academic Skills & School Achievement

STANDARDIZED TESTS GIVEN BY SCHOOLS:
All measure reading, math, and writing skills.

- **Iowa Test of Basic Skills (ITBS)**
- **Washington Assessment of Student Learning (WASL)**

TESTS GIVEN BY SPECIALISTS:

Woodcock-Johnson Psychoeducational Battery (W-JPEB)
Twenty-seven-test battery. Evaluates individual cognitive ability, scholastic achievement, and interest level. Used to diagnose learning disabilities for instructional planning, vocational rehabilitation, and counseling.

Wide-Range Achievement Test–Revised (WRAT-R)
Three paper-pencil subtests, which measure basic educational skills of word recognition, spelling, and arithmetic. Identifies individual learning difficulties. Used for educational placement, measuring school achievement, vocational assessment, and job placement and training.

Peabody Individual Achievement Test (PIAT)
Four-hundred-item test of mathematics, reading, comprehension, and general information. Provides an overview of individual scholastic attainment. Used to screen for areas of weakness requiring more detailed diagnostic testing.

Adaptive Behavior Scales

Vineland Social Maturity Scale–Revised
One-hundred-seventeen-item interview covering eight categories of self-help in general, eating, dressing, communication, self-direction, socialization, and locomotion. Measures successive stages of social competence and adaptive behavior. Used to measure individual differences, which may be significant in cases of mental deficiencies and emotional disturbances, in order to plan therapy or individual education.

Woodcock-Johnson Scales of Independent Behavior (SIB) *(2 years–Adult)*
Assesses functional behavior, self-help skills, and communication skills. Usually used with developmentally delayed individuals.

A.A.M.D. Adaptive Behavior Scale *(3 years–6 years)*
Assesses social and daily living skills of children whose adaptive behavior indicates possible mental retardation, emotional disturbance, or other learning handicaps. Used for screening and instructional planning.

Personality & Social/Emotional Functioning

A variety of tests can be used to examine various personality or emotional hypotheses about children. These tests include the following:

The Achenbach Child Behavior Checklist (CBCL) *(2 years–16 years)*
Assesses behavioral problems and competencies of children and adolescents. Evaluates child behavioral problems from subject's perspective with Youth Self-Report (for ages 8–11

years), from parent's point of view with Child Behavior Checklist, and from teacher's perspective on classroom behavior with Teacher Report Form. Direct Observation Form used by experienced observer to rate on basis of a series of at least six ten-minute observation periods.

Behavioral Assessment Scale for Children (BASC) *(2 ½ years–18 years)*
Assesses the range of behavior for typically developing children in order to look for areas of psychological damage.

Minnesota Multiphasic Personality Inventory–Adolescent Version (MMPI-A) *(Adolescents–Adults)*
One-hundred-fifty-item true/false test of ten clinical variables or factors. Assesses individual personality. Used for clinical diagnosis and research on psychopathology.

Children's Depression Inventory *(8 years–13 years)*
Twenty-seven-item pencil-paper inventory measuring overt symptoms of child depression such as sadness, anhedonia, suicidal ideation, and sleep and appetite disturbance. Assesses severity of depression in children and adolescents. Also used to measure progress during treatment.

Various Projective Tests

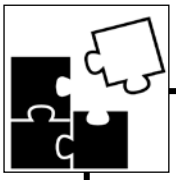
TAT, CAT, Robert's Apperception Test for Children, Piers-Harris Children's Self-Concept Scale, Sentence Completion Test
Used with caution, as they are not standardized. They can be helpful when used with other sources and by a trained clinician.

Adapted from *Tests: A Comprehensive Reference for Assessments in Psychology, Education and Business*, second edition, Richard C. Sweetland, Ph.D., and Daniel J. Keyser, Ph.D., general editors. Kansas City, MO: Test Corporation of America, 1986. Updated for NCASAA by Peggy Tribble, Ph.D., May 2000.

UNIT 3: Common Diagnoses of Dependent Children

Following are some of the possible diagnoses that may apply to the children with whom you work:

Reactive Attachment Disorder



Difficulty forming loving, lasting, intimate relationships, due to a failure to attach, to bond, or to trust a primary caregiver during the first two years of life.

What Causes Reactive Attachment Disorder (RAD)?

Any of the following factors, especially occurring to a child during the first two years of life, puts a child at high risk of developing an attachment disorder:

- ✓ Maternal drug and/or alcohol use during pregnancy;
- ✓ Premature birth;
- ✓ Abuse (physical, emotional, sexual);
- ✓ Neglect;
- ✓ Sudden separation from primary caretaker (illness or death of mother, chronic illness or hospitalization of child);
- ✓ Undiagnosed and/or painful illness (colic, chronic ear infections);
- ✓ Frequent moves or placements;
- ✓ Inconsistent or inadequate daycare;
- ✓ Chronic maternal depression;
- ✓ Teenage mothers with poor parenting skills; and/or
- ✓ Drug-addicted infant.

What Are the Signs of Reactive Attachment Disorder?

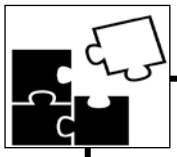
Although the following symptoms may be seen in many children, a child suffering from reactive attachment disorder will display all or most of them:

- ✓ Manipulative, superficially engaging, or charming;
- ✓ Abnormal eye contact;
- ✓ Indiscriminately affectionate with strangers;
- ✓ Lacking ability to give and receive affection;
- ✓ Extreme control battles often manifest in covert or "sneaky" ways;
- ✓ Destructive to self, others, animals, material things;
- ✓ Accident prone;
- ✓ Stealing;
- ✓ Hoarding or gorging food, abnormal eating patterns;
- ✓ Preoccupation with fire, blood, gore;
- ✓ Lack of impulse control and cause-and-effect thinking (frequently acts hyperactive);
- ✓ Learning lags and speech disorders, abnormal speech patterns;
- ✓ Lack of conscience;
- ✓ Crazy, chronic, obvious lying;
- ✓ Poor peer relationships;
- ✓ Persistent nonsense questions and incessant chatter; and/or
- ✓ Inappropriately demanding and clingy.

What Treatments Are Available?

Children need extensive treatment to learn how to trust, thus enabling them to love. The most recent treatment of choice is attachment therapy. It uses a combination of therapeutic techniques, such as body therapies, psychodynamic techniques, holding techniques, and grief and loss work. The treatment of choice for RAD is a highly controversial issue. In any case, these children need extensive treatment at an early age in order to make up for the neglect they received in utero and as infants.

Separation Anxiety Disorder



Excessive anxiety about being away from home or separated from people to whom one is attached.

What Causes Separation Anxiety Disorder?

The disorder may be triggered by life stress, such as the death of a relative, friend, or pet; geographic move; or a change in schools.

What Are the Signs of Separation Anxiety Disorder?

Separation anxiety disorder lasts at least a month, causing significant distress or impairment in functioning; the duration of the disorder reflects its severity.

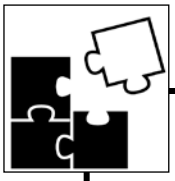
A child suffering from separation anxiety disorder may:

- ✓ Experience great distress (crying, clinging, panic) when separated from home or people to whom he/she is attached;
- ✓ Need to know the whereabouts of these people;
- ✓ Be preoccupied with fears that something terrible will happen to them;
- ✓ Be uncomfortable traveling alone;
- ✓ Refuse to attend school or camp or to visit a friend's house;
- ✓ Be unable to stay alone in a room;
- ✓ Cling to a parent or shadow the parent around the house;
- ✓ Have difficulty at bedtime;
- ✓ Be reluctant to sleep alone;
- ✓ Experience nightmares that reveal the anxiety; and/or
- ✓ Experience physical problems (nausea, stomachaches, dizziness).

What Treatments Are Available?

The child should receive a thorough evaluation before treatment is started. For some children, medication can significantly reduce the anxiety and allow them to return to school. These medications may also reduce the physical symptoms. Generally, psychiatrists use medications as an addition to psychotherapy. Both psychodynamic play therapy and behavioral therapy have been found helpful in reducing anxiety disorders. In psychodynamic play therapy, the therapist helps the child work out the anxiety by expressing it through play. In behavioral therapy, the child learns to overcome fear through gradual exposure to separation from the parents.

Learning Disabilities



Inability to acquire, retain, or broadly use specific skills or information, resulting from deficiencies in attention, memory, or reasoning, and affecting academic performance.

What Causes Learning Disabilities (LD)?

Many types of learning disabilities exist, and no single cause accounts for them. However, the basis of all learning disabilities is believed to be abnormal brain function. An estimated three to fifteen percent of school children in the United States may need special educational services to compensate for learning disabilities. Boys with learning disabilities outnumber girls five to one.

What Are the Symptoms of Learning Disabilities?

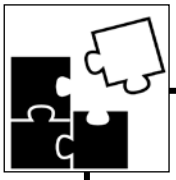
A child suffering from a learning disability may:

- ✓ Have problems coordinating vision with movement;
- ✓ Be clumsy at physical tasks (cutting, coloring, buttoning, tying shoes, running);
- ✓ Have problems with visual perception;
- ✓ Have problems with phonologic processing (recognizing sequences or patterns and distinguishing among sounds);
- ✓ Have problems with memory, speech, reasoning, and listening;
- ✓ Have problems with reading, arithmetic, or writing (most learning disabilities are complex, with deficiencies in more than one area);
- ✓ Be slow to learn the names of colors or letters, to assign words to familiar objects, to count, and to progress in other early learning skills;
- ✓ Exhibit delayed learning to read and write;
- ✓ Have a short attention span and memory span;
- ✓ Have difficulty with printing and copying (activities that require fine motor coordination);
- ✓ Have difficulty communicating and controlling impulses;
- ✓ Have discipline problems; and/or
- ✓ Be easily distracted, hyperactive, withdrawn, shy, or aggressive.

How Is a Learning Disability Diagnosed & Treated?

A doctor examines the child for any physical disorders. The child then takes a series of intelligence tests, both verbal and nonverbal, including testing for reading, writing, and arithmetic skills. Psychological testing is the final step of evaluation. No drug treatment has much effect on academic achievement, intelligence, and general learning ability. However, certain drugs, such as methylphenidate, may improve attention and concentration. The most useful treatment for a learning disability is an education that is carefully tailored to the individual child.

Attention-Deficit/Hyperactivity Disorder



Excessive, long-term, and pervasive behaviors, including distractibility (poor sustained attention to tasks), impulsivity (impaired impulse control and delay of gratification), or hyperactivity (excessive activity and physical restlessness).

What Causes Attention-Deficit/Hyperactivity Disorder (AD/HD)? AD/HD is not caused by poor parenting, family problems, poor teachers or schools, too much TV, food allergies, or excess sugar. AD/HD is very likely caused by biological factors that influence neurotransmitter activity in certain parts of the brain and have a strong genetic basis. Approximately four to six percent of the U.S. population has AD/HD; however, if one person in a family is diagnosed with AD/HD, there is a twenty-five to thirty-five percent probability that another family member also has AD/HD.

What Are the Signs of AD/HD?

The American Psychiatric Association's *Diagnostic and Statistical Manual* recently renamed the disorders formerly known as ADD and ADHD to be AD/HD.

AD/HD includes three subtypes:

1. A predominantly inattentive subtype (formerly ADD). Signs include:
   - Easily distracted by irrelevant sights and sounds;
   - Failing to pay attention to details and making careless mistakes;
   - Rarely following instructions carefully and completely; and
   - Losing or forgetting things like toys, pencils, books, and tools needed for a task.
2. A predominantly hyperactive-impulsive subtype (formerly ADHD). Signs include:
   - Feeling restless;
   - Fidgeting and squirming;
   - Running, climbing, leaving a seat in situations where sitting or quiet behavior is expected;
   - Blurting out answers before hearing the entire question; and
   - Having difficulty waiting in line or for a turn.
3. A combined subtype, which is the most common of the three.

AD/HD refers to all types of attention-deficit disorders, both with and without hyperactivity. To be considered for a diagnosis of AD/HD, these behaviors must appear before age seven and last for at least six months. The level of disturbance must occur more frequently and in a more severely pronounced manner than among other children in the same age group. And above all,

these behaviors must create a real handicap in at least two areas of a child's life, such as school, home, or a social setting.

What Treatments Are Available?

Clinical experience has shown that the most effective treatment for AD/HD is a combination of medication and therapy or counseling to learn coping skills and adaptive behaviors. The most well known treatments of AD/HD are psychostimulants, such as Ritalin and Dexedrine, and some antidepressants that affect the levels of dopamine, noradrenaline, and serotonin in the central nervous system. Taken in normal doses, stimulants can result in decreased appetite, stomachaches, agitation, irritability, and insomnia for some children. The long-term effects of taking these drugs are not yet known.

Medications can result in an improvement in core symptoms such as impulsive behavior and inattention as well as improved school and social performances. For that reason, treatment for AD/HD is more effective when regular use of drugs is combined with behavior treatment. Reward systems for appropriate behavior or performance, teaching parents child-management skills, and therapy that instructs parents and teachers in improved contingency management skills can help most children. Children who regularly take their medication and practice behavior techniques routinely do better than those who rely on stimulants alone.

When Should a Person Seek Help?

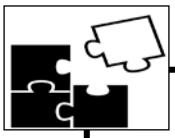
Since many children exhibit occasional inappropriate or hyperactive behaviors, widespread confusion has arisen about the diagnosis and treatment of AD/HD. Due to those uncertainties, parents and guardians should not attempt to diagnose their children. Children who are responding to stressful family situations, are bored in the classroom, or are passing through certain stages of development may appear inattentive, hyperactive, or impulsive—yet they do not have AD/HD.

To determine whether a child needs to be examined by a physician, psychologist, or other medical specialist, you should consider several critical questions:

- ✓ Are the child's troublesome behaviors excessive, long-term, and pervasive?
- ✓ Do they occur more often than in his/her peers?
- ✓ Are his/her behaviors a continuous problem and not just a response to a temporary situation?
- ✓ Do his/her behaviors occur in several settings, or only in one specific place, such as the playground or school?

You should talk to the child's teacher to get a clearer reading on the child's daily behaviors. You should also seek a consultation with a health professional to rule out other possible psychological problems, such as depression or a learning disorder.

Childhood Depression



A feeling of intense sadness beyond an appropriate length of time.

What Causes Childhood Depression?

Children who develop major depression are likely to have a family history of the disorder, often a parent who experienced depression at an early age. Depression in children can be triggered by events or problems, such as the death of a parent, a friend moving away, difficulty in adjusting to school, difficulty making friends, or drug or alcohol abuse. However, some children become depressed without profoundly unhappy experiences.

What Are the Symptoms of Childhood Depression?

The defining features of depression in children are the same as they are for adults. However, recognition and diagnosis of the disorder are more difficult in youth because expression of the symptoms varies with youth's developmental stage, and children may have difficulty properly identifying and describing their internal emotional or mood states. Therefore, symptoms of depression may manifest in children as the following:

- ✓ Frequent vague, nonspecific physical complaints, such as headaches, muscle aches, stomach-aches, or tiredness;
- ✓ Frequent absences from school or poor performance in school;
- ✓ Talk of or efforts to run away from home;
- ✓ Outbursts of shouting, complaining, unexplained irritability, or crying;
- ✓ Being bored;
- ✓ Lack of interest in playing with friends;
- ✓ Among older youth, alcohol or substance abuse;
- ✓ Social isolation, poor communication;
- ✓ Fear of death;
- ✓ Extreme sensitivity to rejection or failure;
- ✓ Increased irritability, anger, or hostility;
- ✓ Reckless behavior; and/or
- ✓ Difficulty with relationships.

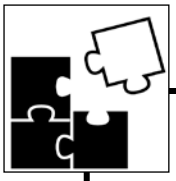
Five or more of these symptoms must persist for two or more weeks before diagnosis of depression is indicated.

If these characteristics are present in a child with whom you are working, request that an assessment be completed by a qualified mental health professional who can diagnose and treat childhood depression. The Department of Children and Family Services (DCFS) will need to make the referral for this assessment.

What Treatments Are Available?

Treatment often combines short-term psychotherapy, medication, and targeted interventions involving the home or school environment. In order to prevent the recurrence of depression, it is recommended that treatment be continued for at least six months after the remission of symptoms.

Conduct Disorder



A repetitive and persistent pattern of behavior in which children or adolescents violate the rights of others or violate norms and rules appropriate to their age.

What Causes Conduct Disorder?

Researchers have not yet discovered what causes conduct disorders, but they continue to investigate several psychological, sociological, and biological theories. Psychological and psychoanalytical theories suggest that aggressive, antisocial behavior is a defense against anxiety, an attempt to recapture the mother-infant relationship, the result of maternal deprivation, or a failure to internalize controls. Sociological theories suggest that conduct disorders result from a child's attempt to cope with a hostile environment, to get material goods that come with living in an affluent society, or to gain social status among friends. Other sociologists say inconsistent parenting contributes to the development of the disorders. Finally, biological theories point to a number of studies that indicate children could inherit a vulnerability to the disorders. Children of criminal or antisocial parents tend to develop the same problem. Other biologists believe that male hormones or problems in the central nervous system could contribute to the erratic and antisocial behavior. None of these theories can fully explain why conduct disorders develop. Most likely, an inherited predisposition and environmental and parenting influences all play a part in the illness.

What Are the Signs of Conduct Disorder?

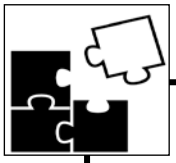
Children who have demonstrated at least three of the following behaviors over six months should be evaluated for possible conduct disorder:

- ✓ Steals, without confrontation (e.g., forgery) and/or by using physical force (e.g., muggings, armed robbery, purse-snatching, or extortion);
- ✓ Consistently lies (other than to avoid physical or sexual abuse);
- ✓ Deliberately sets fires;
- ✓ Is often truant from school or absent from work;
- ✓ Has broken into someone's home, office, or car;
- ✓ Deliberately destroys the property of others;
- ✓ Has been physically cruel to animals and/or to humans;
- ✓ Has forced someone into sexual activity with him/her;
- ✓ Has used a weapon in more than one fight; and
- ✓ Often starts fights.

What Treatments Are Available?

Treatments, including behavior therapy and psychotherapy (either individual or group sessions), are aimed at helping young people realize and understand the effect their behavior has on others. Some children also suffer from depression or attention-deficit/hyperactivity disorder; use of medications as well as psychotherapy has helped lessen their symptoms of conduct disorder. Moralizing and threatening do not work. Often the most successful treatment is to separate the child from a damaging environment and to administer strict discipline.

Post-Traumatic Stress Disorder



Re-experiencing a very distressing event that has overwhelmed a child's coping mechanism and has created intense feelings of fear and helplessness.

What Causes Post-Traumatic Stress Disorder (PTSD)?

A child who experiences a catastrophic event may develop PTSD. A stressful or traumatic event involves a situation where someone's life has been threatened or severe injury has occurred, such as experiencing or witnessing one of the following:

- ✓ Physical or sexual assault or abuse;
- ✓ Family and community violence;
- ✓ Severe accidents;
- ✓ Life-threatening illnesses; or
- ✓ Natural disasters (flood, fire, earthquakes).

A child's risk of developing PTSD is related to the seriousness of the trauma, whether the trauma is repeated, the child's proximity to the trauma, and his/her relationship to the victim(s).

What Are the Signs of PTSD?

PTSD affects how a child feels and acts. Signs of stress may include the following:

1. A child may re-experience the trauma by:
- Talking about the trauma over and over again;
- Including trauma-related events in play;
- Dreaming about the trauma;
- Feeling like the trauma is happening all over again; and/or
- Becoming very distressed when reminded of the trauma.

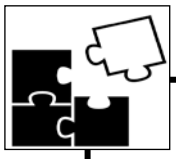
2. A child might withdraw from the trauma experience by:
- Avoiding thoughts or feelings about the trauma;
- Avoiding activities associated with the trauma;
- Forgetting parts of the trauma;
- Losing skills such as toilet training or language skills;
- Wanting to be alone more than usual;
- Becoming less affectionate toward others; and/or
- Feeling like there is nothing to look forward to in the future.

3. A child may experience restlessness and agitation, such as:
    - Having difficulty falling asleep or staying asleep;
    - Becoming easily angered, irritable, or jumpy;
    - Having concentration problems;
    - Expressing fear (fear of being left alone or sleeping alone);
    - Becoming overly watchful and easily startled; and/or
    - Reporting physical complaints when reminded of the trauma.

What Treatments Are Available?

Treatment of PTSD in children generally involves "talking therapies" (such as cognitive behavioral therapy, family therapy, or brief psychotherapy) and may include the prescription of medication by a psychiatrist.

Fetal Alcohol Syndrome



A combination of particular facial features, growth deficiency, and central nervous system damage resulting from alcohol exposure during pregnancy.

What Causes Fetal Alcohol Syndrome (FAS)?

A fetus exposed to any amount of alcohol may suffer from fetal alcohol syndrome. Alcohol causes physical damage to the central nervous system. The risk of severe birth defects increases with the amount of alcohol consumption. However, even small amounts of alcohol can be harmful; therefore, women are recommended to avoid alcohol during the entire pregnancy.

What Are the Symptoms of FAS?

A child with this condition will have one or more of these effects:

- ✓ Poor sucking ability;
- ✓ Poor sleeping habits;
- ✓ Irritability from alcohol withdrawal;
- ✓ Unusually small body, head, eyes, or jaw;
- ✓ Cleft palate;
- ✓ Heart defects;
- ✓ Hip dislocation and other joint deformities;
- ✓ Mental retardation;
- ✓ Learning disabilities;
- ✓ Speech and language difficulties;
- ✓ Hyperactivity;
- ✓ Inappropriate emotional responses;
- ✓ Problems with fine and gross motor skills;
- ✓ Memory deficit or “quirky memory”;
- ✓ Inability to generalize from one situation to another;
- ✓ Easily stimulated or distracted;
- ✓ Difficulty with cause and effect;
- ✓ Seeming lack of remorse;

- ✓ Lack of boundaries;
- ✓ Overly affectionate;
- ✓ Hyper/under sensitivity to touch, sound, light, and textures; or
- ✓ Hygiene problems.

What Treatments Are Available?

There is no cure for fetal alcohol syndrome. However, children with FAS can be helped. The treatment involves recognizing the symptoms and addressing the problems by providing medical and dental care or placing them in special school programs.

CHAPTER 8

Educational Advocacy

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I N T R O D U C T I O N

In 1975, the U.S. Congress passed a comprehensive law which mandates that every student is entitled to a Free and Appropriate Education (FAPE). No longer can a student be denied admission to a school or relegated to an isolated location because of a disability. However, the strength of this law is also its greatest weakness. This law was designed for parents to play an important role in the student's education. Unfortunately, many students in the foster care system do not have a parent to advocate on their behalf. As Court Appointed Special Advocates, you will become the student's voice at school.

In pursuit of the CASA mission, this handbook was developed so that you will be equipped with the tools necessary to assure that all students in the foster care system are guaranteed the opportunity to materially benefit from their education.

UNIT 1: INTRODUCTION

THE LAW

Prior to the enactment of federal laws providing public education entitlements to all students with disabilities, vast numbers of these students either received an education that did not meet their needs or received no education at all. Legal involvement in the education of children with disabilities began with legislative, administrative, and judicial activity either permitting or requiring their exclusion from public education. In 1893, the Massachusetts Supreme Judicial Court upheld the expulsion from the public schools of a child who was "weak in the mind." In a 1919 case, the Wisconsin Supreme Court approved the exclusion of a child who had the academic and physical ability to benefit from school, but who drooled uncontrollably, had a speech impediment, and exhibited facial contortions.

Cases of this type continued until quite near the present time. In many states, legislation permitted the exclusion of any child whenever school authorities judged that the child would not benefit from public education or that the child's presence would be disruptive to others. Until 1969 a North Carolina statute actually made it a crime for a parent to "persist in forcing ... the attendance of a child with disabilities after exclusion from the public school." Parents of children with disabilities were simply fed up and as a result two federal district court cases were filed that are central to the movement for the right to education of children with disabilities: 1) Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania; and 2) Mills v. Board of Education. These two cases from the early 1970s articulated the principles that all children are entitled to a free public education ("FAPE"), and that any exclusion of children from public education cannot take place without a meaningful opportunity to challenge it. By 1974 there were 36 pending lawsuits over the rights of children with disabilities to education. It was, however, in 1975, when U.S. Congress passed P.L. 94-142 (now referred to as the Individuals with Disabilities Education Act or IDEA) that conditions began to change dramatically for students with disabilities. Now every child with a disability is entitled to a free appropriate public education "specially designed at no cost to parents to meet the unique needs of a child with a disability." (20 USC § 1412; Cal. Ed. Code § 56031)

Special Education is an entitlement which means that it does not matter whether the child is under the court's jurisdiction, is in the mental health system, or is in a foster home, group home, camp, state institution, or any other living arrangement. If the child meets the basic eligibility requirements of federal and state special education law, the child is entitled to special education services and the procedural protections of the law.

In addition to IDEA, two other federal statutes -- Section 504 of the Rehabilitation Act of 1974 and the Americans with Disabilities Act (ADA) -- provide protections to children with disabilities. Both statutes are general laws prohibiting discrimination against persons with disabilities. Although they do create additional substantive rights for children with disabilities, their primary importance in this area is that they create alternative enforcement mechanisms.

THE ROLE OF THE SOCIAL WORKER

Educational success for children in the dependency system is crucial; few children will leave the system functioning better than before they entered unless they have been assisted in achieving educational success. Social workers have an important role in assuring that the educational needs of children with disabilities are met. By being aware that a child may have special

education needs and how those needs may impact upon a child's case, the CASA, together with the social worker, will be able to develop a case plan that more fully meets the child's needs.

Further, the CASA is in a position to be an advocate for the child by working with the CSW, the school district, the education rights holder ("ERH"), and caregivers to make sure that the child is correctly identified as needing special education services, that the services are meeting the child's needs and that the child is making progress in school.

SCHOOL DISTRICTS

Advocating for children in foster care who need special education services is complicated by the fact that there are 81 school districts within Los Angeles County. They range in size from Gorman Elementary School District, which has a total enrollment of 75, to Los Angeles Unified School District which serves almost 800,000 children. Each school district has its own governing body -- the local school board -- which is elected by the voters of the district. Unlike working with the County Department of Mental Health or other county agencies where there is only one bureaucracy with which you need to work, here you may be working with a variety of districts. Each school district may have its own policy for implementing the state and federal requirements for special education. *Although it is important to know how each district operates, it is equally important to remember that each district must fully comply with the federal and state law regardless of the local policy*. A single school district or a group of school districts may be organized within a geographic area to coordinate the administration and delivery of special education services within the region's boundaries. These are known as Special Education Local Plan Areas (often referred to as the acronym SELPA). Within Los Angeles County there are 16 SELPAs – two of which (Los Angeles Unified and Long Beach Unified) are single school districts.

In addition to the local school districts, there is the Los Angeles County Board of Education which operates the Los Angeles County Office of Education (LACOE). Its responsibilities, while in some respects similar to a local school district, reach across the entire 4000 square miles of Los Angeles County. It provides both direct services to pupils as well as assistance to school districts.

California's compulsory education law (Cal. Ed. Code § 48200) requires parents, legal guardians, or other persons having control or charge of a child ages 6 to 18 years to send that child to school. The primary purpose of the statute is to ensure that every child of school age attends school.

All children have a school district which is providing for education. In order to be an effective advocate for the child, you need to know which school district is responsible for the education of the child. It is determined by where the child resides. For instance, if a child lives with a relative, the local school district where the relative resides must enroll the child; if the child lives in a group home, the local school district where the group home is located is responsible. An exception to this general rule is Metropolitan State Hospital where the Special Education division of LACOE runs the school.

THE MCKINNEY-VENTO ACT (as applied to foster youth)

The McKinney-Vento Homeless Assistance Act, as reauthorized by the No Child Left Behind Act of 2001, ensures educational rights and protections for homeless children. In light of the Act's definition of "homeless children and youth," these provisions will apply to many youth in foster care.

- Homeless youth include children "living in emergency or transitional shelters," foster youth who have run away from child welfare placements and unaccompanied homeless youth, or youth "awaiting foster care placement"

- The expansive age range covered under the Act extends to school as well as preschool programs

- Youth covered under the Act have a right to:

    - Remain in their school of origin until the end of any academic year or, if longer, the duration of the youth's "homelessness"
    - Receive transportation to their school of origin[1]
    - School placement decisions guided by the "best interest" of the youth and with an aid to "continue the child's or youth's education in the school of origin" unless doing so is contrary to the wishes of the child or his/her parent or guardian
    - Choose between the local school where they are living or the school where they were last enrolled
    - Immediate enrollment in the new school even absent records normally required for enrollment such as proof of residency, immunizations, school records, or other documents
    - Prompt transfer of school records when a child enters a new school district
    - Get various specified school services
    - Be free from harassment and isolation
    - Prompt resolution of any school placement disputes with ongoing enrollment in the school of origin pending resolution of those disputes

[1] "School of origin" is defined as, " the school that the foster child attended when permanently housed or the school in which the foster child was last enrolled. If the school the foster child attended when permanently housed is different from the school in which the foster child was last enrolled, or if there is some other school that the foster child attended with which the foster child is connected and that the foster child attended within the immediately preceding 15 months, the liaison, in consultation with and with the agreement of the foster child and the person holding the right to make educational decisions for the foster child, shall determine, in the best interests of the foster child, the school that shall be deemed the school of origin." Cal. Educ. Code § 48853.5(e).

UNIT 2: CONFIDENTIALITY AND RELEASE OF SCHOOL RECORDS

Are school records confidential?

Yes. School records are the official history of a student's career in the public school system. In addition to the academic transcript, they may contain descriptions of emotional development, psychological and medical reports, reports of disciplinary problems, family histories, and subjective, anecdotal material, including a whole range of information that may or may not be accurate.

Prior to 1974, these records were frequently accessible to anyone to whom the school district chose to give access. Then in 1974, Congress passed the Family Educational Rights and Privacy Act of 1974, commonly known as the Buckley Amendment or FERPA. 20 U.S.C. See 1232g. The purpose of FERPA is threefold: (1) to ensure students and parents have access to the child's educational records, (2) to enable parents to correct inaccurate records, and (3) to prevent the release of student records to third parties without parental knowledge or consent.

In 1976, California enacted its own legislation to implement the requirements of FERPA. (Cal. Ed. Code §§ 49060-49079)

Do social workers have access to school records?

Under FERPA, the primary right of access is given to parents. However, a school district may give access to any person for whom the parent has given consent of access to the records (Cal. Ed. Code § 49075). In addition, a court may order the school to give access to the records (Cal. Ed. Code § 49077). Therefore, social workers can either have the parent sign a release of records form or request that the Dependency Court order release of records. California law does require the school to make a reasonable effort to notify the parent and pupil in advance of compliance with a court order if possible within the requirements of the judicial order. Under §49076 of the Education Code, School Districts are permitted to allow child welfare services agencies to access educational records.

Do CASAs have access to school records?

Yes. CASAs in Los Angeles County (CASA of Los Angeles), by order of the court contained in their Letters of Appointment to a specific child or children, have access to all school records and copies thereof. This is specific to Los Angeles County.

Does a pupil have access to his or her own records?

A pupil, who is 16 years of age or older or who has completed the 10th grade, may have access to his or her own school records without parental consent or a judicial order. (Cal. Ed. Code § 49076 (a)(6))

Can anything be done if there are mistakes in the school records?

California law gives the parent the right to challenge the content of any pupil record. This includes the right to meet with the superintendent of the school district. If a satisfactory conclusion cannot be reached, the parent may appeal to the governing body of the school district. The decision of the governing body is final. If the decision of the governing body is unfavorable or if the parent accepts an unfavorable decision by the superintendent, then the parent may submit a written statement of his or her objections to the information which then becomes a part of the school record. (Cal. Ed. Code § 49070)

Can a social worker interview a suspected victim of child abuse at school?

Yes. California Penal Code § 11174.3 makes it clear that a social worker may interview a suspected victim of child abuse during school hours, on school premises, when there has been a report of abuse within the child's home. The child shall have the option of being interviewed in private or selecting a member of the staff of the school to be present at the interview. The presence of this person in the interview is to lend support to the child not to participate in the interview. The staff person selected by the child may decline to be present, but if they choose to be present, they are bound by the laws of confidentiality.

UNIT 3: CORRECTIVE EDUCATIONAL MEASURES

In conjunction with a request for an assessment for special education services, **corrective measures** should be used to assist a student who has problems in school. This is a guide only and whether these intervention services are appropriate depends on the needs of each individual student. It is NOT necessary for the school to convene a Student Success/Study Team ("SST") meeting or execute other specific corrective measures before the ERH is permitted to request a special education assessment—this can be done at any time. Some strategies to improve a student's academic performance or behavior at school follow.

1. **PRAISE** - Always praise the student for earnest efforts or for accomplishments, no matter how small.

2. **TALK -** Ask the student what he or she thinks is causing the academic or behavioral problems. Students are frequently very specific about what they see or feel is the problem.

3. **CONFERENCES -** The CASA needs to meet with the teacher, parent/caregiver, or CSW to discuss the problem and develop a plan of action to remedy it. Review the cumulative school records for signs of problems. Be sure to take note of health issues, test scores, conferences and comments. While waiting to convene an initial Individualized Education Plan ("IEP") meeting (see subsequent section on Special Education), you can request an SST meeting—but be sure to stipulate that you do not waive any special education timelines!

4. **DAILY/WEEKLY PROGRESS REPORTS -** This improves communication between the student, parent/guardians, CSW and teacher. Immediate feedback works well in correcting poor work habits, poor attitudes, and lack of interest. After receiving the progress reports, the student should be asked what problem area he or she would like to work on the following day. This way the student self-corrects the problem.

5. **IMPROVE STUDY HABITS -** Students need a study area at home. Parents or caregivers need to give importance to homework by keeping the house quiet and making sure there are materials and supplies provided at home.

6. **CLASSROOM OBSERVATIONS -** Visit the classroom. The information you gain may be extremely valuable in determining the course of action to take in order to help the student. Call ahead of time and let the teacher know that you plan to visit. Report to the Main Office for a Visitor's Pass. Take notes during the visit.

7. **TUTORING -** The CASA needs to speak to the teacher regarding the needed areas of tutoring and match existing tutoring programs with the student's need. This is an excellent intervention if the student is willing to attend tutoring on a regular basis. This service is available in the community and in many schools (i.e. those that do not meet certain standards imposed by the No Child Left Behind Act). The CASA should also ask the CSW about DCFS-funded tutoring options.

8. **SCHOOL RESOURCES -** The CASA should check with the school support staff for additional resources that may be of benefit to the student. Resources within the school may include the elementary counselor, the pupil services and attendance counselor, the career counselor, the school psychologist, the school nurse, school Parent and Family Centers, school clinics, Healthy Start Programs and Impact Program.

9. **REGULAR AND PUNCTUAL ATTENDANCE -** Poor attendance is often a stumbling block in obtaining an assessment to determine whether a student qualifies for special education services. When students miss school, they often fall behind, miss important assignments, and are unable to catch up. The school staff is often reluctant to refer students with poor attendance to special education services because poor academic performance is a natural consequence of poor attendance.

10. **CHANGE OF CLASSROOM -** There may be a personality clash with the teacher that is at the root of a student's poor academic performance or behavioral problems, or the problems may be related to specific teaching techniques or methods of classroom management/control of a certain teacher. There can also be certain combinations of students in the same class that can produce constant behavioral problems. At the elementary school, speak with the principal. At the secondary level, speak with the counselor.

11. **CHANGE OF SCHOOL -** This action is not related to academic or disciplinary problems. This action may become necessary if the student has safety concerns, particularly related to gang problems, or if other students have knowledge of and are talking about the abuse the student experienced, thereby causing shame and embarrassment.

12. **BILINGUAL ASSESSMENT -** A student who appears to understand and speak English very well may, in fact, be struggling with the speed and comprehension of regular classes. Ask the Bilingual Coordinator to check and see if the student is in the appropriate classes. Check the student's grades at the 5th week, 10th week, 15th week and 20th week reporting periods.

13. **TRANSPORTATION -** The best situation is when the student is driven to and from school each day. If this is not possible, and the distance to the school is far, getting bus tokens or bus passes for the student may make a big difference by assisting a student who already feels burdened by not doing well. Ask school personnel to check with the Transportation Section to determine if the student is eligible for school district transportation.

14. **PARTICIPATION IN SCHOOL/SPORT ACTIVITIES -** This can help a student connect with the school, a caring adult, and/or make friends.

15. **COMPLETE PHYSICAL EXAM -** This should include vision and hearing checks so that certain physical problems can be ruled out. It is important to tell the physician what types of problems the student is having in school. Observe the student carefully during your classroom visitations. The teacher and nurse may also have valuable information based on their encounters with the student.

16. **COUNSELING PROGRAMS -** The CASA should determine the services that are already being provided and coordinate additional needed services with private community and/or

    school programs. This should be considered when dealing with students who have emotional and or behavioral challenges.

17. **PARENT EDUCATION CLASSES -** These are helpful and frequently necessary for caregivers when problems exist with the student. They offer problem solving and intervention techniques related to the various stages of child development. They are available through various community agencies, community and private colleges, and public schools.

18. **REFERRAL TO A PSYCHOLOGIST -** Symptoms of depression may indicate a need for reasonable accommodations (504) or a special education assessment. Through the court system, a 730 Evaluation might be in order if the student's symptoms are interfering with school progress. Treatment may include medication and a referral for counseling therapy.

19. **STUDENT SUCCESS TEAM (SST) aka Student Study Team -** This is a function of the general education program.

- This team uses a systematic problem solving approach to assist students who are experiencing difficulties in the area of academics, behavior, health, attendance or other school related issues.

- Members of the team include the student, the referring teacher, the parent/guardian, an administrator/designee to chair the committee, appropriate staff to review the student's case.

- The team identifies the student's strengths, clarifies problems and concerns, and provides a foundation for collegial support.

- The team develops strategies and organizes resources.
- The team provides a system of accountability for students identified as "at risk" of not succeeding in school.
- **SST PROCESS -** A successful team follows these steps:
    a. Parent, caretaker, teacher, CASA, CSW and student concerns are addressed in this conference
    b. Interventions and modifications are implemented and documented
    c. If initial interventions are not successful, then the teacher completes SST referral and submits it to the chairperson
    d. SST meeting is scheduled and participants are notified
    e. SST meeting is held and the following are discussed:
        - Student data
        - Teacher documentation
        - Parent/guardian concerns and observations
        - Identification and prioritization of concerns
        - Interventions previously tried
        - Plan for additional interventions or referral for special education process
        - On average, 3 to 6 weeks later (no timeline is imposed by statute), the team reconvenes to continue ongoing planning to meet students' needs
        - Monitor results of intervention
        - Discuss possible referral for special education assessment*

NOTE: Again, it is NOT necessary for the school to convene a Student Success/Study Team ("SST") meeting or execute other specific corrective measures before the ERH is permitted to request a special education assessment—this can be done at any time.

20. **ALTERNATIVE EDUCATION PROGRAMS -** For secondary students, alternative settings should be considered such as Opportunity Programs/Classes, Continuation Schools, Alternative Education Work Centers (AEWC), Community Day Schools, job training programs or adult school campuses or Occupational Centers (for students 18 or older). These types of programs are appropriate for students who are behind in their schoolwork and behind in their credits. These programs are geared to work with potential dropouts. Many of the programs are based on individualized contracts and also have a small teacher to student ratio.
21. **PARENT PARTICIPATION** - Encourage parents/caretakers to attend Parent Advisory Council Meetings, "Back to School Night," Open House, report card conferences, and most importantly, to assist with their homework on a daily basis. Schools need interest and participation from the student's caregiver to successfully **educate children.**

UNIT 4: EARLY INTERVENTION (AGES 0 - 3 YRS.)

What are early intervention services?

- Specific services to help improve an infant's or toddler's functioning.
- These services are provided in a way that is responsive to families and children.
- Different agencies may cooperate to provide appropriate services to a child and family.

ELIGIBILITY

Who is eligible for services?

Infants and toddlers from birth to 36 months may be eligible for early intervention services if through documented evaluation and assessment they meet one of the criteria listed below:

have a developmental delay in either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing and are under 24 months of age at the time of referral, with a 33% delay in one or more areas of development or are 24 months of age or older at the time of referral, with a 50% delay in one area of development or a 33% delay in two or more areas of development; or

have an established risk condition of known etiology, with a high probability of resulting in delayed development.

See Cal. Gov. Code: Sec. 95014(a)

What Early Intervention services are available?

Based on the child's assessed developmental needs and the families concerns and priorities as determined by each child's Individualized Family Service Plan (IFSP) team, early intervention services may include:

assistive technology

audiology

family training, counseling, and home visits

health services

medical services for diagnostic/evaluation purposes only

nursing services

nutrition services

occupational therapy

physical therapy

psychological services

service coordination (case management)

social work services

special instruction

speech and language services

transportation and related costs

vision services

Who makes the referral for Early Intervention services?

Anyone can make a referral, including parents, medical care providers, neighbors, family members, foster parents, CASAs, and day care providers.

The first step that parents may take is to discuss their concerns with their health care provider/doctor. You can also call the local regional center or school district to request an evaluation for the child.

If the child has a visual impairment, hearing impairment, or severe orthopedic impairment, or any combination of these contact the school district for evaluation and early intervention services. After contacting the regional center or local education agency, a service coordinator will be assigned to help the child's parents through the process to determine eligibility. Parent-to-parent support and resource information is also available through Early Start Family Resource Centers.

What happens after a referral?

Within 45 days, the regional center or local education area shall:

Assign a service coordinator to assist the family through evaluation and assessment procedures.

Obtain parent consent for evaluation is obtained.

Schedule and complete evaluations and assessments for the child's development.

If an infant or toddler is eligible for early intervention services, an Individual Family Service Plan (IFSP) will be developed that addresses the strengths, needs of the infant or toddler, parent concerns, and early intervention services.

Identify early intervention services that are provided in the family home or other community settings.

Who provides services?

Early intervention services that are needed for each eligible infant or toddler are purchased or arranged by a regional center or a local education agency.

Family Resource Centers provide family support services.

How much do these services cost?

There is no cost for evaluation, assessment and service coordination. Public or private insurance is accessed for medically necessary therapy services including speech, physical and occupational therapies. Services that are not covered by insurance will be purchased or provided by regional centers or local education agencies.

How can I find out more information>

Call your local family regional center, local education agency, or family resource center for resource information or a referral to Early Start services.

If you need additional information about how to get Early Start services call (800) 515-BABY or e-mail earlystart@dds.ca.gov**.**

INDIVIDUALIZED FAMILY SERVICE PLAN

What is an IFSP?

An Individualized Family Service Plan (IFSP) is a written plan for providing early intervention services to eligible infants or toddlers and their families.

What information must an IFSP contain?

An IFSP must contain information about:

- the infant's or toddler's current levels of physical, cognitive, communication, social or emotional, and adaptive development, based on evaluation and assessment information;
- with the agreement of the parent (caregiver/surrogate parent), the concerns of family members/caregivers, what is important to them, and their resources;
- the major developmental outcomes to be achieved for the infant or toddler and the family, and how to determine the degree to which progress toward achieving the outcomes is being made;
- the specific early intervention services necessary to meet the unique needs of the infant or toddler and family to achieve the outcomes, including the name of the service provider, how often services will be provided, the length of each session, whether the services will be delivered individually or in a group, the projected dates for initiation, and the anticipated duration of the services;
- the natural environments (e.g., home, child care, school program or private program) in which early intervention services shall be provided;
- other services the child needs which are not covered by the early intervention program and the funding source for these services;
- the name of the child's service coordinator; and
- a statement of the transition steps, which are initiated at least 90 days before the child turns three years old, or, at the discretion of all parties, when the child is two years and six months.

What specific services may be available for an eligible infant or toddler or the child's family under the early intervention program?

- Services that are designed to meet the developmental needs of an eligible infant or toddler or the child's family are considered early intervention services. These services include, but are not limited to, family training, counseling, and home visits; special instruction; speech-language pathology and audiology services; occupational therapy; physical therapy; psychological services; service coordination; medical services only for diagnostic or evaluative purposes; early identification; screening and assessment services; health services necessary to enable the infant

or toddler to benefit from the other early intervention services; nursing services; nutrition services; social work services; vision services; assistive technology devices and services; and transportation and related costs. Early intervention services may include such services as respite and other family support services.

RESPONSIBLE ADULT & SURROGATE PARENTS ("EDUCATION RIGHTS HOLDERS")

Although we describe Responsible Adult and Surrogate Parents in Unit V, information presented here pertains specifically to Early Intervention, ages 0 - 3, and differs slightly from the information contained in Unit V (School Children, ages 3-22).

What is a responsible adult?

- A responsible adult is a person appointed by the Court to make educational decisions for a child who is a dependent or ward of the Court whose parent's or guardian's educational rights to make the decisions have been limited by specific order.

What is a surrogate parent?

- A surrogate parent is a person appointed by the school district or regional center for an infant or toddler who does not have a parent in order to obtain early intervention services and the Court is unable to appoint a responsible adult.
- A surrogate parent may consent to evaluations/assessments and authorize services on an IFSP.

Under what circumstances should a surrogate parent be appointed?

California Government Code Section 7579.5 states that the local education agency (i.e. school district) must appoint a surrogate parent for a child with a disability under the following circumstances:

- The biological or adoptive parents cannot be identified or located after reasonable effort.
- The child has a court-appointed person authorized to make educational decisions.

The child's court-appointed "parent" is unwilling or unable to serve as the surrogate parent.

Must a surrogate parent always be appointed for children who are in foster care?

A surrogate parent does not have to be appointed for a child in foster care if that child:

- has a biological or adoptive parent whose location is known and whose right to make educational decisions has not been limited, or
- is residing with permanent foster parents.

Are there criteria that a local education agency or regional center must use in selecting a surrogate parent?

State and federal law require that each person appointed as a surrogate parent shall:

- not be an employee of a public or private agency involved in the education or care of the child (so, the following **may not** act as or be appointed as a surrogate parent: DCFS/Children's Social Worker (CSW), Regional Center Social Worker/Case Manager/Consumer Advocate, any staff member or owner of a Group Home, any staff member of a residential treatment center),
- have no interest that conflicts with the interests of the child he or she represents, and

- have knowledge and skills that ensure adequate representation of the child.

A local education agency shall, as a first preference, select a surrogate who is a relative caregiver, foster parent, or CASA. If none of these is willing or able to serve, another person may be appointed to be the surrogate. Cal. Gov. Code Sec. 7579.5(b).**Is a child's guardian considered to be a parent under the law or must a guardian be appointed as a surrogate parent?**

- A guardian is considered a parent.

What is the definition of a parent in the law?

A parent can include:

- a biological or adoptive parent,
- a guardian,
- a person acting as a parent of a child, such as a grandparent or stepparent with whom a child lives, as well as persons who are legally responsible for a child's welfare, and
- an appointed surrogate parent.

What rights does a surrogate parent have?

- In the early intervention process, surrogate parents have the same rights as biological or adoptive parents.

Who appoints surrogate parents?

- Surrogate parents are appointed by the child's local education agency (i.e. school district) or regional center.

APPEALS/COMPLAINTS

What can a CASA do if he or she disagrees with the results of the evaluation/assessment of the child?

- At the IFSP meeting, you may request or encourage the parent, guardian, or surrogate parent to request that the evaluation report be amended;
- you may request or encourage the parent, guardian, or surrogate parent to request additional evaluation/assessment of the child from the regional center or school district;
- you may obtain or encourage the parent, guardian, or surrogate parent to obtain an additional evaluation of the child by a private evaluator (at the expense of the local education agency);
- you may request that the director of the regional center or superintendent of the school district amend or remove the information from the child's records; or
- you may encourage the parent, guardian, or surrogate parent to start the appeal process.

What can a CASA do if he or she disagrees with the decisions made by the school district or regional center about a child's eligibility for early intervention services?

- There are two types of formal procedures in California---mediation and due process hearing---that may be used when there is a disagreement about whether an infant or toddler qualifies for early intervention services or whether an evaluation, assessment, placement or provision for early intervention services for a child is appropriate.
- Parents (including guardians, surrogate parents, or permanent foster parents), school districts, or regional centers may initiate these procedures by sending a letter to the Office of Administrative Hearings, 2349 Gateway Oaks Drive, 200, Sacramento, CA 95833 (916) 263-0550,.
- In addition, informal meetings between a parent and the regional center or school district may be used to reach agreement prior to initiating the formal appeal procedures.

Do parents have a right to examine and receive copies of the records of their child?

- Yes, these records must be made available to parents (including guardians, surrogate parents, or permanent foster parents) within five (5) business days of the request.
- A regional center or school district may charge a reasonable fee for copies of records in an amount not to exceed the actual cost of reproducing records (this is typically waived for foster youth and/or youth otherwise eligible for free legal services).
- The amount of the fee shall not prevent the parents from exercising their right to inspect and review those records.

What can a CASA or caregiver do if the School District or regional center violates a child's rights under special education law or discriminates against a child?

- When there is a violation of federal or state early intervention law by a regional center, school district or private service provider receiving funds under this law, a written complaint may be filed with either the Department of Developmental Services, Attention: Chief, Early Start Program Development Section, 1600 9th Street, Sacramento, CA 95814, or the Office for Civil Rights, U.S. Department of Education, the Old Federal Building, 50 United Nations Plaza, Room 239, San Francisco, CA 94102
- The complaint must be in writing and describe the alleged legal violation(s), including any supporting documentation (for example, referral letters for evaluation/assessment, IFSPs, etc.). If the person filing the complaint is unable to put it in writing, the service coordinator shall directly assist the person or identify resources which can aid in completing the written complaint.

UNIT 5: SERVICES FOR PRE-SCHOOL & SCHOOL CHILDREN AGES 3-22 YEARS

MAINTAINING RECORDS

The CASA's Log

It is important to note that, during the course of each educational advocacy assignment, the advocate should documents any and all contact with the school district/schools.

It is suggested that this documentation take the form of a "log". This log should list the date, time, in method of contact, person or persons contacted, phone number, location, and a (very) brief description of the matter discussed. The advocate should also keep copies/files of all paperwork generated by the advocacy. The log should be carried to all meetings having anything to do with the educational advocacy.

A handy tip is to use a small tablet that can be carried in a purse or pocket and to take it with you so that the facts/data can be documented as soon as possible.

Remember: If the case has to go to a fair hearing, your log will become important evidence.

RESPONSIBLE ADULT/Education Rights Holder

What is a responsible adult?

A responsible adult (also referred to as an education rights holder or "ERH") is a person appointed by the Court to make educational decisions for a child who is a dependent or ward of the Court when that child's parent's or guardian's educational rights to make the decisions have been limited by specific order of the Court. (AB 490 §361)

Who can be appointed as a responsible adult?

The Court should consider appointing a responsible adult relative, non-relative extended family member, foster parent, family friend, mentor or Court Appointed Special Advocate (**CASA**) as the educational representative if one is available and willing to serve. (AB 490 §§361,726)

SURROGATE PARENTS

What is a surrogate parent?

A surrogate parent is a person appointed by a local education agency (LEA) to represent a student for the purpose of the Individual Education Program (IEP) to insure that the rights of the student to a free and appropriate public education (FAPE) are protected.

When is a surrogate parent appointed for a foster youth?

When the Court has been unable to appoint a person to act as the responsible adult. The Court must make a referral to the LEA for appointment of a surrogate parent.

Do all foster youth need a surrogate parent?

No. The LEA is mandated to appoint a surrogate parent only when it 1) cannot locate a parent after reasonable efforts; 2) cannot identify a parent; or 3) the student is a ward or dependent of the juvenile court and the Court is unable to appoint a responsible adult.

Who is considered a parent under special education law?

A parent means 1) a biological or adoptive parent; 2) a guardian; 3) a person acting as a parent (such as a grandmother, a step parent with whom the child lives, and persons legally responsible for a child's welfare); or 4) a responsible adult or surrogate parent who has been appointed.

Can anyone be a surrogate parent?

No. If it is found that a surrogate parent is needed, school officials must seek someone who has knowledge and skills to advocate for the student and has no conflict of interest. They must first determine if a responsible adult has been appointed by the Court. If not, the school must determine if is there is a relative caretaker, foster parent or **CASA** involved with the student who is willing to act as the surrogate parent. If so, there is a preference in the law that the school district must appoint one of these persons. If not, the school district may select a person from its own pool who has sufficient training and knowledge of special education issues to act as a surrogate parent for the student. (Cal. Ed. Code § 7579.5 (b))

Who can appoint surrogate parents?

Only the local education agency (i.e. school district or county office of education) has the authority under the law to appoint surrogate parents. This does not limit the Court's authority to appoint a responsible adult or legal guardian for a child. If a legal guardian is appointed, the guardian is considered to be a "parent" for all special education purposes. In this circumstance, the school district has no authority to appoint a surrogate parent. (Cal. Ed. Code § 7579.5 (b)(1))

Who cannot be a surrogate parent?

The following **<u>may not</u>** act as or be appointed a surrogate parent:

- DCFS/Children's Social Worker (CSW).
- Regional Center Social Worker/Case Manager/Consumer Advocate.
- Any staff member or owner of a Group Home.
- Any staff member of a residential treatment center.

If you, as the CASA, have any objections to a parent, foster parent or relative caretaker making educational decisions for the child, you can request that the court limit the rights of the parent(s) for educational purposes only. You will have to present the reasons for your objections to the court.

If you know parental rights have already been limited or terminated, then it is not necessary to follow these steps. If the decision has been made (between you and your supervisor) that you should be the responsible adult/surrogate parent, you should inform the school authorities immediately that you, as the CASA, are requesting to be appointed as surrogate parent. Otherwise the school authorities will have to determine whether there is another person involved with the child who falls under the definition of a parent in special education law.

May foster parents sign their foster child's IEP as the child's parent?

If a child does not have a parent, a child's parent cannot be located, or the juvenile court has limited the parents' right to make educational decisions for the child, the Court may appoint the foster parent as the responsible adult to make educational decisions for the child. If the Court is unable to appoint a responsible adult then it must make a referral to the local education agency for appointment of a surrogate parent.

CASA of Los Angeles Policy

In CASA cases where relative caretakers or foster caretakers meet the criteria to serve as the responsible adult or surrogate parent and express their willingness to do so, the CASA should, after consultation with his/her supervisor, step aside in favor of that person and support his/her appointment as responsible adult or surrogate parent. The CASA shall aid, advise, and guide that person to help ensure that the educational advocacy is in the best interest of the student at all times.

REFERRAL FOR ASSESSMENT OF A STUDENT

FOR SPECIAL EDUCATION SERVICES

The following information pertains to students 3-22 years.

OVERVIEW

Some students need special education and other related services if they are to materially benefit from their education. These students are referred to as "disabled" in federal special education law and as students with "exceptional needs" in California state law.

Every student with a disability is entitled to a free, appropriate public education ("FAPE"). This means "special education specifically designed at no cost to the parents to meet the unique needs of a student with a disability." (20 USC § 1412; Cal. Ed. Code § 56031)

There are, however, a series of steps that must be followed in order for a student to be identified as being disabled and in need of special education. These are:

1. **Referral for a complete assessment**
2. **The assessment process**
3. **Determining eligibility**
4. **Developing an individualized education program ("IEP")**

You should consider referring a student for assessment if you have information that suggests he/she has educational, developmental or social/emotional challenges that are not being met by his/her current education services or placement.

The assessment is necessary to:

Determine if the student is eligible for special education services under one of the disability categories established by law. *See Eligibility Criteria - Appendix A.*

Develop an individualized education program (IEP) so that the student receives an appropriate education to help the student materially benefit from his/her education.

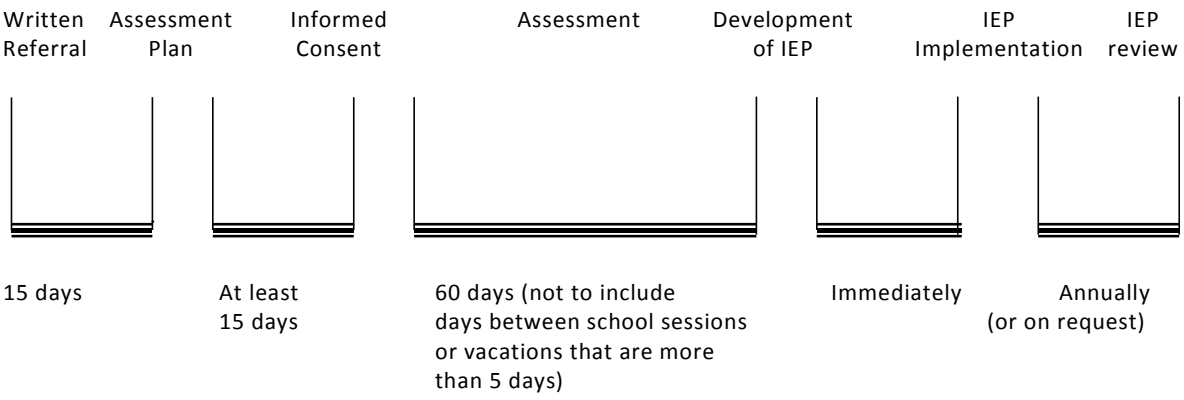
Who can request an assessment?

Any CASA, CSW, teacher, parent, agency, appropriate professional, or other members of the community may request an assessment for the student. However, only the education rights holder (who may be the biological or adoptive parent, guardian, person who has responsibility for the child, responsible adult, or the surrogate parent) may give consent for the assessment. (Cal. Ed. Code § 56302)

The school may suggest that certain alternatives be initiated (i.e., modification of the current program, student study or guidance committee team meeting, use of community resources) before making a special education referral. This is not necessary. While in some students' cases, certain non-special education alternatives may be beneficial, you should initiate the special education assessment referral process at the same time. If the referral for assessment is not initiated, it may take many months to a year or more to see whether there is sufficient benefit to the child from the alternatives. However, when the parent or surrogate parent initiates the request for assessment, the assessment must be completed within 60 days of receiving the signed Assessment Plan form.

Submit your request for assessment in writing and address it to the principal. Include in your letter that you are requesting an assessment for possible special education services, and the reason why you feel the child requires the services. Include the child's name, address, date of birth, caregiver's name, your name, and how to contact you**.** Date the request and send it by certified mail with copies to the psychologist and your file. *See Timeline for Assessment and Development of the IEP, next page.*

TIMELINE CHART



Timeline for Assessment to IEP Implementation

Prior to referring a student for assessment

A. Gather information to justify an assessment through interviews.

Speak with people having significant contact with the student:

- **Caregivers** (parent, foster parent, group home staff). Ask about general health, maturity, how he/she gets along with others, behavior problems, sleep problems, school problems.
- **Teacher(s), school counselors, guidance counselors** (for secondary students). Ask about school history, any previous referrals for special help, attendance problems, academic problems, behavioral problems, communication skills, maturity, friends, motivation, problems in attention and memory, favorite/least favorite classes, and post-graduation goals.
- **School nurse**. Ask if she knows the student, does he/she get sick often, has he had hearing and vision exams, is he/she on medication, does he/she come to the health office complaining of headache/stomach aches, does he/she want to be excused from P.E.?
- Complete your own informal assessment by using the Learning Disabilities Checksheet. *See Appendix E*.

B. Gather information through review of relevant school records.

The Dependency Court routinely orders that school records be released to the Department of Children and Family Services pursuant to Cal. Ed. Code § 49077.

How may records be obtained?

- Whether or not appointed the responsible adult/surrogate parent, the CASA is entitled to receive copies of all school records.
- In addition to providing the copies of the records, the school district must also:
    - explain and interpret the records on request, and
    - allow you to correct or remove information in the record you believe to be inaccurate, misleading, or violative of the student's privacy or other rights.

Check attendance and tardy records for the past two years.

- Is the student presently enrolled in the school? Was he/she previously enrolled? When?
- Is attendance and tardiness an issue? Meet with the administrator over the attendance office or pupil services and attendance counselors for clarification of school attendance policy. In secondary school, ask to see notes used to verify absences. Is there a pattern to the absences, i.e., every Friday, or during midterm or final exams?

Review the cumulative record ("cum") and interview teachers, guidance counselors, and, in secondary school, the dean of discipline for additional information.

- Review grades obtained for past three years. Note problems.
- Has the student been in special classes? English as a Second Language (ESL) classes?
- Review anecdotal records. Note possible problems. Has the student ever been referred to a Student Success Team (sometimes referred to as aGuidance Committee) for local review?

- What school resources or adaptations/program modifications have been suggested?
- Is the student receiving all services and program modifications indicated in cumulative records and/or his/her existing IEP?

  See "Collection of School Records" in Handouts - School Records and Forms---An example of a Cumulative Record ("cum") and how to read and make sense of the information in the cum can be found.

C. Determine who has or should have the legal right to make educational decisions.

- You may have to determine if a responsible adult or surrogate parent is necessary and if you will have to request an order from the court limiting parental rights for educational purposes only.
- *See Responsible Adult/Surrogate Parent section in this chapter.*

THE ASSESSMENT PROCESS

How can an assessment for special education eligibility be requested?

- The referral for assessment must be in writing and may be made by the CASA, parent, guardian, surrogate parent, foster parent, CSW, or any other relevant person. (Cal. Ed. Code § 56029)
- The letter should be dated and addressed to the school administrator, with copies to the school psychologist and the case file.
- It should include the reason that an assessment is being requested. Give as many reasons as possible using information obtained from the "Prior to Requesting an Assessment" list. The more evidence you include, the better (i.e., "John was referred to the Student Success Team last year; however, he is still failing math and reading. This semester he has visited the nurse several times a week complaining of stomach aches. He claims students on the playground are hitting him".)

See Appendix E - School Records and Forms for a sample letter requesting an assessment.

- Call school to confirm that they received the letter.
- Preferably, the request should be sent certified mail with a return receipt request.

What should happen after the school receives the request for a complete assessment?

- Within 15 days of the request for assessment the education rights holder should receive an Assessment Plan form. This form will list the proposed assessment plan and the name and title of the person responsible for doing each part of the assessment. (Cal. Ed. Code § 56321)
- A copy of the notice of parent rights and procedural safeguards should be attached to the assessment plan. **Please see Appendix E - School Records and Forms for a sample of the Assessment Plan form.**
- Did the school include a copy of the notice of parents' rights?
- Is the notice in the primary language of the parent?
- Does the education rights holder understand the proposed plan?

- Does the plan explain the types of assessments to be conducted, and the person (name and profession) who will be conducting each part of the assessment?

Each part of the assessment should be conducted by persons competent to perform that particular assessment.

An individual assessment of the student's educational needs in all areas of suspected disability should be conducted by qualified persons. A speech and language specialist should perform the speech evaluation, psychological assessment should be conducted by a credentialed school psychologist, health assessment by a credentialed school nurse or physician, and behavioral problems by a behavioral specialist. (Cal. Ed. Code, §§ 56324; 56320)

What is a complete assessment and what should it include?

Psycho-educational assessment is the term frequently used for the type of assessment performed to determine eligibility for special services.

- It should include a comprehensive evaluation of the student's functioning in all areas of potential concern, including, when appropriate, health and development, vision, hearing, motor abilities, speech and language, self-help skills, orientation and mobility, academic performance, and social and emotional status. (Cal. Ed. Code § 56320 (f))

- It should provide relevant functional and developmental information, including information provided by the parent or caregiver that may assist in (1) determining whether the child is a child with a disability and (2) the actual content of the child's IEP, including information related to enabling the child to be involved in and progress in the general curriculum.

Tests and assessment materials must:

- Be approved by the ERH in writing prior to administration.

- Be conducted by a qualified person. The assessor must meet federal and state certification, licensing, registration, or other comparable requirements that may apply to the area in which the assessor is providing special education or related services. Cal. Educ. Code § 56329; Cal. Code Regs. tit. 5 § 3001(z). The assessor must be "knowledgeable" of the child's disability. Cal. Educ. Code § 56320(g).

- Be administered individually (not in a group).

- Be selected and administered so as not to be racially, culturally, or sexually discriminatory.

- Be completed in all areas related to the suspected disabilities. Cal. Educ. Code § 56320(f); 34 C.F.R. § 300.304(b)(4).

- Be administered in a pupil's primary language or other mode of communication (i.e. sign language). Cal. Educ. Code § 56320(a); Cal. Code Regs. tit. 5 § 3001(y). If the student is non-English speaking or bilingual, the tests should be administered by a bilingual examiner who will usually administer a receptive language test in both languages in order to determine the language in which the student is most proficient; if this is not feasible, an assessment may be conducted with an interpreter.

- Include an observation of the student's academic performance in the regular classroom setting. The observation must be done by an IEP team member other than the student's regular classroom teacher. 34 C.F.R. § 300.310(b)(2).

- Not be based on any single test. 20 U.S.C. § 1414(b)(2)(B).
- Helpful in providing functional and developmental information that may assist in determining 1) whether the child is a child with a disability and 2) the content of the child's individualized education program, including information related to enabling the child to be involved in and progress in the general curriculum.
    - Screening tests such as the WRAT (Wide Range Achievement Test) or group administered achievement tests might need to be followed up by in-depth tests.
    - A test of written language can only be used to determine a problem in writing just as a suspected reading or math problem should be assessed with reading and math diagnostic tests.
    - It is frequently helpful for students under 5 years old and those with very special needs and delays to be assessed by developmental scales, tests of developing language, interviews, and observation forms.
- If the student has a communication (speech/language) problem, tests that do not require a verbal response should be used in the assessment (i.e., pointing, gesturing, signing). Pupils with visual or hearing disabilities should be assessed with tests specifically designed for these populations.

- Whenever a student exhibits a serious behavior problem (e.g., self-injurious or assaultive behavior, or behavior that causes serious property damage) for which instructional/behavioral approaches specified in the student's IEP are found to be ineffective, a functional analysis assessment should be requested. It must be conducted by a qualified behavioral specialist.

    A functional analysis assessment systematically analyzes specific troublesome behaviors engaged in by a student in terms of the behavior's frequency, duration, intensity, antecedent events, and consequences, and the setting in which the behavior occurs.

How can I help the student receive the most comprehensive assessment by the most competent examiners?

- Review the Assessment Plan with the ERH. Check the areas of assessment and the individual who will be doing the assessment in that area.
- Is the student being assessed in <u>ALL</u> the areas of suspected disability? If not, call the school psychologist and request assessment in all areas (especially if this is the child's first assessment). For example, the student may be scheduled for a speech and language assessment but not a hearing test. Ask for an audiological exam. If the student appears clumsy, or cannot copy well, ask for a visual motor assessment.
- Do you have a previous assessment, a privately done assessment, or a concern expressed by a professional seeing the student (i.e. a psychologist, physician, or caregiver) that is not answered by the proposed Assessment Plan? Provide a copy of the report to the appropriate school staff. Put your concern in writing or contact the school psychologist.
- Check the name and title of those responsible for each of the assessment areas. Typically, the school psychologist performs the cognitive testing and some of the academic testing (along with the teacher or resource specialist); the speech and language (LAS) therapist performs a

communication assessment; medical assessments are done by a credentialed school nurse or physician; and a behavioral specialist performs the behavioral evaluations.

- If you have specific concerns, contact those performing the assessments. Tell them your concerns and those of others dealing with the student and ask if their assessment will address these areas. Tell them that you will need a copy of each report for the child's file. ERHs have a right to request and receive copies of all assessments conducted. 20 U.S.C. Sec. 1414(b)(4); 34 C.F.R. Sec. 300.562.

What if you, the CASA (whether or not you are the responsible adult/surrogate parent), and the CSW, ERH, or caregiver disagree with the assessment report?

Students are entitled to receive an independent educational evaluation at the district's expense. Cal. Educ. Code § 56329(b). Additionally, the ERH can request additional district assessments or independent assessments if the ERH disagrees with the results or feels that the assessments are insufficient (i.e. did not assess all necessary areas). The district must, "without unnecessary delay," either: (1) agree to the assessment and provide the parent a list of resources where independent evaluations can be obtained; or (2) initiate Due Process (see subsequent section) to show that its assessment was appropriate. 34 C.F.R. §§ 300.502(b)(2).

Resources available for independent evaluations include:

- Regional Centers
- Department of Mental Health
- 730 Evaluation (ordered by the court)
- Private Practitioners (some will accept Medi-Cal)

DETERMINING ELIGIBILITY AND DEVELOPING THE INDIVIDUAL EDUCATION PROGRAM (IEP)

THE IEP MEETING

An individualized education program team conference including the parent and his/her representatives shall be scheduled to discuss the assessment, team recommendations, and reasons for the recommendations. (Cal. Ed. Code § 56341)

What should be the CASA's primary concerns in anticipation of the IEP meeting?

That the child receive the most appropriate education suited to his or her own unique needs.

Who will be at the meeting?

The IEP team shall include all the following persons (Cal. Ed. Code § 56341):

- A representative designated by the administration who is qualified to provide or supervise special education services (this may be the resource specialist, the vice principal for special services, chairman of special education, or someone else in an administrative/supervisory capacity).
- The student's present teacher, or the special education teacher who knows the student and has observed the student in an appropriate setting.

- At least one regular education teacher, if the child is or may be participating in the regular education environment.
- Those who have conducted the assessment or are knowledgeable about the assessment procedures used and are qualified to interpret the results and make recommendations based on the assessment. Those performing the assessments in specialized areas such as speech and language and adaptive physical education generally will be present, particularly at the Initial Assessment and for any Change of Placement Assessment.
- For students with suspected learning disabilities, at least one person other than the student's teacher who has observed the educational performance of the student.
- One or both parents, and any representative selected by the parents, the responsible adult or the surrogate parent, and the CASA, whether or not the CASA has been appointed as the responsible adult, and the CSW should be present at all meetings.

  When appropriate, the student with special needs, although not required by law. Discuss with your supervisor and the student.
- **Will the results of the school district's assessment be discussed at the IEP meeting? What additional questions should I ask?**
- The IEP team will review and explain the results of the assessment. This should be done in language anyone can understand.
- Take notes of all relevant information.
- Ask for clarification of any information you do not understand completely.
- Academic assessment should include: a) standardized test results. These typically will be given to you in grade equivalent scores, such as, "He is reading at grade 3.5". Grade scores let you know how the student performs on the test relative to a comparison group of students. This score may help in qualifying the student for special education services, b) diagnostic tests and curriculum based tests which tell precisely what curriculum-based skills have and have not been mastered, c) a portfolio of work samples, teacher-made tests, projects, etc.
- Whenever a student exhibits a serious behavioral problem that interferes with the implementation of the goals and objectives of the student's IEP, a behavioral intervention plan should be considered and discussed at this time.
- After all the other presentations have been made, add any information that you have about the student.

What should be in the IEP?

The IEP document should include:

- The student's present level of performance in all problem areas (e.g., reading, communication, social/emotional, gross/fine motor skills) that may be contributing to his/her poor performance.
- How the student's disability affects the student's involvement and progress in the general curriculum. The disability category that makes the student eligible for special education. - *See Eligibility Criteria - Appendix A.*

- Individualized annual goals and short-term objectives, including the personnel responsible for implementing the goals. These should be based on the assessment findings and other information presented at the meeting. Goals and objectives should be related to meeting each of the student's educational needs that result from the student's disability, including those needs that would enable the child to be involved in and progress in the general curriculum. Goals and objectives should be measurable so that when reviewed, it is possible to determine the extent to which a goal or objective was met.

- The type of special education services to be provided and how often (e.g., Resource Specialist Program (RSP) 40 minutes per day, Special Day class - 5 periods per day, 520 minutes per day).

- The Designated Instruction and Services (DIS) the student is to receive. This term is used in California law; federal law refers to these services as "related services". The type of service, how often it is to be received, and for how long, should be specified on the IEP (e.g., individual speech and language services, twice a week for 30 minutes each).

- Any specialized materials or methods (e.g., large print for a student with visual impairments; work and testing in small groups for a student with attention problems). Supplementary aids and services (e.g., one-to-one aid for a child) or supports for school personnel to be provided.

- Assistive technology devices (e.g., computer, speech-to-text keyboard, grip pencil, charts) or services, if required.

- Any interagency services recommended under Educationally-Related Mental Health Services ("ERMHS") (e.g., individual psychotherapy, physical therapy). *See Section on Educationally-Related Mental Health Services - this section.*

- A Behavioral Intervention Plan, if a functional assessment was performed.

- A statement of transition service needs for students 14 or older (e.g., participation in advanced placement courses or a vocational education program) and a statement of the specific transition services a student is to receive beginning at age 16 (or younger, if determined appropriate by the IEP team).

- The extent to which the child will participate in the regular program.

- For students whose primary language is other than English, linguistically appropriate goals, objectives, programs, and services.

- When appropriate, pre-vocational career education for students in grades kindergarten to 6, and vocational, career and work experience education, including independent living skills training, for students in grades 7 to 12, who require differential proficiency standards.

- Extended school year ("ESY") services, when needed. If in doubt, ask for this!

Who should attend the IEP meeting? Should foster parents, caregivers, and biological parents attend?

Yes, it is very important for anyone who has relevant information about the student to attend the meeting. This can include the foster parents, biological parents, group home workers, as well as neighbors, friends, an attorney or advocate, or any professional who has knowledge of the student and his or her needs. It is very important for the CSW to attend the IEP meeting even though he/she does not have the right to sign the IEP to authorize the implementation of services for the child.

What is your role at the IEP meeting?

- You have special knowledge of the student that the other members of the team may not have.
- Ask questions about the assessment, the educational placement, and the services the team is recommending.
- Do you agree with the assessment findings? If not, supply information that has not been brought out by others.
- Do you agree with the goals and objectives? Do they seem reasonable for a student of this age and ability? Are they objective and measurable? If not, suggest alternatives and/or ask the team to amend them.
- Do you agree with the student's placement in a particular special education class, or in a particular school? If not, say so at this time.
- Do you agree with the kind and amount of related services (also called designated instruction and services or DIS), such as counseling, speech, adapted physical education, etc. Are the services adequate to enable the student to benefit from his or her educational program?
- If you are not satisfied with the IEP as formulated at the meeting, you have the right to say so, but only the ERH has the right to appeal. *See Due Process Hearings/Complaints - this section.*

What should the CASA bring to the IEP meeting and what should the CASA take from the IEP meeting?

Items suggested to be brought to the IEP meeting include:

- Business cards
- List of phone numbers for follow-up contacts

  (i.e., supervisors if you are unavailable)
- Pencil and paper for note taking
- This manual
- Any documented information or previous tests/evaluations that have not already been shared with the school.

CASA should leave with:

- Copy of the draft IEP agreement, with goals, objectives, and services. REMEMBER: it is not necessary for the ERH to sign the IEP at the meeting! It is recommended that the ERH take the draft IEP document home to review it in a quiet environment and sign when/if the ERH approves it.
- Phone numbers/business cards of all parties attending the meeting.

Remember, if the assessment indicates a student needs a particular type of service, the school district may not refuse to provide the service on the ground that it does not have that service available. The district must find a way to provide it.

What special education program options are available for a special education student?

School districts must have available a continuum of program options to meet the needs of special education students. The types of placement options that must be available on regular public school campuses include: (1) regular class with modifications, (2) regular class with consultation by special education personnel to the teacher, (3) regular class with related services, (4) regular class with resource specialist program (RSP), (5) special day class and regular class, (6) special day class (full-time). In addition to special education services offered on regular school campuses, services also must be available for those students who require them at public special education schools, nonpublic special education schools (NPS), in their homes, at hospitals, or in 24-hour residential programs.

What factors should be considered to determine whether a classroom is an appropriate placement for a child?

There are several things you may want to consider in trying to determine whether a classroom placement is appropriate for a child. The most important question is, can the classroom properly implement the child's IEP? It is always a good idea to observe the classroom placement(s) recommended by the school district. Some of the factors to consider are: (1) the teacher's qualifications; (2) the teacher's style of teaching; (3) the classroom organization; (4) the number of students in the class; (5) the age and academic ability levels of the students in the class; (6) the gender of the students in the class; (7) the socio-emotional functioning level of the students in the class, including their behavior; (8) the behavior management system used in the class; (9) whether the students in the class participate in activities with students in the school who do not have disabilities; and (10) for a student who has limited English proficiency, whether there are provisions in the classroom to address the student's needs.

Should the CASA monitor the child's progress toward the IEP goals and objectives?

Yes. How often the child's progress is monitored will depend on each individual case. How the student is doing in school should be checked with the caregiver, the school, and student on a regular basis. This should include classroom visitation. Bring your copy of the IEP with you. This will help you monitor implementation of the goals and objectives of the IEP. Some questions to consider are: Does the class seem appropriate? How is the child progressing? Are the areas agreed upon in the IEP being addressed? Are all services being provided?

What should the CASA do if the student is not making progress toward the IEP goals and objectives?

Your first step is to check with the child's teacher and caregiver to determine what the problem is. You may want to recommend that the caregiver request an IEP meeting to discuss whether the IEP should be changed. *Also see, Due Process Hearings/Compliance Complaints - this section.*

FOLLOW-UP: WHAT TO EXPECT

You should expect to attend an annual IEP meeting at the same time <u>every year</u>.

How often are IEP meetings held for each student with an IEP?

- IEP meetings must be held at least once a year for students with IEPs. The goals of the IEP will be reviewed and renewed or rewritten (depending on the results of the progress made or not made the previous year). This is the time where decisions regarding classroom placement, appropriateness, etc. will be discussed and determined.

- IEP meetings may be requested at any time by the parent, guardian, surrogate parent, or person legally responsible for the child. When an IEP is requested, the school district must hold it within 30 days of the date of the written request (not counting periods of school vacation longer than 5 days**).**

RELATED SERVICES

What are related services?

- Any services which are necessary to assist a student to benefit from his/her special education program. (34 CFR § 300.34)

- The term "related services" means transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education, and includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation (including therapeutic recreation), counseling services, including rehabilitation counseling, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training (including training for assistive technology. *See Appendix C - Glossary, for Federal and State definitions of these services.*

- The list of related services is not exhaustive and may include other developmental, corrective, or supportive services if they are required to assist a student with a disability to benefit from special education.

How does Designated Instruction and Services (DIS) differ from related services?

- DIS is the term used by California law to identify the same services federal special education law calls related services. (Cal. Ed. Code, § 56363; 5 CCR §§ 3051-3051.18)

See Appendix C - Glossary, for definition of Designated Instruction and Services.

What does "necessary to assist a student to benefit from his/her education" mean?

- The service is considered a related service only if it is necessary to help the student benefit from educational program. For example, a student and his/her family might require social work services because of problems at home, but in spite of these problems, the student is progressing appropriately in school. The student might require the service, but not for educational reasons. Consequently, it would not be considered a related service.

- If, however, the student were not performing appropriately in school as a result of familial problems, the receipt of social work services may be "related" to the student's ability to succeed in school and, therefore, the responsibility of the school district as part of the student's special education program.

May the amount of related services a student receives or IEP objectives for the related services be changed without convening an IEP meeting?

- No. IEP meetings must be held for purposes of "developing, reviewing, and revising" a student's Individual Education Program (IEP). This includes changing related services (Cal. Ed. Code, §§ 56340, 56341(a), 56343(c); 34 CFR § 300.343(a) and Part 300, Appendix C, Nos. 43 and 51)

May a student who is placed full-time in a regular classroom be entitled to receive related services?

- Yes. Any student who meets the eligibility requirements for special education is entitled to the related services needed to assist him or her to benefit from special education. State regulations explicitly say that related services may be provided to students "who are serviced throughout the full continuum of educational settings", which includes the regular classroom. (5 CCR § 3051 (a)(1))

- Students with disabilities who are not eligible for special education may still be entitled to receive supportive services necessary to enable them to benefit from their school program under other state and ederal laws that ensure access of persons with disabilities to state and federally funded programs. (Gov't. Code § 11135; *See also,* Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act.)

EDUCATIONALLY-RELATED MENTAL HEALTH SERVICES

Is there a way to get mental health services for my client?

Yes! For 25 years, California provided mental health services that students with disabilities required to access their education through AB 3632 (also referred to as 26.5 or AB 2726), a joint program between schools and county departments of education.

In 2011, the California Legislature placed responsibility for educationally related mental health services ("ERMHS") with the school districts, thereby ending the AB 3632 model of service provision. The Legislature used the term "ERMHS" when it ended AB 3632, and the California Department of Education used "ERMHS" in ongoing discussions and in policy guidance memoranda about the transition from AB 3632 to purely school-based ERMHS.

Because eligibility for services is based upon educational need (not court involvement), ERMHS can continue to support a foster youth after he or she successfully leaves court supervision.

What are "ERMHS?"

ERMHS describes the wide range of services that were previously provided under AB 3632.

IDEA requires that schools provide the services necessary for a child to access his or her education, for example:

- assessment of mental health needs, including interpretation of such assessments and integration of information in service planning;
- consultation with the student, family, and staff to develop an appropriate program to serve the youth;
- individual, group, family, and parent counseling;
- teaching education rights holders the skills to enable them to support implementation of their youth's IEP;
- day treatment;
- positive behavior intervention, including 1:1 behavioral aides;

- assessment for, and administration and management of medications; and
- residential placement.

34 C.F.R. §§ 300.34(a), .34(c)(2), .34(c)(8), .34(c)(10), .34(c)(14), .104; Cal. Educ. §§ 56363(a), (b)(9), (b)(10), (b)(11), (b)(13); 2 C.C.R. §60020(i). Of course, this list is illustrative, not exhaustive. Cal. Educ. § 56363(b); *See also* 34 C.F.R. § 300.34.

"Counseling" means "services provided by qualified social workers, psychologists, guidance counselors, or other qualified personnel" and should include therapeutic counseling when a child requires it. 34 C.F.R. § 300.34(c)(2).

Some schools call these services other names like "educationally *required* mental health services" or "educationally related *behavioral* services." Regardless of what your district calls ERMHS, they should understand what you are asking for if you request ERMHS for your youth.

Are ERMHS like other related services under IDEA?

Yes. With the repeal of AB 3632, ERMHS are just like other related services under IDEA. See Factsheet Three: Special Education for more information on the rules governing special education.

What Is different now that AB 3632 has ended?

County departments of mental health are no longer *required* to participate in providing ERMHS through special education. Schools are responsible.

Schools can still contract with county departments of mental health. If your county department of mental health is voluntarily providing ERMHS, the recommendation of the county assessor *may* not be binding on the IEP team.

Finally, medication monitoring will be reviewed carefully on a case-by-case basis and funding for medication through the IEP may be limited to children for whom medication is an integrated part of their educational program, such as a residential placement.

Who assesses for and provides ERMHS?

Local educational agencies have three basic options for how to provide ERMHS: they can use their own school-based staff, they can contract with their local department of mental health, or they can contract with nonpublic agencies.

Regardless of which option is used, assessors must be "trained and knowledgeable personnel," 34 C.F.R. § 300.304(c)(iv), and must be capable of "[o]btaining, integrating, and interpreting information about child behavior and conditions relating to learning." 34 C.F.R. § 300.34(c)(10).

Assessments must identify all needs "whether or not commonly linked to the disability category in which the child has been classified." 34 C.F.R. § 300.304(c)(6).

Where can I find more information?

The California Department of Education's website has several guidance memoranda on ERMHS:

http://www.cde.ca.gov/sp/se/ac/ab114twg.asp

BEHAVIORAL INTERVENTION PLANS

What is a behavioral intervention plan ("BIP")?

- A written document that is developed when a special education student exhibits a serious behavior problem that significantly interferes with the implementation of the goals and objectives of the student's IEP. Cal. Ed. Code § 56520 and following (Cal. Ed. Code § 56520, *et seq.*; 5 CCR § 3052) *The purpose of this law is to replace specific maladaptive behaviors with alternative acceptable behaviors. The behavioral intervention plan becomes a part of the student's IEP.*
- BIPs might also be referenced in terms of the "Hughes Bill" (a.k.a. AB 2586: the legislation that deals with the behavior interventions that can be used with students receiving special education who have difficulties conforming to acceptable behavior patterns).

What are considered serious behavior problems under this law?

- Self-injurious behavior;
- Assaultive;
- Major property damage;
- Other serious behavior problems that are considered pervasive and maladaptive.

Who must attend an IEP meeting when a behavioral intervention plan is being developed?

- A behavioral intervention case manager with documented training in behavioral analysis including positive behavioral interventions.
- Qualified personnel knowledgeable about the student's health needs.
- Others who may attend include:
    - Other individuals whom the ERH or the district believe possess expertise or knowledge necessary for the development of the plan;
    - The CASA whether or not he/she has been appointed as ERH;
    - The CSW should attend the IEP meeting, even though he/she does not have the authority to sign the IEP document.

What positive behavioral interventions may be included as part of the plan?

- Altering the situation that typically precedes a serious behavior problem (e.g., providing choice, changing the setting, offering variety and a meaningful curriculum, removing environmental pollutants such as excessive noise or crowding, or establishing a predictable routine).
- Teaching adaptive behaviors (e.g., choice-making, self-management, relaxation techniques, and general skill development).
- Teaching alternative behaviors that produce the same consequences as the inappropriate behavior (e.g., to make requests or protests using socially acceptable behavior, to participate with alternative communication modes rather than unacceptable attention-getting behaviors, and by providing the student with activities that are physically stimulating as alternatives for self-stimulating behaviors).

- Positively reinforcing acceptable behaviors and ignoring and redirecting unacceptable behaviors.

Are there any interventions that are specifically prohibited?

- Any intervention likely to cause physical pain;
- The use of noxious sprays or mists or otherwise unpleasant substances in proximity to the student's face;
- Any intervention that denies adequate sleep, food, water, shelter, bedding, physical comfort, or access to bathroom facilities;
- Verbal abuse, ridicule, humiliation, or any intervention likely to cause excessive emotional trauma;
- Four-point restraints or prone containment;
- Locked seclusion;
- Any intervention that precludes adequate supervision;
- Any intervention that deprives the student of the use of one or more of his or her senses**.**

TRANSITION SERVICES

What are transition services?

- A coordinated set of activities for a student, designed to promote movement from high school to post-high school activities, such as:
    - post-high school education;
    - vocational training;
    - integrated employment (including supported employment);
    - continuing and adult education;
    - adult services;
    - independent living; and
    - community participation.

(Cal. Ed. Code, § 56345.1; 20 USC § 1401 (a)

- They are based on the individual student's needs, taking into account the student's preferences and interests.
- Transition needs and services are written on a student's IEP and include instruction, related services, community experience, employment and other post-high school adult living objectives, and, when appropriate, daily living skills and functional vocational evaluation.
- A statement of interagency responsibilities should also be included as a part of transition services. This might include, for example, a plan for the child's CSW to refer the child to the Independent Living Program and the expected date that such services will start.

When must an IEP contain a statement about transition services?

- At age 14, an IEP must include a statement of the transition service needs of the student (such as participation in advanced placement courses or a vocational education program).
- At age 16 (or younger, if determined by the IEP team) a statement of needed transition services, including, if appropriate, interagency responsibilities or needed linkages.
- The statement must be reviewed and updated annually.

How is it determined what transition services are needed?

- The school district must assess the child's needs in this area.

Should other agencies, such as the Regional Center, Department of Children and Family Services, Department of Rehabilitation, or Department of Mental Health participate in the transition planning?

- Yes, the statement of needed transition services on the IEP must include, where applicable, a statement of the responsibilities of other participating agencies.
- However, the school district remains ultimately responsible for ensuring that these services are provided.
- If a participating agency, other than the school district, fails to provide the transition services described in the IEP, the school district is required to reconvene the IEP team to identify alternative strategies to meet the transition objectives for the child set out in that program.

Independent Living Program Services

- Beginning at age 14 the CSW is required to coordinate ILP Services with the IEP team during transition service planning. The CSW must link up the ILP Coordinator with the IEP Team.

DISPUTES: COMPLIANCE COMPLAINTS AND DUE PROCESS HEARINGS

COMPLIANCE COMPLAINTS

When is it appropriate to file a Compliance Complaint?

A Compliance Complaint may be filed when the student has been found eligible for special education and:

a. The student's IEP hasn't been properly:[2]

a. Implemented. <u>For example</u>:
   i. IEP calls for 2 hours of speech therapy a week, but the district is only providing 30 minutes a week.
   ii. IEP is not being implemented at all.

b. Written. <u>For example</u>:
   i. The IEP fails to include a transition or behavior plan.

[2] 5 Cal. Code Regs. § 4650(a)(7).

ii. The goals and objectives do not address all academic needs.

c. Reviewed. For example:
   i. Goals and objectives were not reviewed for progress.
   ii. Transitional IEP not held to review goals.

d. Other. For example:
   i. Student's school records were not provided upon request.
   ii. School failed to follow procedural guidelines of IDEA in disciplining a special education student; and

b. The statute of limitations has not expired (within one year of incident or three years for an ongoing violation).[3]

A Compliance Complaint may also be filed on behalf of a student who has requested assessments for special education eligibility but has not yet been found eligible (if the allegation is that the assessment request has not been responded to within the mandated timelines).

What is included in a Compliance Complaint?[4]

- The name of the child, the address of the residence of the child and the name of the school the child is attending;
- For homeless youth, the available contact information for the child and the name of the school the child is attending;
- Background Information: client's eligibility for special education, relevant medical, psychiatric, and personal history, and areas of educational need;
- Facts surrounding the problem the complaint seeks to address;
- Allegations and citations to the law;
- Evidence you have included; and
- Remedy sought: provision of records, compensatory education, proper placement, etc.

A Compliance Complaint must be made in writing to:

Procedural Safeguards Referral Service

Mediation Unit, Special Education Division

California State Department of Education (CDE)

1430 N. Street

P.O. Box 944272

Sacramento, CA 94244-2720

(800) 926-0648 (phone)

(916) 327-3704 (fax)

[3] 34 C.F.R. 300.153(c).

[4] 34 C.F.R. 300.153(b).

What should I expect during the Complaint process?[5]

You will receive a complaint investigation notification telling you the name and contact information of the investigator assigned to the matter and the allegations the investigator will investigate. This notification is sent two weeks prior to the date of the investigation.

You will be contacted within the next 30 days by the CDE investigator who will develop findings of fact regarding the allegations. The investigator may contact the client as well. During this time, the school and/or school district must fill out a report in response providing a list of findings in regard to each allegation and any relevant information and supporting documentation.

You will receive a final report stating what the investigator has found allegation by allegation, whether or not the district was in compliance and suggested corrective action, if any. You will receive this report within sixty days from receipt of the complaint investigation notice.

Within 60 days after receipt of the complaint investigator notification, the parties to the dispute may chose to negotiate or mediate a resolution.

Can I appeal the CDE Investigator's Final Report?[6]

Yes! An appeal must be made within in 35 days of receipt of the compliance report and must ask the Superintendent of Public Instruction for reconsideration. Mail the request to:

General Counsel

California Department of Education Legal Dept.

P.O. Box 944272

Sacramento, CA 94244-2720

The Superintendent of Public Instruction will send a response within 15 days. Pending reconsideration, the CDE Final Report remains in effect and enforceable.

DUE PROCESS HEARINGS

What should happen if there is a disagreement with the school district's (or other agency's) special education decisions about a child?

There are three different types of procedures in California that can be initiated (prior to going to court) when there is a disagreement in special education about the identification, assessment, or education and placement of a child, or the provision of a free, appropriate public education of the child.

They are the informal meeting, the non-hearing mediation conference, the hearing request mediation, and the due process hearing request. The due process hearing request has three components of its own, as described below

[5] Cal. Educ. Code § 56043(p); 5 Cal. Code Regs. §§ 4662-4664.

[6] 5 Cal. Code Regs. § 4665.

Who may initiate this process?

Only a parent, a legal guardian or the person with educational rights, i.e., the surrogate parent or court-appointed education rights holder, may request this process.[1] In addition, the school district may also request this process. Children's social workers do not have the authority to make this request. At the present time, under state law, students cannot initiate due process procedures unless they are emancipated or are wards or dependents of the court for whom no parent can be identified or located and for whom no appropriate surrogate parent has been appointed.

What are the three types of available procedures?

The Informal Meeting

An informal meeting is simply a meeting with a school district administrator who has the authority to resolve the issues in contention. Informal meetings usually are scheduled within a few days of an IEP meeting where a disagreement occurred. There is *no* requirement that either party, the parent or the school, agree to an informal meeting. It is totally optional whether either party chooses to meet informally.

There are certain circumstances which might lead one to use the informal meeting process. Informal meetings can be useful when the school administrator has the reputation of being reasonable to parent requests in special education matters, when the parent and the administrator have a good relationship, and when the request for specific special education services by the parent is substantiated by sufficient evidence or when it requires a relatively simple, non-costly change.

The drawbacks of the informal meeting are 1) there is no additional pressure (such as, the likelihood of a hearing if issues are not resolved) on the district, 2) the power relationship between the district and parent is in favor of the district, and 3) "stay put" provisions do not pertain to this procedure.

This means that there is no obligation on the school district to maintain the child in the current educational placement while the informal meeting takes place.

To schedule an informal meeting, contact the office of the director of special education for the school district. If you are unable to get an informal meeting scheduled within a few days, it is probably better to select another procedure.

Non-Hearing Mediation Conference

The non-hearing mediation conference is also a voluntary procedure and, therefore not required. It is called a *non-hearing mediation* because this procedure is initiated prior to requesting a hearing. It is somewhat confusing, however, since once a hearing is requested, another type of mediation (i.e., a *hearing* request mediation) is automatically scheduled.

[1]Throughout this section "parent" shall refer to the person who has the right to make educational decisions whether it is a parent, legal guardian, foster parent who holds education rights, responsible adult or surrogate parent.

According to the law, the purpose of the pre-hearing mediation conference is to resolve issues in dispute in a non-adversarial atmosphere. Consequently, attorneys or other independent contractors used to provide legal advocacy services (such as, non-attorney advocates) are not allowed to attend or participate in the non-hearing mediation conferences. However, the parent or the school district is not prohibited from consulting with an attorney or advocate prior to or following the pre-hearing mediation conference. The children's social worker, however, may accompany and advise the parent at the pre-hearing mediation conference.

The non-hearing mediation is conducted by a mediator who works for the California Office of Administrative Hearings' Special Education Division. The mediator does not have any affiliation with the local school district. Mediators are required to be knowledgeable in the process of reconciling differences in a non-adversarial manner, and in the laws and regulations governing special education.

If the issues in dispute are resolved at the pre-hearing mediation, a copy of the written resolution will be mailed to each party within ten days following the mediation conference. If the mediation conference fails to resolve the issues to the satisfaction of all parties, the party who requested the non-hearing mediation has the option of filing for a state-level due process hearing.

Since the non-hearing mediation conference is a new appeal procedure, it is difficult to say definitively what its benefits and drawbacks are.

There are two advantages to this process. The first advantage is that, unlike the informal meeting process, a mediator will participate. This is a neutral third person who shold be trained in the art of mediation and knowledgeable of special education law. The presence of a good mediator can counter some of the imbalance of power between school district staff and an unrepresented parent. The second advantage is that, like the informal meeting process, non-hearing mediation is a simple process compared to a due process hearing. It still requires preparation, but many people who are neither attorneys nor advocates are able to meaningfully engage in this process. If the non-hearing mediation is not successful, the parent can walk away without giving up any of their rights. As discussed below, a parent risks forfeiting some of their rights if they do not prosecute the complaint correctly once a due process complaint is filed.

One disadvantage in this process is that the school district representative is likely to be more knowledgeable about special education law and practice than the parent. Even if the mediator takes an aggressive stance in trying to represent the interests of the parent, the mediator does not come to the mediation knowledgeable about the child or the child's educational circumstances. Knowledgeable preparation of a case frequently is the key to success. A parent may be at a disadvantage without adequate case preparation by an advocate or attorney and guidance during the mediation process.

There are other drawbacks to the pre-hearing request mediation. First, since this procedure does not lead automatically to a due process hearing if issues are not resolved, there is no pressure on the parties to resolve matters. Second, the "stay put' provision does not apply to this procedure. This means that there is no obligation on the school district to maintain the child in his or her current educational placement while the pre-hearing mediation takes place.

Once a pre-hearing mediation is requested, it will be scheduled within fifteen days of the receipt of the request. Pre-hearing mediation conferences are to be scheduled at a time and place reasonably convenient to the parent and student, typically in a conference room at the school district office.

Due Process Hearing Request

As mentioned above, filing a due process hearing request sets three different proceedings into action: (1) a mandatory dispute resolution session, (2) an optional mediation, and (3) a due process hearing.

Once a due process hearing request has been filed, a child has a right to "stay put" until the dispute is resolved. Usually this means that the child has a right to the placement and services from their last agreed-upon and implemented IEP. The parties can, however, agree to change a child's placement and/or services while a due process hearing is pending. Normally stay put is invoked by the parent telling the school district that they want their child to have stay put. It is important to use those two words: "stay put." If the school district refuses, the parent can ask the Office of Administrative Hearings to order the school district to honor stay put until the hearing is over.

A special note about school discipline: when a child is suspended for more than 10 total days in a school year and/or is recommended for expulsion, that child has a right to a special IEP team meeting to determine if the alleged conduct was a manifestation of the child's disability. This is called a manifestation IEP, or a manifestation determination meeting. If the school does not follow these procedures or if the parent disagrees with any decision made regarding a disciplinary change of placement for a child with a disability, they have a right to an expedited hearing. These hearings are conducted within 20 school days, and a decision is issued within 10 school days after the hearing. Expedited hearings are not discussed in further detail here, but it is important to be aware of this special procedure.

Parents who do not speak English have a right to an interpreter at no cost to them at mediation and at the hearing.

Filing a due process hearing request without an attorney or advocate can be risky. Most times a party gets one bite at the apple when filing a hearing request: if the parent leaves an issue out but resolves the issue that they ask for, they may be deemed to have given up their other claims by filing the due process hearing request.

(1) Mandatory Dispute Resolution Session

A mandatory dispute resolution session is must be scheduled within 15 days of receipt of a request for the due process hearing by the school district. This meeting cannot be skipped unless both the parent and the school district agree in writing to waive the meeting. The school district cannot bring an attorney to a mandatory dispute resolution session unless the parent brings an attorney. It is important to understand that anything discussed at the mandatory dispute resolution session is not confidential: this means that anything that is said by either side may be used against them at hearing.

(2) Mediation

The California Office of Administrative Hearings automatically schedules a mediation session within 30 days of receiving a due process hearing request. The school district or parent may waive the hearing request mediation. The purpose of mediation is to resolve the dispute between the school district (or other agencies) and the parent in an informal, non-adversarial manner, even though a request for a hearing has been filed or even if the hearing has begun. The hearing request mediation is conducted by the same mediators who do the pre-hearing request mediation. However, the administrative law judge who conducts your mediation will not be the judge at your hearing.

Advocates and attorneys are permitted to participate in mediations. Being represented at the mediation is an important consideration because advocates and attorneys frequently can present the case at the mediation in such a way that the school district representatives will prefer to settle the case rather than go on to a hearing. It also allows the parent to negotiate with the school district from a position of equality. Without representation, parents frequently are at a disadvantage because their knowledge of special education law may not be as great as that of school district personnel.

The hearing request mediation also has other advantages. If the matter is not resolved at the mediation, all parties are aware that the case proceeds to a hearing, which puts additional pressure on the parties to settle the case. Another important consideration is that during the hearing request mediation, all discussions are confidential: whatever is said at mediation cannot later be used at hearing.

If the hearing request mediation resolves the issues in contention, then the mediator writes up the agreement that has been reached and all parties to the agreement (and other agencies) sign the mediation agreement. If the issues are not resolved, the mediator helps the parties define what the specific issues are for the hearing.

(3) Due Process Hearing

Once the California Office of Administrative Hearings Special Education Division has received a request for a hearing, the hearing is to be completed within 45 days of the end of the "resolution period," which is usually 30 days after the hearing request is made. The hearing is presided over by an administrative law judge from the California Office of Administrative Hearings Special Education Division. The hearing officer does not have any affiliation with any parties to the hearing and must be knowledgeable about administrative hearings and laws and regulations governing special education.

Any party to the hearing has the right to be accompanied and advised by an attorney or advocate and by individuals with special knowledge or training relating to the problems of children and youth with disabilities. If either party to a due process hearing is represented by an attorney, notice must be given to the other party at least 10 days prior to the hearing. Failure to provide notice is considered a good reason to postpone the hearing if the other party requests it.

A hearing is similar, in many ways, to a trial. All parties to the hearing (that is, the parent, the school district, etc.) have the right to: 1) present evidence, written arguments, and oral arguments; and 2) confront, cross-examine, and compel the attendance of witnesses. All parties also have the right to be informed by the other parties to the hearing, at least 10 days prior to the hearing, as to what they believe the issues are to be decided at the hearing and their proposed resolution of the issues. The parties must also give a list of any witnesses they intend to call and copies of any documents they intend to use to each other at least five days prior to hearing. For parents who are not represented by an attorney or advocate, they may request that the California Office of Administrative Hearings Special Education Division provide a mediator to assist the parent in identifying the issues and their proposed resolution.

To request a pre-hearing mediation, hearing request mediation or a hearing, a written request must be sent to:

Office of Administrative Hearings
Special Education Division
2349 Gateway Oaks Drive, Suite 200
Sacramento, CA 95833
Tel. (916)263-0880

A copy of this request must also be sent to the school district or other agencies that are parties to the hearing.

Where is there more detailed information about the hearing process?

The California Office of Administrative Hearings Special Education Division maintains a FAQ (frequently asked questions) on its webpage with more information about the hearing process:

http://www.dgs.ca.gov/oah/SpecialEducation.aspx

If a parent needs an attorney but cannot afford one, are there low cost or free attorneys who represent children in special education matters?

Yes. The California Office of Administrative Hearings Special Education Division maintains a list of low cost and free attorneys. As of this publication, that list is available on the Office's website by going to the link below and clicking the tab "Low Cost of Free Attorney/Advocate" in the middle of the webpage:

http://www.dgs.ca.gov/oah/SpecialEducation/Resources.aspx

Here in Los Angeles County, court-involved youth also have access to free education legal representation through the 317(e) panel. Ask your client's dependency attorney about submitting a referral to get a 317(e) education attorney appointed!

If a parent has used an attorney at a hearing, are there circumstances under which the school district is responsible for paying the fees of the parents' attorney?

Yes. Parents are entitled to recover the fees they owe an attorney for preparing for and conducting a hearing (and sometimes a hearing request mediation or IEP meeting), if the parent is considered to have prevailed at the hearing which means that the parent substantially won on at least one or more of the issues. If a parent is represented by a legal services organization that does not charge them, the full cost of the representation is still recoverable by the legal services organization if the parent prevails, as defined by law.

UNIT 6: SECTION 504

What is Section 504?

Section 504, which is part of the Rehabilitation Act of 1973, is a federal law prohibiting discrimination against anyone considered to be a qualified handicapped person.

- This law and its regulations provide that all who are eligible be provided with a free, appropriate education which may include modifications to the regular program or special education and related services.

Who is considered a qualified handicapped person under Section 504?

- A qualified handicapped person means any person who:
    - Has a physical or mental impairment which substantially limits one or more major life activities (such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working);
    - Has a record of such impairment; or
    - Is regarded as having such an impairment.
- In addition, with respect to preschool, elementary, or secondary school services, the person must be:
    - Of an age during which non-handicapped persons are provided such services;
    - Of any age during which it is mandatory under state law to provide such services to handicapped persons; or
    - One to whom a state is required to provide a free, appropriate public education under the federal special education law.

What does a physical or mental impairment mean under Section 504?

- A physical or mental impairment means:

Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal;special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or

- Any mental or psychological disorder (such as mental retardation, organic brain syndrome, emotional or mental illness), and specific learning disabilities.

How does a student request services or program modifications under Section 504?

- A parent, guardian, or foster parent may request an evaluation under Section 504.
- It is always best to put such a request in writing.

What services or program modifications are available under section 504?

- This law is designed to reasonably accommodate the student's handicapping condition so that the student's needs are met as adequately as the needs of students without disabilities.

- Program modifications may be required for a student who can otherwise be educated appropriately in the regular classroom. Modifications may include but are not limited to: additional time to complete tests, books in Braille, help going from one class to another, or permission to walk around in the class when needed.
- Students also might need special education or related services (which are also available under this law if needed to adequately accommodate a student's disability). These services would include any that are available under the federal special education law, the IDEA, and that are described in this resource manual.

When should an evaluation be requested under Section 504 and when under the IDEA?

- Whenever making a referral for a special education evaluation, it is also a good idea to request that the student be evaluated under Section 504.
- In this way, if the student does not qualify for special education and related services under the IDEA, the student may still qualify for these services or program modifications under Section 504.
- However, it is also possible to request that a student be evaluated under Section 504 after the student is found not to be eligible under the IDEA.
- When requesting an evaluation of a student under both Section 504 and the IDEA, remember to ask that the school district's Section 504 Coordinator be present at the initial IEP meeting to discuss the results of the Section 504 evaluation.

If the student is not found to qualify for services under Section 504, can this decision be appealed?

- Yes. The school district is responsible for arranging the Section 504 hearing process.
- The hearing must be impartial, although the hearing officer may be from another school district.
- The student's ERH has the right to be represented by an attorney or non-attorney advocate.

UNIT 7: DISCIPLINE PROCEDURES

This chapter is divided into three sections. The first focuses on definition of terms and disciplinary procedures that relate to all students, whether or not they have disabilities. The second section specifically applies to students who do *not* have disabilities and are *not* eligible for special education services — that is, the majority of public school students. The third section pertains to disciplinary procedures *only* for students with disabilities.

Section I: Disciplinary Terms and Procedures for All Students

What is a suspension?

- Suspension is a form of school discipline where the student is temporarily removed from the educational setting (either an in-school suspension or where student is sent home). This action is a result of offenses committed by the student that violate Education Code Sections 48900(a)-(q_, 48900.2-4, or 48900.7.
- The act for which a student is suspended must be related to school activity or school attendance while:
    - On school grounds
    - Going or coming from school
    - During a lunch period (both on or off campus)
    - Going to, during, or coming from a school-sponsored activity (i.e. a field trip)

What rights does the child have when suspended?

- Prior to suspension, the child has a right to an informal conference with the principal. The exception to this is when the student presents a clear danger to people or property; when this is the situation, the student must be given notice of his/her right to a hearing and the school must hold the hearing meeting within 2 days.
- The school must attempt a less restrictive means of discipline and intervention before suspension or expulsion (for example, detention or a counseling referral), unless the student presents a clear danger to people or property and/or disrupts the educational process for other students.
- The school must make a reasonable attempt to contact the ERH at the time of the student's suspension, and the school must provide a written notice of the action to the ERH.
- Suspension is not to be used in response to truancy, tardiness, or absence.
- A suspension cannot be longer than 5 consecutive school days, and this can only be extended if a child was recommended for expulsion. In a given academic year, students cannot be suspended for more than 20 school days, unless they have transferred schools. Then they can be suspended up to 30 days.

May a student be suspended for a first offense?

- For many offenses, suspension should be imposed only when other means of correction fail to bring about proper conduct.
- For more serious offenses, however, a student may be suspended on the first offense.

What is an expulsion?

- Under California law, expulsion means removal of a student from the immediate supervision and control or the general supervision of school personnel. The student is removed from the school district for up to one year because other disciplinary interventions are not appropriate.

Under what conditions is a school required to expel a student?

- The governing board must expel any student who commits a "zero tolerance" offense:
    - possess, sell, or otherwise furnish a firearm;
    - brandish a knife at another person;
    - unlawfully sell a controlled substance; or
    - commit a sexual assault.

What are the permissible reasons that a student may be suspended from school or recommended for expulsion?

- Caused, attempted to cause, or threatened to cause physical injury to another person.
- Willfully used force or violence upon the person of another, except in self-defense.
- Possessed, sold, or otherwise furnished any firearm, knife, explosive, or other dangerous object (unless the pupil had obtained written permission to possess a dangerous object from a certificated school employee and the principal or the principal's designee concurs).
- Unlawfully possessed, used, sold, or otherwise furnished, or was under the influence of, any controlled substance, an alcoholic beverage, or an intoxicant.
- Unlawfully, offered, arranged, or negotiated to sell any controlled substance, an alcoholic beverage, or an intoxicant of any kind, and then either sold, delivered, or otherwise furnished to any person another liquid, substance, or material and represented it as a controlled substance, alcoholic beverage, or intoxicant.
- Committed or attempted to commit robbery or extortion.
- Caused or attempted to cause damage to school property or private property
- Stole or attempted to steal school property or private property.
- Possessed or used tobacco, or any products containing tobacco or nicotine products.
- Committed an obscene act or engaged in habitual profanity.
- Unlawfully possessed or unlawfully offered, arranged, or negotiated to sell any drug paraphernalia.
- Disrupted school activities or otherwise willfully defied the valid authority of supervisors, teachers, administrators, school officials, or other school personnel engaged in the performance of their duties.
- Knowingly received stolen property or private property.
-
- Possessed an imitation firearm. Imitation firearm means a replica of a firearm that is so substantially similar in physical properties to an existing firearm as to lead a reasonable person to conclude that the replica is a firearm.

- Committed or attempted to commit a sexual assault or a sexual battery.
- Harassed, threatened, or intimidated a pupil who is complaining witness or witness in a school disciplinary proceeding for the purpose of either preventing that pupil from being a witness or retaliating against that pupil for being a witness, or both.
- Committed sexual harassment that is sufficiently severe or pervasive to have a negative impact upon the individual's academic performance or to create an intimidating, hostile, or offensive educational environment. (Only pertains to students in grade 4 and above.)
- Caused, attempted to cause, threatened to cause, or participated in an act of hate violence. (Only pertains to students in grade 4 and above.)
- Intentionally engaged in harassment, threats or intimidation directed against a student or group of students that is sufficiently severe or pervasive to have the actual and reasonably expected effect of materially disrupting classwork, creating substantial disorder, and invading the rights of that student or group of students by creating an intimidating or hostile educational environment.
- Has made terrorist threats against school officials or school property that include any statement, whether written or oral, by a person who willfully threatens to commit a crime which will result in death, great bodily injury to another person, or property damage in excess of $1000, with the specific intent that the statement is to be taken as a threat and hereby causes that person reasonably to be in sustained fear for his or her own safety, or for his or her immediate family's safety, or for the protection of school district property, or the personal property of the person threatened or his or her immediate family.

Who may suspend or expel a student?

- A teacher may suspend a student from the teacher's class for the day of the suspension and the day following; however, the teacher must immediately report the suspension to the principal and send the student to the principal or the principal's designee.
- Only the principal, or the principal's designee, may suspend a student from school.
- The principal or the superintendent may recommend a student be expelled; however, final action for expulsion is by the governing board.

Instead of recommending suspension or expulsion for a student, may the principal of a school, the principal's designee, the superintendent of schools, or the governing board require a student to perform community services on school grounds during non-school hours?

- Yes. Community service may include, but is not limited to, work performed on school grounds in the areas of outdoor beautification, campus betterment, and teacher or peer assistance programs.
- However, community service is not available for offenses for which suspension or expulsion is required.

How often may a student be removed from a particular class period without being sent to the principal or principal's designee (i.e., without being officially suspended)?

- Removal from a particular class may not occur more than once every five school days.

For how many days may a student be suspended from school?

- The principal, the principal's designee, or the superintendent may suspend a student for no more than five consecutive days.

What is an opportunity transfer?

- An opportunity transfer is a planned transfer from one school to another in the district for:

- progressive discipline — repeated attempts to resolve the student's misconduct have been unsuccessful; or
- a single, serious act of misconduct — where the school administrator has discretion to recommend this action rather than expulsion.

Who selects the school to which a student who receives an opportunity transfer will be transferred?

- Although parental input should be solicited and considered, the selection of receiving school is at the discretion of the principals of both the issuing and receiving schools.
- Every effort must be made by both the issuing and receiving schools to ensure that the opportunity transfer is completed within 5 school days from the date the issuing school initiates the transfer.

What should an ERH do if he/she disagrees with the opportunity transfer of his/her student to another school?

- The parent should request an appeal from the administrator issuing the opportunity transfer within two school days of the decision by the school to assign the student to another school.

How many levels of appeal are there when an ERH disagrees with the opportunity transfer of his/her student?

- There are two levels of appeal.
  - Parent conference with the school principal.
  - If the parent disagrees with the principal's decision, the parent may appeal this decision and have a conference with the appropriate school district administrator.

How will the parent learn the outcome of the appeal and how long will it take?

- The appropriate administrator will report the decision to the parent, in writing, within 5 school days of the conference.

What school will the student attend awaiting the outcome of the appeal of the opportunity transfer?

- The student is officially assigned to the designated receiving school pending the outcome of the appeal.
- The parents are responsible for enrolling the student in the designated school.

Are students who given an opportunity transfer to another school for disciplinary reasons eligible for athletic competition?

- A student who is transferred for disciplinary reasons is ineligible for athletic competition at the receiving school for a period of not more than one calendar year from the date of transfer.

Can I request a transfer for the protection or personal welfare of my client?

In LAUSD, a parent/ERH can request a transfer if he/she believes it is necessary for the protection or personal welfare of a student.

A common use of a transfer is if the child is being forced into a gang or has been threatened by a gang. These are known as Safety and Protection Permits (SAPPs) and are issued for the purpose of promoting safety for all students.

SAPPs can also be issued for other reasons, including childcare, continuing enrollment, parent employment, sibling location, or senior status

Section II: Disciplinary Procedures for Students without Disabilities

For how many days may a regular education student be suspended during a school year?

- The total number of days for which a student may be suspended from school must not exceed 20 school days in any school year.
- However, if for purposes of adjustment, a student enrolls in another regular school, an opportunity school or class, or a continuation education school or class, the total number of school days for which the student may be suspended must not exceed 30 days in any school year.

Under what conditions is a school required to expel a student?

- The governing board must expel any student who:
    - possessed, sold, or otherwise furnished a firearm;
    - brandished a knife at another person;
    - unlawfully sold a controlled substance; or
    - committed sexual assault
- These are referred to as the "zero tolerance" offenses.

For how long may a regular education student be expelled?

- A regular education student (i.e., a student who does not have an IEP) may be expelled for the duration of the semester in which the offense is committed and the next semester.
- However, if a student commits one of the "zero tolerance" offenses, the governing board must have a date of one year from the date of the expulsion occurs when the student will be reviewed for readmission to the school.

What happens to the student during the period of expulsion?

- Current California law requires that a regular education student (i.e., a student who does not have an IEP) who is under an expulsion order must be referred to an alternative educational program.
- Depending on the nature of the offense, the alternative educational program may either be within the school district or in a program operated by the county board of education.

Section III: Disciplinary Procedures for Students with Disabilities

For how long may a student with an IEP be suspended from school?

- According to federal law, a student with an IEP may be suspended for up to, but not more than, 10 consecutive school days if he or she poses an immediate threat to the safety of other students or to him/herself.

- Cumulative suspensions of more than 10 days per school year may indicate a pattern of exclusion from school and therefore constitutes a significant change of placement without an IEP meeting, in violation of the IDEA. Decisions must be made on a case-by-case basis.

When may a student with an IEP be suspended or kept out of school for longer than 10 school days?

- In the case of a truly dangerous student, a suspension may exceed 10 consecutive school days if:
    - the student's parent or guardian agrees; or
    - a hearing officer or a court orders it.
- In the case of a student who carries a weapon to school or to a school function, knowingly possesses or uses illegal drugs, or sells or solicits the sale of a controlled substance while at school or a school function, the student may be placed in an interim alternative educational setting for the same amount of time that a student without a disability would be subject to discipline, but for not more that 45 days.

Who determines the student's interim alternative educational setting?

- The interim alternative educational setting shall be determined by the IEP team.
- The interim alternative educational setting shall also:
    - enable the student to continue to participate in the general curriculum, although in another setting, and to continue to receive those services and modifications, including those described in the student's current IEP, that will enable the student to meet the goals set out in that IEP; and
    - include services and modifications designed to address the student's behavior which lead to placement in this alternative setting.

Must a school district develop or revise a behavioral intervention plan for a student with a disability when it suspends the student?

- Yes. A school district must develop or revise a behavioral intervention plan for a student with a disability either before or not later than 10 days after changing the school placement of a student:
    -
    - to an appropriate interim alternative setting, another setting, or suspension for not more than 10 days; or
    - to an appropriate interim alternative educational setting for not more than 45 days.

What is a "manifestation determination" review?

- Whenever disciplinary action is contemplated by a school district for a student with a disability (such as placement in an interim alternative educational setting, another setting, suspension, or change of placement), a review must be conducted of the relationship between the student's disability and the behavior for which the student is to be disciplined.

- This review is referred to as a "manifestation determination" meeting, hearing, or review. It may also be referred to as a manifestation IEP meeting.
- The purpose of this review is to determine whether the misbehavior of the student is a manifestation of the student's disability.

Who conducts the manifestation determination review?

- The review must be conducted by the IEP team and other qualified personnel.

What information must the IEP team consider before making the determination that the student's misbehavior is not a manifestation of the student's disability?

- The IEP team must consider, in relation to the behavior subject to disciplinary action, all relevant information, including:
    - evaluation and diagnostic results, including information supplied by the student's ERH;
    - observations of the student; and
    - the student's IEP and placement.

What questions must the IEP team consider before making the determination that the student's misbehavior is not a manifestation of the student's disability?

- Was the student's IEP and placement appropriate?
- Were the special education services, supplementary aids and services, and behavioral intervention strategies provided consistent with the student's IEP and placement?
- Did the student's disability impair the student's ability to understand the impact and consequences of the misbehavior?

Did the student's disability impair the ability of the student to refrain from engaging in the misbehavior? The IEP team must answer the first two questions "yes" and the last two "no" to make a determination that the student's misbehavior was not a manifestation of the student's disability.

If the IEP team determines (after following appropriate procedures) that the misbehavior was not a manifestation of the student's disability, what disciplinary action may the school district take?

- The relevant disciplinary procedures applicable to student's without disabilities may be applied to the student.
- However, the school district must ensure that the special education and disciplinary records of the student with a disability are transmitted for consideration to the person or persons making the final determination regarding the disciplinary action.

What options does the student's ERH have if he/she disagrees with the determination that the student's behavior was not a manifestation of the student's disability?

- If the student's parents disagree with a determination that the student's behavior was not a manifestation of the student's disability or with any decision regarding placement, the parent may request a hearing.

  When the ERH of a student with a disability requests a hearing regarding the placement of the student in an interim alternative educational setting, what is the student's school placement during the appeal process?

- The student remains in the interim alternative educational setting pending the decision of the hearing officer or until the time designated for the student to remain in that setting expires (not more than 45 days), whichever comes first.

- The student's placement in the interim alternative educational setting may be changed if both the parent and the school district agreed to the change.

  After the time the student is designated to remain in the interim alternative educational setting expires (not more than 45 days), to what school placement does the student return?

- The student returns to the placement the student was in prior to placement in the interim alternative educational setting.

- The student returns to the prior placement even if the school district proposes a change in that placement and the parent challenges the proposed change by initiating a hearing.

  What options does the school district have if their personnel maintain that it is dangerous for the student to be in the current placement (i.e., the placement prior to removal to the interim alternative education setting)?

- The school district may request an expedited hearing.

  What rights does a student who has engaged in behavior that violates school rules have under the special education laws if the student has not been identified as a student with a disability (i.e., a student with an IEP)?

- A student who has not been determined to be eligible for special education, but has violated school rules, may assert any of the protections provided for under the federal special education law if the school district had knowledge that the student was a student with a disability before the behavior that precipitated the disciplinary action occurred.

  How is it to be determined if the school district had knowledge that the student was a student with a disability before behavior that precipitated disciplinary action occurred?

- The school district will be considered to have knowledge that the student is a student with a disability if:

    - The parent of the student has expressed concern in writing (unless the parent is illiterate or has a disability that prevents compliance with this requirement) to school district personnel (e.g., teacher, counselor, principal) that the student is a student in need of special education and related services;

    - The behavior or performance of the student demonstrates the need for such services;

- The parent of the student has requested an evaluation of the student to determine special education eligibility; or
- The teacher of the student, or the personnel of the school district, has expressed concern about the behavior or performance of the student to the director of special education or the district personnel.

Are there special considerations when issuing an opportunity transfer to a student with a disability?

- Yes. A student with a disability may be given an opportunity transfer following consultation with the Special Education Unit coordinator or designee, only if it is determined that the student's IEP can be fully implemented at the receiving school.

When appealing an opportunity transfer for a student with a disability, is the process any different?

- The process is the same as for a student without a disability.
- However, at the first level of appeal, the principal may consult with the school-site special education staff or the Special Education Unit coordinator or designee.
- At the second level of appeal, the cluster leader or designee, or the cluster-designated committee, must consult with the Special Education Unit coordinator.

May a school district report a crime committed by a student with a disability to law enforcement and judicial authorities?

- Yes.

UNIT 8: OTHER IMPORTANT INFORMATION & FREQUENTLY ASKED QUESTIONS ABOUT SPECIAL EDUCATION

Some of these questions appear in the Education Plan section of Unit V.

What happens when a foster child transfer schools?

- The proper and timely transfer between schools of pupils in foster care is the responsibility of both the local educational agency and the county placing agency. (Cal. Educ.§49069.5(b))
- As soon as the county placing agency becomes aware of the need to transfer a pupil in foster care out of his or her current school, the county placing agency shall contact the appropriate person at the local educational agency of the pupil. The county placing agency shall notify the local educational agency of the date that the pupil will be leaving the school and request that the pupil be transferred out. (Cal. Educ. Code § 49069.5(c))
- Upon receiving a transfer request from county placing agency, the local educational agency shall within two (2) business days, transfer the pupil out of the school and deliver the educational information and records of the pupil to the next educational placement. (Cal. Educ. Code § 49069.5(d))
- The local educational agency shall ensure that any absence from school due to a decision to change the placement of a pupil made by a court or placing agency, the grades and credits of the pupil will be calculated as of the date the pupil left school, and no lowering of grades will occur as a result of the absence of the pupil under these circumstances. (Cal. Educ. Code § 49069.5(g))

What happens when a student with an IEP moves from one school district to another?

- The new school district must immediately provide an interim placement, to last not more than 30 days;
- The interim placement must conform to the student's current IEP;
- Within 30 days, the IEP team convene a meeting, review the program, and make a final recommendation;
- Records and reports from the old school district may be used in making the recommendation.

APPENDIX A: ELIGIBILITY CRITERIA

These eligibility criteria appear in the federal regulations for IDEA. California law defines eligibility slightly different from federal law but must conform with the federal definitions.

§ 300.7 Child with a disability.

(a)(1) As used in this part, the term child with a disability means a child evaluated in accordance with §§ 300.530-300.536 as having mental retardation, a hearing impairment including deafness, a speech or language impairment including blindness, serious emotional disturbance (hereafter referred to as emotional disturbance), an orthopedic impairment, autism, traumatic brain injury, any other health impairment, a specific learning disability, deaf-blindness, or a multiple disability, and who because of that impairment needs special education and related services.

(2) The term child with a disability for children aged 3 through 9 may include a child -

(i) Who is experiencing developmental delays, as defined by the State and as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas: physical development, cognitive development, communication development, social or emotional development or adaptive development;

(ii) Who, for that reason, needs special education and related services; and

(iii) If the State adopts the term for children of this age range (or a subset of that range) and the LEA chooses to use the term.

(b) The terms used in this definition are defined as follows:

1) Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age 3, that adversely affects a child's educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences. The term does not apply if a child's educational performance is adversely affected primarily because the child has an emotional disturbance, as defined in paragraph (b)(4) of this section.

2) Deaf-blindness means concomitant hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational problems that they cannot be accommodated in special education programs solely for children with deafness or children with blindness.

(3) Deafness means a hearing impairment that is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification, that adversely affects a child's educational performance

(4) Emotional disturbance is defined as follows:

(i) The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance.

(A) An inability to learn that cannot be explained by intellectual, sensory, or health factors.

(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

(C) Inappropriate types of behavior or feelings under normal circumstances.

(D) A general pervasive mood of unhappiness or depression.

(E) A tendency to develop physical symptoms or fears associated with personal or school problems.

(ii) The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.

(5) Hearing impairment means an impairment in hearing, whether permanent or fluctuating, that adversely affects a child's educational performance but that is not included under the definition of deafness in this section.

(6) Mental retardation means significantly sub-average general intellectual functioning, existing concurrently with deficits in adaptive behavior and manifested during the developmental period, that adversely affects a child's educational performance

(7) Multiple disability means concomitant impairments (such as mental retardation-blindness, mental retardation-orthopedic impairment, etc.), the combination of which causes such severe educational problems that the problems cannot be accommodated in special education programs solely for one of the impairments. The term does not include deaf-blindness.

(8) Orthopedic impairment means a severe orthopedic impairment that adversely affects a child's educational performance. The term includes impairments caused by congenital anomaly (e.g., clubfoot, absence of some member, etc.), impairments caused by disease (e.g., poliomyelitis, bone tuberculosis, etc.), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns that cause contractures).

(9) Other health impairments means having limited strength, vitality or alertness, due to chronic or acute health problems such as a heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes, that adversely affects a child's educational performance.

(10) Specific learning disability is defined as follows:

(i) General. The term means a disorder in one or more of the basic psychological processes involved in understanding or using language, spoken or written, that may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations, including such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia.

(ii) Disorders not included. The term does not include learning problems that are primarily the result of visual, hearing, or motor disabilities of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage.

(11) Speech or language impairment means a communication disorder, such as stuttering, impaired articulation, a language impairment, or a voice impairment, that adversely affects a child's educational performance.

(12) Traumatic brain injury means an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child's educational performance. The term applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; and speech. The term does not apply to brain injuries that are congenital or degenerative, or to brain injuries induced by birth trauma.

(13) Visual impairment including blindness means an impairment in vision that, even with correction, adversely affects a child's educational performance. The term includes both partial sight and blindness.

Note 1: If a child manifests characteristics of the disability category "autism" after age 3, that child still could be diagnosed as having "autism" if the criteria in paragraph (c)(1)(i) of this section are satisfied.

Note 2: As used in paragraph (a)(2) of this section, the phrase "at the discretion of the State and LEA" means that if the State adopts the term "developmental delay" for children aged 3 through 9, or for a subset of that age range (e.g., children aged 3 through 5, etc.), LEAs that choose to use "developmental delay," rather than identify these children as being in particular disability category, must conform to the State's definition of the term.. However, a State may not require an LEA to use "developmental delay" for children in this age range, or for a sub-set of this age range, cannot independently use "developmental delay" as a basis for establishing a child's eligibility.

Note 3: With respect to paragraph (b)(1) of this section (relating to "developmental delay"), the House Committee Report on Pub. L. 105-17 includes the following statement:

The Committee believes that, in the early years of a child's development, it is often difficult to determine the precise nature of the disability. Use of "developmental delay" as part of a unified approach will allow the special education and related services to be directly related to the child's needs and prevent locking the child into an eligibility category which may be inappropriate or incorrect, and could actually reduce later referrals of children with disabilities to special education. (H. Rep. No. 105-95, p. 86 (1997))

Note 4: With respect to paragraph (b)(4) of this section (relating to using the term "emotional disturbance"), the House Committee Report on Pub. L 105-17 includes the following statement:

The committee wants to make clear that changing the terminology from "serious emotional disturbance" to "serious emotional disturbance (hereinafter referred to as 'emotional disturbance')" in the definition of a "child with a disability" is intended to have no substantive or legal significance. It is intended strictly to eliminate the pejorative connotation of the term "serious." It should in no circumstances be construed to change the existing meaning of the term under 34 CFR 300.7(b)(9) as promulgated September 29, 1992 (H. Rep. No. 105-95, p. 86 (1997))

Note 5: A child with attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) may be eligible under Part B of the Act if the child's condition meets one of the

disability categories described in § 300.8, and because of that disability the child needs special education and related services. Some children with ADD or ADHD who are eligible under Part B of the Act meet the criteria for "other health impairments" (see paragraph (c)(9) of this section). Those children would be classified as eligible for services under the "other health impairments' category if (1) the ADD or ADHD is determined to be a chronic health problem that results in limited alertness, that adversely affects educational performance, and (2) special education and related services are needed because of the ADD and ADHD. The term "limited alertness" includes a child's heightened alertness to environmental stimuli that results in limited alertness with respect to the educational environment.

Other children with ADD or ADHD may be eligible under Part B of the Act because they satisfy the criteria applicable to other disability categories in § 300.8(b). For example, children with ADD or ADHD would be eligible for services under the "specific learning disability category" if they meet the criteria in paragraph (c)(10) of this section, or under the "emotional disturbance" category if they meet the criteria in paragraph (c)(4). Even if a child with ADD or ADHD is found to be not eligible for services under Part B of the Act, the requirements of Section 504 of the Rehabilitation Act of 1973 and its implementing regulations of 34 CFR Part 104 may still be applicable.

APPENDIX B: SPECIAL EDUCATION ACRONYMS

(Terms most frequently used in Education)

DISABILITIES

ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
CH	Communicatively/Communication Handicapped
DB	Deaf/Blind
DHH	Deaf & Hard of Hearing
ERMHS	Educationally-Related Mental Health Services
HI	Hearing Impaired
HH/HOH	Hard of Hearing
IWEN	Individuals with Exceptional Needs
LD	Learning Disabled/Learning Disability
LH	Learning Handicapped
LSH	Language, Speech & Hearing
LSS	Language & Speech Services
MH	Multi-handicapped
MR	Mental Retardation
MS	Multiple Sclerosis
OH	Orthopedically Handicapped
OHI	Other Health Impaired
OI	Orthopedically Impaired
OMH	Other Multi-handicapped
PH	Physically Handicapped
PKU	Phenylketonuria
SDL	Severe Disorder of Language
ED	Emotionally Disturbed
SH	Severely Handicapped
SLI	Speech and Language Impairment
SM	Socially Maladjusted
TB	Tuberculosis
VH	Visually Handicapped
VI	Visual Impairment/Visually Impaired

AGENCIES, DEPARTMENTS, COMMITTEES, etc.

CAC	Community Advisory Committee
CASA	Court Appointed Special Advocates
CCS	California Children's Services
CDE	California Department of Education
CSW	Children's Social Worker
DCFS	Department of Children and Family Services
DMH	Department of Mental Health
LACOE	Los Angeles County Office of Education
LEA	Local Education Agency (includes schools, school districts, SELPAs and county offices of education)
LPA	Local Plan Area (Local Planning Area)
OCR	Office of Civil Rights (U.S. Dept. of Education)
OSEP	Office of Special Education Programs (U.S.)
OSERS	Office of Special Education and Rehabilitative Services (U.S. Department of Education)
PTSA	Parent Teacher Student Association
SARB	School Attendance Review Board
SDE	State Department of Education
SEA	State Education Agency
SELPA	Special Education Local Plan Area

LEGISLATIVE

AB	Assembly Bill (State Legislation)
AB 490	Bill passed in 2003 that created new rights and duties related to the education of dependents and wards in foster care.
ADA	The Americans with Disabilities Act - prohibits discrimination of the basis of disability in employment and places of public accommodation.
CAC	California Administrative Code
CFR	Code of Federal Regulations
EC	Education Code
EHA	Education of the Handicapped Act (aka PL 94-142)

IDEA	The Individuals with Disabilities Education Act - the primary federal special education statute. Prior versions of this statute are also known as "P.L. 94-142" the Education for All Handicapped Children's Act (EACHA); the Education of the Handicapped Act (EHA).
IDELR	Individuals with Disabilities Law Report (the earlier version of this (EHLR) reporting system was called Education of the Handicapped Law Report**.**
PL	Public Law
PL99-457	The federal Early Intervention Program for Infants and Toddlers (also known as the Part H Program)
SB	Senate Bill
504	Section 504 of the Rehabilitation Act of 1973. The federal statute prohibiting discrimination on the basis of disability in programs receiving federal funding.
USC	United States Code

SERVICES, RELATED SERVICES, PROGRAMS & PROGRAM PLANS

APE	Adaptive Physical Education
DC	Development Center
DIS	Designated Instructional Services (California's term for Related Services)
ESY	Extended School Year
IEP	Individualized Education Program
IEPT	Individualized Education Program Team
IFSP	Individualized Family Service Plan
IHP	Individualized Habilitation Plan
IPI	Individually Presented Instruction
IPP	Individualized Program Plan (used by Regional Centers)
ISP	Individualized Service Plan
ITP	Individualized Treatment Plan/Individualized Transition Plan
LRE	Least Restrictive Environment
MTU	Medical Therapy Unit
NPS	Nonpublic School
OT/PT	Occupational Therapy

PE	Physical Education
PT	Physical Therapy
ROC	Regional Occupational Center
ROP	Regional Occupational Program
RS	Resource Specialist
RSP	Resource Specialist Program
RT	Recreational Therapy/Recreational Therapist
SDC	Special Day Class
SSS	State Special Schools
SST	Student Success Team
VE	Vocational Education

OTHER SPECIAL EDUCATION TERMS FREQUENTLY USED

AB	Adaptive Behavior
CA	Chronological Age
ESL	English as a Second Language
FAPE	Free Appropriate Public Education
FES	Fluent English Speaker
FTE	Full Time Equivalent
FY	Fiscal Year
IQ	Intelligence Quotient
LCI	Licensed Children's Institution
LEP	Limited English Proficient
LES	Limited English Speaking
MA	Mental Age
MGM	Mentally Gifted Minor
NEP	Non-English Proficient
SD	Standard Deviation
SPI	Superintendent of Public Instruction
SR	Stimulus-Response
SSI	Supplemental Security Income
SSPI	State Superintendent of Public Instruction

TDD	Telecommunication Device for the Deaf
TTY	Teletypewriter (connected to telephone)

APPENDIX C: SPECIAL EDUCATION GLOSSARY

The following is a list of terms used in specialized areas, such as education, psychology, and medicine. The short definition of these words included here will hopefully be helpful to CASAs when reading reports, attending meetings and conferences, and/or talking with specialists who have contacts with the student.

ACADEMIC: Refers to subjects such as reading, writing, math, social studies, and science.

ACCESS: A personal inspection and review of a record, an accurate copy of a record, an oral description or communication of a record, or a request to release a copy of an educational record.

ADVOCATE: A person who represents and provides support to parents of students with disabilities.

AFFECTIVE: Pertains to feelings or emotions.

ANNUAL REVIEW: A scheduled meeting of the IEP team on at least an annual basis to review, revise, and update the IEP.

APHASIA: A weakening or loss of the ability to send and/or receive verbal and/or written messages; not connected with diseases of the vocal cords, eyes, or ears.

APPEAL: An integral part of the due process and complaint procedures. If the party filing a complaint disagrees with the findings, the party may give input at the local Board presentation of findings or request review of the findings by the State Superintendent of Instruction. A parent or district that disagrees with the due process decision may appeal that decision through the court of appropriate jurisdiction.

APPROPRIATE EDUCATION: "Appropriate Education," as in "free, appropriate, public education," is an educational program and/or related service(s) as determined on an individual basis which meets the unique needs of each individual with exceptional needs. Such an educational program and related service(s) are based on goals and objectives as specified in an IEP and determined through the process of assessment and IEP planning in compliance with state and federal laws and regulation. This educational program provides the equal opportunity for each individual with exceptional needs to achieve commensurate with the opportunity provided to other pupils.

APTITUDE TEST: A test which measures someone's capacity, capability, or talent for learning something.

ASSESSMENT/EVALUATION: Assessment encompasses all those functions in the testing and diagnostic process leading up to development of an appropriate, individualized educational program and placement for a student with exceptional needs. Assessment may include screening to identify potentially (i.e., high probability) handicapped students; the observation, testing, and diagnosis of those students to specifically identify each student's disabling conditions and the severity of that condition; interviews; and the definition of educational needs based on disabling conditions and learning profile.

ATTENTION SPAN: The extent to which a person can concentrate on a single task (sometimes measured in length of time).

AUDIOGRAM: A graph showing the range of hearing. Hearing sensitivity for air and bone conducted sounds may be shown on the graph.

AUDIOLOGICAL EXAM: Related to a test of a person's hearing ability.

AUDIOLOGIST: A person who identifies and measures hearing loss and helps in the rehabilitation of those with hearing impairments.

AUDIOLOGY: The study of hearing and hearing disorders.

AUDITORY COMPREHENSION: The ability to understand what one hears.

AUDITORY DISCRIMINATION: The ability to detect subtle differences between sounds in words (tap-cap; cap-cop).

AUDITORY MEMORY: The ability to remember what is heard (words, numbers, stories). This includes both short- and long-term memory.

AUDITORY PERCEPTION: The ability to receive sounds accurately and to understand what they mean.

BEHAVIOR MODIFICATION: A procedure that is based on the belief that all behavior is learned and therefore can be unlearned (changed). One must decide the specific behavior to be changed and decide on a definite plan for accomplishing that goal.

BEHAVIORAL OBJECTIVES: Objectives which are written to describe what a student will be able to do as a result of some planned instruction. Behavioral objectives are usually interpreted as objectives that can be measured in some definitive or quantitative way(e.g., given a list of ten three-letter words, Johnny will orally read eight of the ten words correctly within 90 seconds).

BODY IMAGE: An awareness of one's own body and the relationship of the body parts to each other and to the outside world.

CALIFORNIA CODE OF REGULATION (TITLE 5): State administrative regulations which are supplemental to California Education Code and sections and federal law and regulations dealing with special education.

CALIFORNIA MASTER PLAN FOR SPECIAL EDUCATION: A document adopted January 11, 1974, by the California State Board of Education which includes philosophies, goals, and guidelines for planning more comprehensive services for all individuals identified as having exceptional needs.

CASA: Court Appointed Special Advocate.

CASE CARRIER/CASE COORDINATOR: The professional assigned to coordinate a referral for possible special education placement. The person is responsible for processing the student's referral from the assessment plan through the development of the IEP, and may provide follow-up services while the student is served in a special education program.

CHANDRA SMITH: Consent decree that brings LAUSD into compliance with special education law and provides for the needs of the District's special education children.

CLINICAL OBSERVATIONS: Opinions about or interpretations of behavior made by the person assessing the student which are based on professional experience and expertise. The

interpretations may relate to behaviors not tested directly during the assessment, such as "fear of failure" or "desire to please."

COGNITIVE OPERATIONS: Process involved in thinking. 1. Cognition - comprehension or understanding, 2. Memory - retention and recall of information, 3. Convergent thinking - bringing together of known facts, 4. Divergent thinking - use of knowledge in new ways (creative thinking), 5. Evaluation – critical thinking.

COGNITIVE SKILLS: The act or process of knowing. Analytical or logical thinking.

COMMUNITY ADVISORY COMMITTEE (CAC): A committee of parents and guardians, including parents or guardians of individuals with exceptional needs, and representatives from schools and community agencies, which has been established to advise the SELPA regarding the development and review of programs under the comprehensive local plan.

COMMUNICATIVELY HANDICAPPED [CH OR SI (SPEECH IMPAIRED)]: Those students with disabilities in one or more of the communication skills, such as language, speech, and hearing.

COMPLAINT: An alleged violation by a public agency of any federal or state law or regulation.

CONFIDENTIALITY: Assurance that no information contained in school records be released without parental permission, except as provided by law.

CONSENT: Permission from the parent (eighteen years or older) required by law for assessment, development of a special education program, and placement.

CONTRACTUAL SUPPORT SERVICES: Specially allocated funds designated for special education students whose programs must be supplemented through outside sources.

COORDINATION, FINE MOTOR: Pertains to usage of small muscle groups (writing, cutting).

COORDINATION, GROSS MOTOR: Pertains to usage of large muscle groups (jumping, running). 1. Bilateral - Ability to move both sides of the body at the same time (jumping), 2. Unilateral - Ability to move one side of the body without moving the other (hopping), 3. Cross lateral (cross-pattern) - Ability to move different parts of the opposite sides of the body together or in different sequences (e.g., skipping, which is a highly integrated movement).

COORDINATION, VISUAL MOTOR: The ability to relate vision with movements of the body or parts of the body.

CORE CURRICULUM: The district/COE-defined curriculum. The core curriculum is the range of knowledge and skills which are included in the district-adopted course of study and which must be learned for successful grade promotion and graduation. The curriculum may include academic as well as cultural, social, and moral knowledge and skills. IEP goals and objectives should reflect knowledge and implementation of the district's core curriculum as adapted for the student with disabilities.

CRITERION-REFERENCED TESTING (OR MEASUREMENTS): Measures which answer the question, "What can this student do?" not "How does this student perform compared to other students?" Individual performance is compared to an acceptable standard (criterion) - such as "can correctly name lessons of alphabet" - not to the performance of others as in the norm-referenced testing.

CHILDREN'S SOCIAL WORKER (CSW): Performs social work case management functions including the investigation, supervision, placement and care of dependent children, children in foster homes and other child welfare cases through routine or emergency referrals.

DEAF: A student with a hearing loss that inhibits language processing and affects educational performance.

DEAF-BLIND: Hearing and vision impairments which result in severe communication and educational problems.

DECODING: Ability to change sounds or symbols into ideas.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES (DCFS): Public agency which establishes, manages and advocates a system of services, in partnership with parents, relatives, foster parents and community organizations which ensure that a) children are safe from abuse, neglect and exploitation, b) children in out of home care are safe, secured, nurtured, stable and are provided with the opportunity to succeed.

DESIGNATED INSTRUCTION AND SERVICES (DIS): Instruction and services not normally provided by regular classes, resource specialist programs, or special classes or centers. They include, but are not limited to, such services as speech, occupational and physical therapy, and adapted physical education.

DEVELOPMENTAL: Successive changes during the process of natural growth.

DIAGNOSIS: The process of identifying the nature, cause, or extent of a disease or response; a term which comes to education from medicine.

DIFFERENTIAL STANDARDS FOR GRADUATION: If the IEP team determines that a special education student does not demonstrate evidence of the ability to attain the LEA's regular graduation proficiency standards with appropriate educational services and support, the IEP team develops differential proficiency standards or modified general differential standards, appropriate to the needs and potential of the student.

DIRECTIONALITY: Awareness of the two sides of the body and the ability to identify them as left and right and to project this correctly into the outside world, as in knowing which is the right hand of the person facing you.

DISABILITY: Federal regulations, state statutes, and regulations have defined categories of disabilities which establish the eligibility for special education programs.

DUE PROCESS: Legal procedural safeguards ensuring student and parent rights in the special education assessment, placement, and mediation procedures.

EDUCATIONAL RECORDS: Any item of information directly related to a specific student that is recorded by handwriting, tape, film, e-mail, or other means and maintained by a school or by any staff as required of his or her duty. Student records include information about a student gathered within or outside the school regardless of the form on which it is maintained. Any information maintained for second party review is part of the student's record. Student records do not include informal notes pertaining to the student that are in the sole possession of the writer and are not accessible or revealed to other parties.

ELIGIBILITY: The criteria for determining if a student has special education needs which cannot be met within the regular school program.

ENCODING: Changing ideas into words or written symbols.

EVALUATION, MEDICAL: Examination and diagnosis by a physician.

EVALUATION, PSYCHOLOGICAL OR PSYCHO-EDUCATIONAL: An assessment to determine the level of functioning through the use of group and/or individual tests. The tests determine the level of functioning in three areas: (1) cognitive - how much one knows in certain areas, how one thinks, (2) affective - pertains to feelings and emotions; (3) perceptual-motor - control, coordination, and appropriate responses from all parts of the body. Recommendations for treatment or placement, when indicated, are made as a result of the evaluation.

EXPRESSIVE LANGUAGE SKILLS: Skills required to produce language for communicating with other people. Speaking and writing are expressive language skills.

EXTENDED YEAR: The term "extended year" means the period of time between the close of one academic year and the beginning of the succeeding academic year. The term "academic year" as used in this section means that portion of the school year during which the regular day school is maintained. An extended year program shall be provided for a minimum of 20 instructional days, including holidays. Schools must provide extended year services to individuals with disabilities if the gains for the student during the regular school year would be significantly jeopardized by a summer break without continuous structured programming. Whether or not an individual is entitled to extended school year services is determined by the IEP team.

EYE-MOTOR COORDINATION: The ability to relate vision with movements of the body or parts of the body.

FORMAL ASSESSMENT: Using published, standardized tests, usually for measuring characteristics, such as "intelligence" or "achievement," rather than skills, such as "tying shoes" or "following directions;" tests have a standard set of directions for their use and interpretation.

FOSTER FAMILY: See Cal Ed Code §56155(b)

FREE APPROPRIATE PUBLIC EDUCATION (FAPE): Every school-age student with a disability is entitled to an education which meets his or her individual needs, whether it be in a public school setting or in a private school at public expense, if a public program is not available or appropriate.

GRADE EQUIVALENT: The score a student obtains on an achievement test, translated into a standard score which allows the individual student's score to be compared to the typical score for students in his or her grade level. A "grade equivalent" score of 6.0 means the score that the average beginning sixth grader makes; a "grade equivalent" score of 6.3 means the score that the average student who has been in sixth grade for three months makes.

GROUP HOME: A facility of any capacity which provides 24-hour non-medical care and supervision to youth in a structured environment, with such services provided at least in part by staff employed by the licensee.

OTHER HEALTH IMPAIRED: Students who have persistent medical or health problems, such as heart conditions, epilepsy, diabetes, etc., which adversely affect their educational performance. ADHD is sometimes included in this category.

IDEA (INDIVIDUALS WITH DISABILITIES EDUCATION ACT): The Federal legislation that created amendments to PL 94-142, including changing the title of the Act from the "Education for the Handicapped Act" (EHA) to the "Individuals with Disabilities Education Act".

IEPT (INDIVIDUALIZED EDUCATION PROGRAM TEAM): Comprised of multidisciplinary staff which includes the ERH and is open to any other persons who may have knowledge of the student. The

team is responsible for determining special education eligibility for individuals referred to special education services and appropriate educational program goals.

INDIVIDUAL WITH EXCEPTIONAL NEEDS (IWEN): A student whose educational needs cannot be met by a regular classroom teacher with modifications of the regular school program and who requires and will benefit from special instruction and/or services. Excluded are students whose needs are due solely or primarily to unfamiliarity with the English language or to cultural differences.

INDIVIDUALIZED EDUCATION PROGRAM (IEP): The IEP is a written education plan for each special education student that includes instructional goals and objectives based upon the educational needs specified and developed by the IEP team.

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP): An IFSP is a written plan for providing early intervention services to a student eligible for early intervention service. The plan must be developed jointly by the family and the appropriately qualified personnel involved in early intervention. The plan must be based on the multidisciplinary evaluation and assessment of the student and include the services necessary to enhance the development of the student and the family's capacity to meet the student's special needs.

INFORMAL ASSESSMENT: Using procedures such as classroom observations, interviewing, or teacher-made tests which have not usually been tried out with large groups of people, and which do not necessarily have a standard set of instructions for their use and interpretation.

INTEGRATED PROGRAM: Refers to participation by students in a regular classroom for specified amounts of time during the school day.

INTELLIGENCE TEST: A standardized series of questions and/or tasks designed to measure mental abilities - how a person thinks, reasons, solves problems, remembers, and learns new information. Many intelligence tests rely heavily on the use or understanding of spoken language. Some intelligence tests are designed to be given to one person at a time; these are called individual intelligence tests. Others may be given to several persons at once and are called group intelligence tests. Both types of intelligence tests are given under controlled conditions involving standard instructions and time limits.

INTELLIGENCE QUOTIENT (I.Q.): The score obtained on a test of mental ability; it is usually found by relating a person's test score to his or her age.

LEARNING DISABILITIES: Significant delays in learning or social behaviors, such as learning disabilities resulting from visual perceptual disorders, visual motor disorders, behavior disorders, or a combination of these.

LEAST RESTRICTIVE ENVIRONMENT (LRE): The concept that each student with a disability is to be placed in a learning environment that most closely approximates the learning environment of his or her nondisabled peers (regular classroom) and provides for the most appropriate educational opportunities for the disabled student.

LOCAL EDUCATION AGENCY (LEA): A school district or country office of education which provides education services.

LOCAL PLAN: The state required plan (Cal. Ed. Code §56211) that designates how the local education agencies of the special education local plan area will meet both state and federal

requirements for educating individuals with exceptional needs who reside in the geographic area served by the plan. The local plan is revised every three years as required by the Education Code.

LONG-RANGE GOALS: Global and general "aims statements" which describe what needs to be learned by the student.

LOW INCIDENCE DISABILITY: A low incidence disability is a severe disability with an expected incidence rate of less than 1 percent of the total K-12 statement enrollment. Low incidence disabilities include learning impairments, visual impairments, and severe orthopedic impairments (Cal. Ed. Code §56026.5)

MEDIATION: A conflict resolution process that can be used to resolve special education issues. A mediation is entered into prior to holding the due process hearing. It is the intent of the legislature that the mediation conference be an intervening, informal process conducted in a non-adversarial atmosphere that allows the parties to create their own solutions rather than having one imposed upon them through the judicial process. The mediation conference must be held within fifteen days of state receipt of a hearing request.

MODALITY: A way of acquiring sensation; visual, auditory, tactile, kinesthetic, olfactory, and gustatory are the common sense modalities.

MOTOR PERCEPTUAL TESTS: Tests of eye and hand coordination.

MULTIHANDICAPPED: Students with a combination of disabilities (such as mental retardation and deafness) which cause severe educational problems. Deaf-blind is not included in this category.

NEUROLOGICAL EXAMINATION: Tests to determine dysfunction in the nervous system.

NONDISCRIMINATORY ASSESSMENT: Assessment tools and methods which are: "fair" to the students in the sense that they are given in his or her native language given and interpreted with reference to the student's age and socioeconomic and cultural background; given by trained persons; and appropriate, even if the student has a physical, mental, speech, or sensory disability. Because some tests used in schools often do discriminate against certain students (e.g., by asking questions that relate to the experience of white, middle-class, English-speaking persons), the term culturally appropriate assessment has come into use to emphasize that assessment must be fair to students of other language and cultural backgrounds.

NORMS: Information, provided by the test-maker, about "normal" or typical performance on the test. Individual test scores can be compared to the typical score made by other persons in the same age group or grade level.

OCCUPATIONAL THERAPIST: Trained in helping pupils develop daily living skills, e.g., self-care, prevocational skills, etc.

OCCUPATIONAL THERAPY (O.T.): Treatment provided by a therapist trained in helping the patient develop daily living skills in all areas of daily life, e.g. self-care, prevocational skills, etc.

PARENT: The natural or adoptive parent, guardian, or person appointed to act as parent for a student (surrogate parent), or the student if eighteen years or older and determined to be competent by the individualized education program team coordinator.

PERCENTILE: A point on a test score scale used to divide a set of group scores into sections. For example, the 75th percentile point separates the top quarter from the rest of the group.

PERCENTILE RANK: Is expressed as a number, between 0 and 100, that tells what percentage of individuals in a group earned scores below a certain score. A percentile rank of 78 says that person scored higher than 78 percent of the group and lower than the other 22 percent. Percentile rank should not be confused with percentage score on the test.

PERCEPTION: The process of interpreting sensory information. The accurate mental association of present stimuli with memories of past experience.

PERCEPTUAL-MOTOR TESTS: A test that requires people to use their skills in receiving and interpreting sensory information in responding to tasks that require actions, such as drawing a line between two given lines, copying a circle, etc.

PERSEVERATION: Continuing to behave or respond in a certain way when it is no longer appropriate. Difficulty in shifting from one task to another.

PERSONALITY TEST (OR INVENTORY): A test which measures characteristics, such as emotional control, honesty, attitudes, etc., rather than intellectual ability, or academic achievement.

PHYSICAL THERAPIST: A person trained in administering treatment to bones, joints, muscles, and nerves.

PHYSICAL THERAPY: Treatment of disorders of bones, joints, muscles, and nerves. With the prescription of a physician, the therapist applies treatment in the patient in the form of heat, light, massage, exercise, etc.

PHONETICS: Study of all speech sounds in the language and how these sounds are produced.

PHONICS: Use of phonetics in the teaching of reading. Relating the sound (phoneme) of the language with the equivalent written symbol.

PRESCRIPTIVE TEACHING: In an educational setting, "prescription" refers to planned activities, strategies, and programs that will help the student achieve stated goals and objectives.

PROCEDURAL SAFEGUARDS: Specific procedures designed by state and federal law to protect the rights of students, parents, and school districts.

PROGRAM SPECIALIST: A Program Specialist is a special education staff person who holds a special education credential, health services credential, or a school psychologist authorization, and who has advanced training and related experience in the education of individuals with exceptional needs and specialized, in-depth knowledge of special education services. Often program specialists are assigned to provide expertise to specific categories of handicapping conditions such as orthopedically, severely handicapped, speech and language, etc.

PROJECTIVE CASE: A test in which people are asked to respond freely and openly to questions or pictures which have no "right" answers. The assumption is that people "project" themselves and their feelings, needs, etc. as they respond. These tests are used to measure personality characteristics.

PSYCHOMOTOR SKILLS: Refers to muscle responses, including development of fine-motor small muscles (cutting, etc.) and large muscles (walking, jumping, etc.).

PUBLIC LAW 94-142 (EDUCATION FOR THE HANDICAPPED ACT (EHA) OF 1975, now **entitled IDEA):** The federal legislation governing the education of all handicapped students PL 94-142 mandates that all public schools in the U.S. are to provide "a free, appropriate public education and related services" to "all handicapped students." PL stands for Public Law, 94 means it was passed by the 94th Congress and 142 is the number of the law.

PUBLIC LAW 101-476 (EDUCATION FOR THE HANDICAPPED ACTMENDMENTS): The federal legislation that created amendments to PL 94-142, including changing the title of the Act from the "Education for the Handicapped Act" (EHA) to the "Individuals with Disabilities Education Act" (IDEA).

READING COMPREHENSION: The ability to understand what one has read.

RECEPTIVE LANGUAGE: Receiving and understanding spoken or written communication. The receptive language skills are listening and reading.

REFERRAL: The process of requesting an evaluation for a student who is suspected of having a learning disability. A referral is official and must be in written form; once it is made, time lines and procedural safeguards ensue.

RELATED SERVICES: Related services means transportation and such developmental, corrective, and other supportive services as are required to assist a handicapped student to benefit from special education, and includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation early identification, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training.

RELIABILITY: The extent to which a test provides precise or accurate measures.

RESOURCE SPECIALIST PROGRAM (RSP): The RSP setting provides instruction and services for those individuals with exceptional needs who are assigned to a regular classroom for the majority of the school day.

RESPONSIBLE ADULT: A person appointed by the Court to make educational decisions for a child who is a dependent or ward of the Court whose parent's or guardian's educational rights to make the decisions have been limited by specific order.

SCALED SCORES: The translation of "raw scores" (total points earned on a test) into a score which has similar meaning across age levels. If a scale from 0 to 20 is used, then a scaled score of 10 is an average score, regardless of whether it was obtained by a five-year-old or a fifteen-year-old.

SCHOOL PSYCHOLOGIST: A person trained to give psychological tests, interpret results, and suggest appropriate educational approaches to learning or behavior problems.

SELF-CONCEPT: A person's idea of himself or herself.

SELF-HELP: Refers to feeding, dressing, and other activities necessary for functioning in a family, in school, and in the community.

SERVICE PROVIDER: Refers to any person or agency providing some type of service to students and/or their families.

SEVERELY HANDICAPPED (SH): Those students who require intensive instruction and training, such as developmentally handicapped, trainable mentally retarded, autistic, seriously emotionally disturbed.

SHORT-TERM OBJECTIVES: A series of intermediate steps that will take the student from where he or she is now to accomplishing annual goals.

SMALL FAMILY HOME: Residential facility in the licensee's family residence providing 24-hour care for six or fewer students who are mentally disordered, developmentally disabled or physically handicapped and who require special care and supervision as a result of such disabilities. (Title 22, Regulations 8001 [45].

SOCIAL SKILLS: The ability to get along with one's peers (friends) which includes self-concept or a person's idea of himself or herself and the ability to relate to peers and adults.

SOCIAL MATURITY: The ability to assume personal and social responsibility, expected of persons of similar age. Tests of social maturity measure of how well a person looks after his or her everyday needs (eating, dressing, etc.) and takes responsibility (goes to the store, does chores, etc.) as compared to other persons in his or her age group.

SPECIAL CLASSES: Public schools classes which provide services to students with more intensive needs than can be met by the regular school program or Resource Specialist Program or Designated Instruction and Services. The students are enrolled in the special class for the majority of the school day and are grouped according to similar instructional needs.

SPECIAL EDUCATION AND RELATED SERVICES: Special education refers to a set of educational programs and/or services designed to meet the individual needs of exceptional individuals whose needs cannot be met in a regular classroom. Related services means transportation and other developmental and supportive services (e.g., speech therapy, psychological services, counseling, social work, etc.).

SPECIAL EDUCATION LOCAL PLAN AREA (SELPA): A SELPA may be a single LEA and/or county office or a group of LEA's and/or country offices that are organized within a geographic area to coordinate the administration and delivery of special education services within the region's boundaries.

SPECIFIC LEARNING DISABILITY: This term refers to problems in academic functioning, such as writing, spelling, doing math, or reading, which cannot be explained by ability, vision, hearing, or health impairments.

SPEECH PATHOLOGIST OR THERAPIST: Persons trained to provide analysis, diagnosis, and therapy for speech and language disturbances.

STANDARD DEVIATION: Tells how much a score "deviates," or varies, from the mean score for the group. In a group of scores, the greatest number of scores will usually be close to the mean, or average score. The numerical value of a standard deviation unit is different from test to test, but scores which are more than one standard deviation unit above or below the mean occur less often.

STANDARDIZED ACHIEVEMENT TEST: A series of questions designed to measure facts and information a student has learned in school. Some achievement tests are given to one person at a time and are called individual achievement tests; others (group tests) may be given to several persons at once. All standardized tests have sets of instructions which the person giving the test must follow exactly.

STUDENT STUDY TEAM (SST): A team of educational personnel including classroom teachers who are responsible for developing modifications to the regular program and providing appropriate

learning environments for students who may be exhibiting school related problems. Through combining knowledge and brainstorming efforts, the SST may generate solutions that enable students to remain in regular classrooms rather than be referred for special education programs.

SURROGATE PARENT: A surrogate parent is a person appointed by the SELPA or LEA who acts as a student's parent for the purpose of the IEP process to ensure the rights of an individual with exceptional needs when no parent can be identified or located, or the student is a ward of the state and the parents do not retain educational rights for the student. In the case of a dependent or ward of the Court, a Surrogate Parent is appointed when the Court has not appointed a person to act as the Responsible Adult.

SYMBOLIZATION: The process in which spoken or written symbols take on meaning; that is, are understood by the individual and in turn are used for a verbal or written expression.

TACTILE: Sense of touch.

TEST OF AUDITORY PERCEPTION: A test that tells how well a youngster perceives or hears specific sounds.

TRANSITION: Transition services are a coordinated set of activities for a student, designated within an outcome-oriented process, which promotes movement from school to post-school activities, including post-secondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation. The coordinated set of activities is based upon the individual student's needs, taking into account the student's preferences and interests, and as appropriate include instruction, community experiences, the development of employment and other post-school adult living objectives, and, when appropriate, acquisition of daily living skills and functional vocational evaluation. The process begins at fourteen years or the ninth grade and includes the student, family, education personnel and vocational and adult service providers (Vocational Rehabilitation, Regional Center, Social Security, etc.).

TRIENNIAL ASSESSMENT: Every student shall have a complete reassessment every three years. This reassessment may occur sooner if requested by the parents or teacher. Preparation for the assessment follows the same process as for an initial evaluation, including the assessment plan with written parental consent, and the 50-day time line.

VALIDITY: The extent to which a test really measures what it is intended to measure.

VISUAL DISCRIMINATION: Using the eyes to discriminate letters and words.

VISUAL PERCEPTION: The identification, organization, and interpretation of data received through the eye.

VISUAL-PERCEPTION TEST: A test that requires the person to identify, organize, and interpret information received through the eyes - e.g., find a simple shape "hidden" in a complete picture.

VISUALLY HANDICAPPED: Students who are blind or have partial sight and who, as a result, experience lowered educational performance.

VOCATIONAL APTITUDE (OR INTEREST) TEST: A test designed to give an indication of a person's potential to succeed in particular jobs or careers. The test is usually a questionnaire which asks the individual to describe his or her own characteristics. It is like a written interview.

WORD ATTACK SKILLS: The ability to analyze words.

APPENDIX D: GENERAL EDUCATION ACRONYMS AND GLOSSARY

ACRONYMS

AP	Advanced Placement
AB 922	Ensures school placement, necessary pupil services, resources to assist, monitor, and rehabilitation, for all expelled students during the expulsion.
ACT	Abolish Chronic Truancy
ADA	Average Daily Attendance
AWEC	Alternative Education and Work Centers for Dropouts
C.C.R. 5	California Code of Regulations, Title 5 Education
CCS	County Community Schools
CDS	Community Day Schools
E.C.	California Education Code
FAPE	Free Appropriate Public Education
GED	General Education Development Test
IS	Independent Study
LACOE	Los Angeles County Office of Education
LEARN	Los Angeles Educational Alliance for Restructuring Now
OT	Opportunity Transfer
PERT	Parent Employment Related Transfer
PPS	Pupil Personnel Services employee
ROC/ROP	Regional Occupational Center/Regional Occupational Program
SARB	School Attendance Review Board

GENERAL EDUCATION GLOSSARY

ACHIEVEMENT TEST: A test that is designated to measure what a student has already learned.

BILINGUAL EDUCATION: A system of instruction which builds upon the language skills of a pupil whose primary language is other than English.

CAREGIVER'S AUTHORIZATION AFFIDAVIT: Authorizes a caregiver 18 years or older to enroll a minor in school and consent to school-related medical care on behalf of the minor.

CERTIFICATE OF PROFICIENCY: An examination available to a person 16 years or older, enrolled in the 10th grade, who demonstrates his or her proficiency in basic skills. The certificate of proficiency is equivalent to a high school diploma.

CERTIFICATED EMPLOYEE: Any employee who holds a licensed credential issued by the State Commission on Teacher Credentialing.

CHARTER SCHOOLS: Public schools that operate independently from the existing school district structure.

CLASSIFIED EMPLOYEE: Any employee who does not possess a credential, including paraprofessionals, aides, office staff, custodians, etc.

COMPULSORY EDUCATION: Each parent, guardian or other person having control or charge of any child between the ages of 6 and 18 years, not exempted, shall send the child to the public full-time day school or continuation school.

CONFIDENTIALITY: It is the intent of the Legislature that counselors use the privilege of confidentiality to assist the pupil whenever possible to communicate more effectively with parents, school staff, and others. Cal. Ed. Code 49602.

CUM (Cumulative School Record): A history of a pupil's development and educational progress maintained for the purpose of providing the best possible conditions for his education.

CONTINUATION SCHOOL: A program of instruction for students 16 years or older that accommodates a work study schedule, allows for the completion of required academic courses to graduate from high school.

ENROLLMENT: A student is enrolled in school when all the registration materials are complete and the student has entered the classroom.

EXCLUSION: The act of refusing admittance or removing a pupil from public school attendance for reasons stated in the California Education Code such as contagious or infectious diseases (Cal Ed. Code §48211, §49403, H & SC 12030).

EXCUSE: When verified, absences that are allowable are: illness, quarantine, medical, dental, or optometrical appointments, funeral services (1 day in California; 3 days out of state); for justifiable personal reasons, including an appearance in court, observance of a holiday or ceremony of his or her religion, as the custodial parent of a child who is ill or has a medical appointment during school hours. A pupil absent from school shall be allowed to complete all assignments and tests missed during the absence.

EXEMPTION: The act from being freed from compulsory full time school attendance, work permit, working in the entertainment industry, private tutor, etc.

EXPULSION: The act of discontinuing attendance of a pupil in the public schools by school district as a result of action by the governing school board for reasons listed under EC 48900, 48915 such as a physical injury, possession of weapons, etc.

FOSTERING EDUCATION: Training for school staff that provides information about the way the child welfare system impacts out-of-home care students.

GRADUATION: Completion of required credits; LAUSD requires 220 credits in grades 9-12. Students must successfully complete the Basic Competency Examinations in reading, language, Mathematics and Writing.

HABITUAL TRUANT: Any child is deemed a habitual truant who has been reported as a truant three or more times.

IMMUNIZATION: A means to combat the spread of communicable, dangerous childhood diseases.

INTERDISTRICT TRANSFER: Authorizes the transfer of students between districts; a central district function - a school principal cannot grant, grant, deny or cancel an Inter-district Permit.

INTERSESSION: Instructional programs, similar to summer school, that is offered between year round track sessions.

MEDIATION HEARING: A hearing held with a district attorney hearing officer with the parent and student, and school officials, when the parent and student fail to live up to the SARB contract.

MIDDLE COLLEGE HIGH SCHOOL: At-risk high school students who are performing below their academic potential and place them in an alternative high school located on a community college campus.

RESIDENCE: The residence of the parent (or caregiver) of an unmarried minor is the residence of the minor.

SATURDAY CLASSES: Special classes for mentally gifted minors, makeup classes for unexcused absences occurring during the week, programs of Regional occupational center or regional occupational programs.

SCHOOL ADMISSION: A child shall be admitted to Kindergarten if the child will have his or her fifth birthday on or before December 2 of that school year.

SCHOOL OF ATTENDANCE: Refers to the school a student is attending which may or may not be in his/her area of residence.

SCHOOL OF RESIDENCE: Refers to the school a student would attend because of the location of his/her residence in the school's attendance area.

SUSPENSION: The act of dismissing a pupil from school or classroom on a temporary basis for reasons stated in the California Education Code.

TRUANT: Any child shall be reported as a truant who has been absent from school without valid excuse more than three days or tardy on more than three days.

WORK PERMITS: Permits to work issued by schools for minors under 18 years of age, subject to conditions and exceptions contained in Education Code and Labor Code.

CHAPTER 9

Regional Centers

TABLE OF CONTENTS

Goal

To learn about developmental disabilities, the laws that protect individuals with developmental disabilities and what services and supports are available to them through the California Regional Centers.

Objectives

By the end of this chapter, I will…

- ✓ Have general knowledge of developmental disabilities.
- ✓ Have general knowledge of California Regional Centers.

UNIT 1: What is a Developmental Disability?

A developmental disability is a severe, chronic disability of a person which:	
Federal Definition: (PL 95-602 Signed November 6, 1978)	**California Definition:** (Welfare & Institutions Code §4512 January 1, 1977)
(A) Is attributable to a mental or physical impairment or a combination of mental and physical impairments; (B) Is manifested before the person attains age twenty-two; (C) Is likely to continue indefinitely; (D) Results in substantial functional limitations in three or more of the following areas of a major life activity; • Self-care • Receptive and expressive language • Learning • Mobility • Self-direction • Capacity for independent living • Economic self-sufficiency (E) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.	(A) Originates before age 18; (B) Is expected to continue indefinitely; (C) Constitutes a substantial handicap for the individual; (D) Includes mental retardation, cerebral palsy, epilepsy, and autism; (E) Also includes handicapping conditions closely related to mental retardation or which require treatment similar to that required by persons with mental retardation; (F) Does not always include other handicapping conditions that are solely physical in nature.

California Regional Centers use the state definition of developmental disability to determine eligibility for services provided by the Regional Centers.

Some Causes Of Developmental Disabilities:

- Premature Birth
- Low Birth Weight
- Birth Mother's Age Below 16 Or Over 40
- Poor Prenatal Care
- Complications In Labor
- Traumatic Head Injury
- Alcohol And/Or Drug Abuse During Pregnancy

UNIT 2: What Are Regional Centers and Who Is Eligible?

What is the Lanterman Act?

The Lanterman Developmental Disabilities Act ("Lanterman Act") is the law that gives people with developmental disabilities in California the right to services and supports that will allow them to live a more independent and normal life. The Lanterman Act begins with section 4500 and runs through section 4846 of the California Welfare and Institutions Code. The services and supports must meet both the needs and the choices of each person individually.

Developmental Disabilities as defined by the Lanterman Act

The Lanterman Act defines a developmental disability as a disability that:

1. originates before a person reaches age 18;

2. continues or is expected to continue indefinitely;

3. constitutes a substantial disability for that person; and

4. is mental retardation, cerebral palsy, autism, or a seizure disorder; or

5. is a disabling condition closely related to mental retardation or requiring treatment similar to that required for people with mental retardation. § 4512(a)2.

Disabilities which are "solely physical in nature" are not included. § 4512(a).

Department of Developmental Services (DDS) regulations state that developmental disabilities do not include handicapping conditions that are "solely learning disabilities" or "solely psychiatric disorders." 17 CCR § 54000. Disability Rights California believes that denial of eligibility based on exclusion of handicapping conditions that are "solely learning disabilities" or "solely psychiatric disorders" may not be valid.

How do people who qualify under the Lanterman Act receive services?

The California Department of Developmental Services (DDS) contracts with community-based Regional Centers to coordinate services to people with developmental disabilities. Regional Centers are private, nonprofit corporations.

There are 21 Regional Centers in California, each serving a specific geographical area. The 12 Regional Centers serving Southern California, with their addresses and telephone numbers, are listed at the end of this chapter. A complete list is available from your supervisor.

The Regional Center is the main point of contact in the community to ensure families receive the services and supports they want and need. The Regional Center itself provides some services but it also contracts with other agencies in order to have services provided. § 4620. The Regional Center is required to develop an Individual Program Plan (IPP). The plan must list the services that a client needs. § 4646.

Certain types of services are so specialized that they can only be provided through the Regional Center. Regional Centers do not directly provide most services and supports. They purchase the services from private agencies or obtain them from other public agencies. The person directly responsible for actually developing and implementing the services and supports for a Regional Center client is a social worker, known as a "service coordinator" (sometimes called a "case manager"). §4647.

During someone's school years, the local school district has responsibility for special education and a number of other services. When the person leaves school, they may get more services and supports from another agency or from the Regional Center.

How do professionals determine if someone has a condition covered by the Lanterman Act?

In making a diagnosis, psychologists and doctors use many psychological, physical and other tests. A major part of the testing is to determine a person's cognitive (thinking) and adaptive (functioning) skills. Sometimes the medical and psychological professionals all agree that a developmental disability exists. Sometimes they disagree. If the Regional Center says someone is not developmentally disabled, the fair hearing procedure described later in this chapter can be used to challenge that decision.

Who is eligible for Regional Center services?

Regional Centers serve:

- People with developmental disabilities;
- People who are at high risk of giving birth to a child with a developmental disability; and
- Infants who have a high risk of becoming developmentally disabled.

(The Lanterman Act defines "high risk infant" to mean a child less than 36 months of age whose genetic, medical, or environmental history predicts a much greater risk for developmental disability than the risk of the general population. § 4642.)

Once someone is determined to be developmentally disabled, they remain eligible for Regional Center services unless the condition improves. Eligibility continues even if a client moves to a different Regional Center area. However, if the second Regional Center,

after a thorough assessment, believes and can prove that the original eligibility decision was "clearly erroneous," eligibility may end. § 4643.5(b)

Primary Qualifying Diagnoses for Regional Center Services

Mental Retardation	To be diagnosed with mental retardation, a person must have *both* "significantly subaverage" intelligence and problems with adaptive functioning in two or more areas. "Significantly subaverage", intelligence generally means having a score on a general intelligence test (IQ score) of 70 or below. People with IQ scores up to 75 can be diagnosed with mental retardation if they have adaptive skills like those of a person with mental retardation. IQ scores are not a dependable measure of intellectual functioning in some cases, so it is important to look at adaptive skills. Adaptive functioning areas include: communication; self-care; home living; social/interpersonal skills; use of community resources; self-direction; functional academic skills; work; leisure; health; and safety. Whether or not the criteria for mental retardation are met, the Regional Center should also consider eligibility under the "5th category."
Cerebral Palsy	Cerebral palsy, sometimes referred to as "CP," is a group of disorders that affect the central nervous system. It is the result of damage to the central nervous system -- usually before, at, or shortly after birth. Cerebral palsy can have many effects, including problems with walking, moving and speaking. The degree of disability can run from mild to severe. People with cerebral palsy may also have a diagnosis of mental retardation.
Autism	Autism is a condition that results in abnormal or impaired development in social interaction and communication. Often, people with autism have difficulty relating to other people. They may withdraw from other people, not want to communicate, and often have serious difficulties using language. They may become preoccupied with a particular activity or topic. People with autism may also have a diagnosis of mental retardation.
Seizure Disorders	Seizure disorders are conditions that cause disturbances of electrical activity in the brain. Epilepsy is one type of seizure disorder. Sometimes these disturbances result in a temporary loss of consciousness or motor control. There are many causes for this disability. Sometimes the seizures can be completely controlled with medication. Often they cannot be controlled. If a seizure disorder is controlled, a person may not be considered substantially disabled.

UNIT 3: Regional Center Services and Supports

Once eligibility for Regional Center services is determined, what is next?

Within 60 days after the intake and assessment, a written Individual Program Plan (IPP) must be developed. §4646(c). This plan describes a client's needs, preferences and choices, goals and objectives, and the services and supports needed to reach those goals. The IPP should focus on the client and family, where appropriate. The IPP should promote community integration; an independent, productive, and normal life; and a stable and healthy environment. §4646(c).

What are "services and supports?"

Services and supports are the special kinds of help needed in order to lessen the effects of a developmental disability. These services and supports help clients learn new skills, improve functioning, and have an independent, productive, and normal life. § 4512(b). The services and supports provided by the Regional Center and other agencies are determined through the IPP process. Even if a service or support is not listed in the law, a person is entitled to receive it if it can be proven that they need it.

Once there is an agreement with the Regional Center on the services and supports needed, the Regional Center is responsible for getting them. It can do that in many ways.

How does the Regional Center make sure clients get the services and supports in their IPP?
First, the Regional Center can help get clients services from another agency that provides services to the public, such as the public school, Medi-Cal or In-Home Supportive Services (IHSS). These agencies are called "generic agencies." If a generic agency can provide a service, Regional Centers are required to help get those services before Regional Centers pay for the services themselves. §§ 4648(a)(8), 4640.7(a). This is a good idea, but in practice it can cause problems. Sometimes the Regional Center will just refer consumers to generic agencies without making sure that the needed services are really available through those agencies or that the services will really meet the client's needs. The Regional Center is responsible for advocating to make sure that the services needed are actually available from another agency. § 4648(b). The Regional Center should make sure that no gaps occur in the provision of needed services. If a public agency or private business refuses to pay for a service or support that is needed immediately (and it would otherwise be a Regional Center responsibility) the Regional Center must pay for the service until the responsible party agrees to pay.
Second, *the* Regional Center can purchase services directly from a service provider. The Regional Center can go to a vendor, an agency, or an individual with whom it already has an agreement or it can contract separately with a new agency. § 4648(a)(3)(B). The Regional Center is responsible for locating providers who can meet clients' needs.
Third*, the* Regional Center can provide the client with a "voucher" for the services or equipment needed. § 4648(a)(4). The voucher allows the client (or his/her family, when appropriate) to select who will perform the service. §§ 45120) and 4648(a)(4). The Regional Center still has the responsibility of making sure that the service or item is available.

Services and Supports Provided by the Regional Center

- Adaptive equipment services
- Advocacy
- Advocacy assistance or facilitation
- Assessment
- Assistance in finding, modifying and maintaining a home
- Behavior Modification
- Camping
- Childcare
- Community integration services
- Community residential placement
- Community support facilitation
- Counseling for the consumer
- Counseling for the consumer's family
- Daily living skills training
- Day care
- Development and provision of a 24 hour emergency response system
- Development of unpaid natural supports
- Diagnosis
- Diapers
- Domiciliary care
- Education
- Emergency and crisis intervention
- Emergency housing
- Emergency relief for personal care attendants
- Evaluation
- Facilitated circles of support
- Facilitation, including outreach and education
- Facilitation with a facilitator of the consumer's choosing.
- Financial assistance
- Follow-along services
- Foster family placement
- Habilitation
- Home location assistance
- Homemaker services
- Identification of circles of support
- Infant stimulation programs
- Information and referral services
- Mental health services
- Occupational therapy
- Paid neighbors
- Paid roommates
- Parent training
- Peer advocates
- Personal care or assistance
- Physical therapy
- Protection of civil, service and legal rights
- Protective services
- Provision of circles of support
- Recreation
- Recruiting, hiring and training personal care attendants
- Respite
- Respite for personal care attendants
- Self-advocacy training
- Sexuality training
- Sheltered employment
- Short term out-of-home care
- Social services
- Social skills training
- Sociolegal services
- Special living arrangements
- Specialized dental care
- Specialized medical care
- Speech therapy
- Support services for consumers in homes they own or lease
- Supported employment
- Supported living arrangements
- Technical assistance
- Training
- Transportation services
- Travel training
- Treatment
- Vocational training
- Vouchered services

- Services and supports which are necessary for families to maintain their children with developmental disabilities at home, when living at home is in the best interest of the child.
- Services and supports needed to maintain and strengthen the family unit, where one or both parents is an individual with developmental disabilities.
- Other service and support options which would result in greater self-sufficiency for the consumer and cost-effectiveness to the state.

UNIT 4: Early Intervention/Early Start Services for Children Ages 0-36 Months

In addition to the developmental disabilities listed in Unit 2 of this chapter, children "at risk" of becoming developmentally disabled and parents at risk of having a child with a developmental disability are entitled to services from Regional Centers. §§ 4642, 4644. Signs of a developmental disability are often apparent very early in a child's life and are described as “delays” in development.

For more complete information on working with children ages 0-3, please refer to the IPP and IFSP Advocacy Manual available on-line at casala.org

What is Early Start?

Early Start is California’s response to the mandate in IDEA part C to provide early intervention services for children who qualify. The program is for children under the age of 3. It provides early intervention services and supports to maximize their potential. It is important to note that while Regional Center will provide the majority of the services for children under the age of 3, the local educational agency (i.e. school district) will also provide services for a child who has a low incidence disability (hearing impairment, vision impairment, orthopedic impairment)

CASA Tip

If you are aware that the child you are serving may be at risk for a develop-mental disability, the child may be eligible for Early Intervention/Early Start services. You should advocate for the child to be referred for an assessment.

Which children are served?

Infants and toddlers from birth through 36 months may be eligible for early intervention/early start services if, through documented evaluation and assessment, they meet one of the criteria listed below:

1. the child has a developmental delay in either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing; or
2. has established risk conditions of known etiology, with a high probability of resulting in delayed development.

In prior years, children birth to three years old, who were "at risk" for a developmental delay due to a combination of biomedical factors such as low birth weight, prematurity and drug exposure (among others), were eligible for Early Start services. However, as of October 1, 2009, these children no longer qualify for these services. They may qualify for the "Prevention Program" which provides intake, assessment, case management, and referral to generic agencies. Additionally, toddlers 24-35 months old with a delay in one area between 33% and 49% used to be eligible for Early Start but are now only eligible for the Prevention Program.

Who provides services?

Early intervention services are individually determined for each eligible infant or toddler and are provided, purchased or arranged by a Regional Center or local education agency. Local education agencies are primarily responsible for infants and toddlers with solely low incidence disabilities (vision, hearing and severe orthopedic impairments, including any combination of these low incidence disabilities). Regional Centers are responsible for all other children eligible for Early Start. Family resource centers/networks provide parent-to-parent support, information, and referral for all families.

What services are provided?

There are many things that can be done to address early delays, like infant stimulation, and changes in diet and vitamin intake. The number of preventive measures continues to grow as more is learned about how an infant's mind and body develops. The services provided are based on the child's assessed developmental needs and the families' concerns and priorities as determined by each child's Individualized Family Service Plan (IFSP) team.

Early Intervention/Early Start Services Include:	
• assistive technology • audiology • family training, counseling, and home visits • health services • medical services for diagnostic/evaluation purposes only • nursing services • nutrition services • occupational therapy	• physical therapy • psychological services • service coordination (case management) • social work services • special instruction • speech and language services • transportation and related costs • vision services

How much does it cost?

Early intervention services including evaluation, assessment and service coordination are provided to eligible infants and toddlers and their families at no cost to the family. Early Start is funded by federal funds (IDEA, Part C) and State General Funds. Other publicly-funded early intervention services may also be utilized.

What happens when the child turns 3 years old?

When the "at risk" child turns three years old, the Regional Center will do a new assessment. If the child does not then meet the definition of a developmental disability, that is, the child is not substantially disabled by one of the listed disabilities or conditions, eligibility for Regional Center services will end. The child may still need special education and other supports, but may no longer be eligible for Regional Center services. However, if the child meets the regular definition of developmental disability, he or she will continue as a Regional Center client. If there is a disagreement, the child's representative can file for an administrative hearing.

Between the ages of two years nine months and three years, a plan must be completed to assure a smooth transition to the school system, which may have responsibility for providing many or even all the supports and services that had been provided by the Regional Center.

UNIT 5: Regional Center Disputes and Appeals

What can I do if I disagree with a Regional Center decision?

If there is a disagreement with any Regional Center or developmental center decision which affects a client's eligibility or services, the decision can be appealed. § 4710.5(a).

For instance, a Regional Center's decision may be challenged if it determines the client:

- is not eligible for Regional Center services;
- no longer needs a particular service;
- will have a service reduced or changed; or
- will not receive a service which the client has chosen and believes is needed.

If the Regional Center has made a decision to stop, change or cut back a service or support that the client needs to have continued until the appeal process is finished the decision must be appealed within 10 days of the client being notified of the reduction, change or elimination of a service. Otherwise, the client has 30 days to file an appeal for a fair hearing. However, the services and supports can be stopped, cut back or changed during the appeal process, even if the client wins the right to those services or supports at the hearing.

When the Regional Center provides notice to a client of its action or proposed action it must also provide the client with the correct forms to make a request for a fair hearing.

Who is a Clients' Rights Advocate?

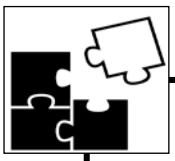
At every Regional Center and every developmental center there is a clients' rights advocate (CRA). The CRA's role is to protect clients' legal rights, entitlement to services, and human rights.

This includes helping with appeals against the Regional Center and other agencies. §4433(d)(1). The CRA also has the right to review records and investigate any suspected violation of rights, abuse or neglect. The CRA takes whatever steps are appropriate to make sure the laws are being followed in licensed facilities. §4433(d)(2).

Clients' Rights Advocates:

- Provide clients' rights advocacy services to persons with developmental disabilities who are consumers of Regional Centers, including ensuring the rights of persons with developmental disabilities, assisting persons with developmental disabilities in pursuing administrative and legal remedies, and direct representations of persons with developmental disabilities in selected cases.
- Investigate and take action as appropriate and necessary to resolve complaints from or concerning persons with developmental disabilities residing in licensed health and community care facilities regarding abuse, and unreasonable denial, or punitive withholding of rights guaranteed under this division.
- Provide consultation, technical assistance, supervision and training, and support services for clients' rights advocates that were previously the responsibility of the Office of Human Rights.
- Coordinate the provision of client's rights services in consultation with DDS, stakeholder organizations, and persons with developmental disabilities and their families representing California's multi-cultural diversity.
- Provide at least two self-advocacy training sessions per year for consumers and family members.

UNIT 6: CASA Advocacy and the Regional Center



- If the CASA suspects that the child to whom they are appointed might benefit from Regional Center services, the CASA should contact their Supervisor for directions on how to proceed.
- If the CASA is appointed to a child who is already a Regional Center client, the CASA should initiate and maintain contact with the Regional Center Services Coordinator assigned to the child and advocate for necessary and ongoing services.
- If the Regional Center denies the child services and an appeal needs to be pursued, the CASA should contact their Supervisor for guidance on how to proceed.
- **For more complete information on working with Regional Center, please refer to the IPP and IFSP Advocacy Manual available on-line at casala.org**

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UNIT 7: Southern California Regional Centers and Clients' Rights Advocate Listing

Regional Center:	Areas Served:	Clients' Rights Advocate:
Eastern Los Angeles Regional Center 1000 S. Fremont Alhambra, CA 91802-7916 626-299-4700 626-281-1163 – Fax info@elarc.org	Alhambra East Los Angeles, Northeast, Whittier	**Office of Clients' Rights Advocate** 1000 S. Fremont Avenue P.O. Box 7916 Alhambra, CA 91802 Phone: (626)576-4437/(626)576-4407 Fax: (626)576-4276
Frank D. Lanterman Regional Center 3303 Wilshire Boulevard, Ste 700 Los Angeles, CA 90010 213-383-1300 213-383-6526 – Fax www.lanterman.org	Central, Glendale, Hollywood-Wilshire, Pasadena	**Office of Clients' Rights Advocacy** 3580 Wilshire Boulevard, Ste 925 Los Angeles, CA 90010 Phone:(213) 427-8761 Fax:(213)427-8772
Harbor Regional Center Del Amo Business Plaza 21231 Hawthorne Boulevard Torrance, CA 90503 Telephone: (310) 540-1711 Fax: (310) 540-9538 Web site: www.hddf.com	Bellflower, Harbor, Long Beach and Torrance	**Office of Clients' Rights Advocacy** 3580 Wilshire Blvd., Ste. 925 Los Angeles, CA 90010 Phone: (213) 427-8761 Fax: (213) 427-8772
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CHAPTER 10

Psychotropic Medications

TABLE OF CONTENTS

UNIT 1: What are Psychotropic Medications?

Psychotropic medications are those drugs administered for the purpose of affecting the central nervous system to impact behavior or psychiatric symptoms. Such medications include, but are not limited to: anti-anxiety agents, anti-depressants, anti-manic agents, anti-panic medications, anti-psychotic medications, and psycho-stimulants.

JV-220 Application Regarding Psychotropic Medication

Clerk stamps date here when form is filed.

Attach a completed and signed JV-220(A), *Prescribing Physician's Statement—Attachment,* with all its attachments, must be attached to this form before it is filed with the court. Read JV-219-INFO, *Information About Psychotropic Medication Forms,* for more information about the required forms and the application process.

Fill in court name and street address:

Superior Court of California, County of

Fill in child's name and date of birth:

Child's Name:

Date of Birth:

Clerk fills in case number when form is filed.

Case Number:

(1) Information about where the child lives:

a. The child lives ☐ with a relative ☐ in a foster home
☐ with a nonrelative extended family member
☐ in a regular group home ☐ in a level 12–14 group home
☐ at a juvenile camp ☐ at a juvenile ranch
☐ other *(specify):* _____
_____

b. If applicable, name of facility where child lives:
_____

c. Contact information for responsible adult where child lives:
(1) Name: _____
(2) Phone: _____

(2) Information about the child's current location:

a. ☐ The child remains at the location identified in (1).
b. ☐ The child is currently staying in:
(1) ☐ a psychiatric hospital *(name):* _____
(2) ☐ a juvenile hall *(name):* _____
(3) ☐ other *(specify):* _____

(3) Child's ☐ social worker ☐ probation officer
a. Name: _____
b. Address: _____
c. Phone: _____ Fax: _____

(4) Number of pages attached: _____

Date: _____

_____
Type or print name of person completing this form

▶ _____
Signature

☐ Child welfare services staff *(sign above)*
☐ Probation department staff *(sign above)*
☐ Medical office staff *(sign above)*
☐ Caregiver *(sign above)*
☐ Prescribing physician *(sign on page 3 of JV-220(A))*

UNIT 2: Practical Actions for Helping Children Who Take Psychotropic Medications

1. What medications is the child taking?

a. List any and all medication(s) including over the counter and medications for other medical reasons.
b. Include dosage levels & frequency.
c. How long has the child been taking each of these medications?

2. Who is prescribing these medications?

a. What is the title and specialty of the person prescribing the medication?
b. What is his/her experience in prescribing to children/adolescents?
c. Is the doctor in the neighborhood, a clinic doctor, a doctor treating the entire group home, or a specialist?

3. What is Childs's diagnosis?

a. Who made the diagnosis? (Child's physician/other physician/clinician or other professional)?

4. On what is the diagnosis/treatment plan based?

a. Was it based on tests or evaluations?
b. Was it based on oral history or a written record?
c. Whose?
   - Caretaker
   - CSW
   - CASA
   - Other
d. Is it accurate?

5. Were "base-line" blood tests taken before prescribing medications?

a. Have blood tests ever been given?
b. Is the child receiving blood tests every 6 weeks?

6. Were other treatment plans discussed or given consideration before prescribing medications?

a. What treatment plans were discussed?
b. Why were they ruled out?

7. Was child ever on any medications in the past?

a. What were the medications?
b. Who prescribed them?
c. Were they administered consistently? (If not, why - multiple placements, Medi-Cal problems, etc.)

8. What is the child's history while on medication?

a. Was the medication successful/unsuccessful?
b. Who did the monitoring?
    - Parent
    - Caretaker
    - Group home staff
    - Hospital staff
c. How were records maintained (written, oral)?

9. Is the school aware of medications?

a. Are they a part of the medication treatment plan? (i.e., are medications administered at school?)
b. Teacher's observations
c. School nurse's observations

10. Is there a court authorization in the legal file?

a. Does it match placements' documentation (or drugs actually being given to child)?
b. Is the authorization current (authorized within the past six months)?
c. Have the court and child's attorney been notified of medications?
d. Has consideration been given to asking the court to order a §730 Medication Evaluation?
e. Will the §730 expert prescribe and recommend a physician who has expertise and will he/she prescribe, treat and follow up on the §730 expert's recommendations?
f. Is the caretaker aware that court authorization is required to administer psychotropic medications to dependents of the court?

UNIT 3: Frequently Asked Questions about the Psychotropic Medication Authorization (PMA) Process

1. **Is a PMA form required for medications prescribed for bedwetting?**
   No

2. **Is a Log number required before submitting a form?**
   No. The clerk's office will assign a log number for tracking purposes when the form is received at court.

3. **When does the authorization period start?**
   It begins from the date of the judge's signature (or court stamp), not from the date of the physician's signature.

4. **Is a new form required when a child changes placement?**
   No, unless the medications are changed, or the form expires. A copy of the form should be included with the child's records.

5. **If the PMA has been denied, but the physician feels it's necessary to continue or change the medication without a break in treatment, what should the physician do?**
   The physician should re-submit, responding to any questions the court or juvenile court mental health has raised, and marking the form "emergency" in section B2.

6. **If the caregiver or placement learns that a PMA has been denied should they stop the medication immediately?**
   The care or placement should take no action with regard to the medication without first consulting the physician.

7. **What if the reason for a denial or modification is not clear, or not legible?**
   Call the juvenile court mental health unit, the child's attorney, or the judge. The phone numbers for JC-MHU are on the mental health review sheet.

8. **If a form is missing or overdue, how can I check on it?**
   If you are the physician or facility that submitted the form, or the child's CSW or DPO, call the clerk's office at (323) 526-6640 (dependency court), or (323) 226-8494 (delinquency court). All others should first check with the physician, CSW, or DPO for a copy of the form. The court is only responsible for distributing the processed form to the physician, to DCFS liaison, and probation placement unit.

UNIT 4: CASA ROLE AND PSYCHOTROPIC MEDICATIONS

In your role as a CASA, your responsibility to the child you are assigned regarding medications is to determine the following:

- Is child being administered medication (of any kind)?
- For what is medication intended: Treatment of a condition? Control? Behavior modification?
- What is the medication(s), dosage and frequency?
- Who prescribe the medication?
- Who administers the medication(s), e.g., caretaker, school nurse?
- Is this information in the legal file? Is there an authorization in the file? Is it current? Does it match your information?
- Who is in a position to interact and/or observe the child while he/she is on medication (school teachers, caretakers, counselors, etc.)? Interview them.
- What is the goal of prescribed medication? Targeted behaviors? Projected length of treatment, alternatives, etc.? Interview the prescribing the physician.
- Are blood level checks taken on a regular basis by the prescribing physician?

Include all of the above information in your report to the court. You may also include your position, concerns and recommendations regarding the medications in your report to the court.

UNIT 5: PSYCHOTROPIC MEDICATION PROTOCOL SUMMARY (Dependency)

The following is a brief summary for obtaining court authorization for prescribing and administering psychotropic medications, in emergency and non-emergency situations, to children under dependency court jurisdiction.

This protocol does not include anticonvulsant medications prescribed expressly to control seizures or medications prescribed to control enuresis. Psychotropic medications must be utilized only for therapeutic purposes.

I. Definition

Psychotropic medications are those drugs administered for the purpose of affecting the central nervous system to impact behavior or psychiatric symptoms. Such medications include, but are not limited to: anti-anxiety agents, antidepressants, antimanic agents, antipanic medications, antipsychotic medications and psychostimulants.

II. The Process

A. Psychotropic Medication Authorization form (PMA) - If a child is under juvenile dependency court jurisdiction, the child's caregiver shall provide the prescribing physician with a Psychotropic Medication Authorization form when the child appears for treatment.

B. Parental Consent - If a child is a dependent of the juvenile court pursuant to Welfare & Institutions Code ("WIC") §300 and the child has been removed from the custody of the parent pursuant to WIC §361, the prescribing physician must obtain authority from the court regarding the prescription and administration of psychotropic medications for that child. If a child is a dependent of the juvenile court pursuant to WIC §300 and is in the custody of the parent or legal guardian, or if the authority to consent has been specifically delegated to the parent or legal guardian by the court, the prescribing physician must make a reasonable attempt to obtain written parental consent before prescribing and administering psychotropic medications to a child.

(1) **Where parent is available and willing to consent - t**he physician shall complete the Form and have the parent or legal guardian with legal custody sign the consent. In a non-emergency situation, once the parent or legal guardian with legal custody signs the form, the physician may prescribe and administer the psychotropic medication to the child. The physician must send the entire form, with the parent's or legal guardian's signature, to the appropriate juvenile court.

(2) **Where no parent or legal guardian with legal custody is available or willing to consent -** If there is no parent or legal guardian with legal custody capable of

authorizing, or willing to authorize the prescription, the physician shall request authorization from the juvenile court by completing the form. Foster parents, relatives, or group home caregivers may not sign consent forms unless they are the child's legal guardian. The physician may not prescribe and administer psychotropic medications to a child without court authorization, absent an emergency.

C. Completing the Psychotropic Medication Authorization Form - All portions of the form must be completed in full and be legible. Failure to provide all requested information will result in delay of the process or denial of the request. An illegible or indecipherable form will be returned.

(1) **Log Number -** each form shall be given a log number for tracking purposes. Log numbers will not be obtained by telephone; rather, log numbers will be assigned upon receipt of the form by the psychotropic desk clerk at the appropriate court location.

(2) **Court Order -** this section of the form shall be completed by the juvenile court judicial officer. The court order will authorize what may be prescribed and administered, and will include any other court order associated with the child's treatment. The prescription and administration of psychotropic medication is authorized when approved and signed by the court, except where the parent or legal guardian with legal custody has consented to the request. In such case, the court will indicate in the "court order" section of the form that parental consent is provided and no further court action is necessary.

(3) **Identifying Information -** this section of the form may be completed by a nurse, social worker, probation officer or caregiver.

(4) **Medical History/Examination -** the prescribing physician must complete this and the "medications" sections of the form, and both sections must be legible and complete. Include all specific information requested. Any clinical information that clarifies the treatment plan may be attached.

(5) **Medications -** this section of the form must be completed by the prescribing physician. The physician must list all prescribed medications the child currently takes and will take if the request is granted, whether or not prescribed by the requesting physician. The physician is encouraged to indicate the range of dosages to be authorized. If the physician does not indicate the range of dosages, a new form will be required for each change in the dosage schedule.

(6) Explanation to child - The prescribing physician must explain, in age-appropriate terms to the child: (a) the recommended course of treatment, (b) the basis for it, and (c) its possible results, including side effects, if any.

(7) **Submission of form -** the form may be sent or faxed to the juvenile court. The prescribing physician must accept telephone inquiries from the judicial officer, child's attorney, Court Appointed Special Advocate (CASA), or Juvenile

Court Mental Health Unit ("JCMHU") regarding the pending request for prescription and administration of psychotropic medication. The physician must include a telephone number on the form where he/she can be reached personally and quickly, if necessary.

D. Immediate prescription and administration of psychotropic medication limited to emergency situations - Detailed information regarding and defining emergency situations can be found in the complete Psychotropic Medication Protocol (that can be obtained from your senior program coordinator or peer coordinator).

E. Psychotropic desk clerk - will: (1) receive the form and log it, (2) send copies of the form to JCMHU and parent or legal guardian, and (3) retrieve the case file.

F. Requirement of parental notice - Prior to the juvenile court authorizing administration of psychotropic medications in non-emergency situations, the child's parent or legal guardian must be provided notice of the request.

G. Juvenile Court Mental Health Unit - JCMHU will (1) review the form, (2) recommend to the juvenile court either to grant, modify, deny, or seek more information, and (3) send the form back to the psychotropic desk clerk.

Recommendation of denial or request for more information - If JCMHU recommends a denial or that more information is required, the psychotropic desk clerk will give the form and file to the appropriate courtroom for same-day processing. If the request is then denied by the court, the courtroom clerk will immediately return the form to the psychotropic desk clerk for processing. The psychotropic desk clerk will provide notice of the denial to the physician and appropriate entities that same day. The physician can: (1) call the JCMHU for assistance, or (2) resubmit a new form with more information and indicate that it is a new submission. The court may also set a noticed hearing on the JCMHU recommendation of denial or request for further information. Upon receiving notice of the denial, the child's social worker is to verify with the physician that the child is no longer receiving the emergency psychotropic medication.

H. Court determination process - the psychotropic desk clerk will send the form and file to the appropriate courtroom. Once the courtroom receives the form and file from the psychotropic desk clerk, the child's attorney is to review the form within 24 hours. Each courtroom shall adopt a procedure to assure that the child's attorney is provided notice of and opportunity to review the form. The juvenile court may approve, modify or deny the request but must do so no later than the following court day unless the court expressly grants a one day continuance to the child's attorney for additional review time.

If the form is signed by a parent or legal guardian with legal custody, the court will verify the person's signature. If the signature can be verified and is proper, the court will indicate that no court action is required in the court order section of the form.

III. Continued treatment - The order authorizing psychotropic medication for a child is valid for up to six months unless otherwise ordered by the juvenile court. The physician must complete a new form to continue the medication when the authorization expires after six months or after the time otherwise ordered by the court. However, the physician can prescribe and administer a continued medication pending a renewal order from the court. A new authorization is not require when a child changes facilities or physicians as long as the medication, strength and dosage range remain the same and as long as the authorization paperwork and medication follow the child.

IV. Child's right to refuse

A. Child 12 years old or older - the juvenile court is in the process of adopting a policy on a child's right to refuse psychotropic medication in cases where a child is not in a juvenile detention facility. Once adopted, the policy will be incorporated into or cross-referenced within the Psychotropic Medication Protocol.

B. Child 11 years old or younger - the juvenile court is in the process of adopting a policy on a child's right to refuse psychotropic medication in cases where a child is not in a juvenile detention facility. Once adopted, the policy will be incorporated into a cross-reference within the Psychotropic Medication Protocol.

Table 2:

Psychotropic Medications

Medication Type	Subgroup	Common Medications	Typical Side Effects (not all inclusive)	Symptoms/ Issues Targeted
Antidepressants	SSRIs (Selective Serotonin Reuptake Inhibitors)	• Citalopram (Celexa) • Escitalopram (Lexapro) • Fluoxetine (Prozac)* • Fluvoxamine (Luvox) • Paroxetine (Paxil) • Sertraline (Zoloft)	• Headache • Agitation • Nervousness • Feeling emotionless • Decreased appetite • Suicidal ideation • Stomach upset • Fatigue • Sexual dysfunction	Symptoms of depression including depressed mood, lethargy, anhedonia, inability to sleep, excessive sleep, and isolation/withdrawn behavior; can also be used in the treatment of anxiety. *Only antidepressant approved for use in children age 8 and older for depression
	Tricyclics	• Clomipramine (Anafranil) • Amitriptyline (Elavil) • Desipramine (Norpramin) • Imipramine (Tofranil) • Doxepin (Sinequan)	• Stomach upset • Headache • Tiredness • Appetite increases • Dry mouth • Urinary retention • Dizziness/drop in blood pressure when going from sitting to standing	
	MAOIs (Monoamine oxidase inhibitors)	• Phenelzine (Nardil) • Tranylcypromine (Parnate)	• Sleepiness • Dizziness • Feelings of skin prickling • Insomnia • Dry mouth • Diarrhea • Nervousness • Muscle aches • Weight gain • Sexual dysfunction • Blood pressure changes	
	Others	• Trazodone (Desyrel) • Venlafaxine (Effexor) • Mirtazapine (Remeron) • Nefazodone (Serzone) • Bupropion (Wellbutrin)	• Seizures • Headache • Appetite changes • Restlessness • Agitation • Hostility • Dizziness	
Antipsychotics	Typical	• Haloperidol (Haldol) • Loxapine (Loxitane) • Thioridazine (Mellaril) • Thiothixene (Navane) • Fluphenazine (Prolixin) • Mesoridazine (Serentil) • Trifluoperazine (Stelazine) • Chlorpromazine (Thorazine) • Perphenazine (Trilafon)	• Weight gain • Involuntary repetitive movements • Agitation • Dizziness • Excess salivation • Lowered white blood cell count • Sexual dysfunction • Joint stiffness • Tardive dyskinesia	Thought disorders such as schizophrenia and psychosis; symptoms such as hallucinations, delusions, impaired judgment, severe difficulty with social interaction, loose associations, and paranoia.

Table 2:

Psychotropic Medications (continued)

Medication Type	Subgroup	Common Medications	Typical Side Effects (not all inclusive)	Symptoms/ Issues Targeted
Antipsychotics	Atypical	• Aripiprazole (Abilify) • Clozapine (Clozaril) • Ziprasidone (Geodon) • Risperidone (Risperdal) • Quetiapine (Seroquel) • Olanzapine (Zyprexa)	• Weight gain • Agitation • Sexual dysfunction • Tiredness • Lactation • Sleepiness • Heart problems • Stiffness	Thought disorders such as schizophrenia and psychosis; symptoms such as hallucinations, delusions, impaired judgment, severe difficulty with social interaction, loose associations, and paranoia.
Anti-anxiety		• Lorazepam (Ativan) • Buspirone (BuSpar) • Prazepam (Centrax) • Propranolol (Inderal) • Clonazepam (Klonopin) • Escitalopram (Lexapro) • Chlordiazepoxide (Librium) • Oxazepam (Serax) • Atenolol (Tenormin) • Clorazepate (Tranxene) • Diazepam (Valium) • Alprazolam (Xanax) • Guanfacine (Tenex) • Diphenhydramine (Benadryl) • Catapres (Clonidine) • Hydroxyzine (Vistaril)	• Confusion • Sleepiness • Agitation • Hallucinations • Fear • Psychosis • Rage • Memory impairment • Slurred speech • Lethargy • Spaciness • Disorientation • Suicidal ideation	Symptoms including racing thoughts, feelings of overwhelming dread, rumination, excessive worry, excessive fear, tension, inability to sleep, inability to concentrate/ focus and irritability.
Attention Deficit/ Hyperactivity	Stimulants	• Amphetamine (Adderall) • Lisdexamfetamine (Vyvanse) • Dextroamphetamine (Adderal) • Pemoline (Cylert) • Dextroamphetamine (Dexedrine) • Methylphenidate (Ritalin and Concerta) • Dexmethylphenidate (Focalin)	• Appetite disturbances • Weight loss • Agitation • Sleep disruptions • Insomnia • Rage • Disorganization • Compulsions • Obsessive thoughts • Forgetfulness • Nervous movements • Suicidal ideation	Symptoms such as inability to focus, severe distractibility, inability to sit, fidgeting, irritability, impulsivity, excessive daydreaming, difficulty following directions/ listening, blurting out statements or words, and aggression.
	Non-Stimulants	• Guanfacine (Intuniv) • Atomoxetine HCL (Strattera)	• Irritability • Sexual dysfunction • Suicidal ideation • Blood pressure issues	
Anti-panic		• Clonazepam (Klonopin) • Paroxetine (Paxil) • Alprazolam (Xanax) • Sertraline (Zoloft)	• Drowsiness • Lack of coordination • Suicidal ideation • Agitation • Disruption of feeling intensity	Panic attacks with symptoms such as sudden fear, impending doom, or nervousness, physical symptoms such as sweating, rapid heartbeat, increased breathing, chest pains, and feeling as if one is dying. Symptoms are present without any actual threat present.

Medication Type	Subgroup	Common Medications	Typical Side Effects (not all inclusive)	Symptoms/ Issues Targeted
Anti-obsessive		• Clomipramine (anafranil) • Fluvoxamine (Luvox) • Paroxetine (Paxil) • Fluoxetine (Prozac) • Sertraline (Zoloft)	• Agitation • Drowsiness • Sleep disruption • Appetite disturbances • Headache • Nervousness • Feeling emotionless • Suicidal ideation • Stomach upset • Fatigue • Sexual dysfunction	Obsessive thoughts that are repetitive and unwanted (they can come in words or pictures and can be violent, sexual, or scary); extreme fear of something such as germs, dirt, or contamination; fears that doors are not locked or the oven was left on; impulsive thoughts of hurting someone or shouting bad things at people; or a fixation on a negative thought or event.
Mood Stabilizers		• Valproic acid (Depakene) • Depakote • Eskalith • Lithium (Lithobid) • Lithonate • Lithotabs • Lamotrigine (Lamictal) • Gabapentin (Neurontin) • Carbamazepine (Tegretol) • Topiramate (Topamax)	• Weight gain • Tremors • Nausea • Appetite disturbances • Blurred vision • Dry mouth • Hives • Giddiness • Elimination disturbances • Seizures • Ringing in the ears	Illnesses such as bipolar disorder for symptoms such as rapid mood shifts, periods of euphoria and periods of depression, paranoia, excessive sleep periods, excessive wake periods, and impulsivity.
Sleep Medications		• Zolpidem (Ambien) • Amobarbital (Amytal) • Lorazepam (Ativan) • Diphenhydramine (Benadryl) • Chloral Hydrate • Triazolam (Halcion) • Eszopiclone (Lunesta) • Phenobarbital • Estazolam (prosom) • Temazepam (Restoril) • Alprazolam (Xanax)	• Sleepiness • Sleep walking • Dry mouth • Lack of coordination • Hallucinations	Inability to sleep, insomnia, frequent night awakening, repetitive nightmares.
Alpha Agonists		• Guanfacine (Tenex or Intuniv) • Catapres (Clonidine)	• Constipation • Dizziness • Drowsiness • Dry mouth	Used in attention/ hyperactivity disorders, to reduce anxiety, and to help regulate emotions.
Hormonal Agents		• Drospirenone and ethinyl estradiol (Yaz and Beyaz)	• Blood clots (especially when smoking) • Water retention • Irritability	Premenstrual dysphoric disorder including severe mood dysregulation.

Source: Adapted from National Alliance on Mental Illness. *Commonly Prescribed Psychotropic Medications*, available at www.nami.org.

Table 1:

Common School-age Child and Adolescent DSM-IV-TR Diagnoses

Mood Disorders

- **Depression**
- **Depression with psychotic features**
- **Bipolar disorder**

Mood disorders are a group of disorders that reflect disturbances in mood stability. Mood issues are the primary feature of the disturbance and children/teens seem stuck in a cycle of depressed mood as in depression or fluctuate their moods quickly, from depressed to euphoric or angry, as in bipolar disorder.

Anxiety Disorders

- **Obsessive-compulsive disorder**
- **Post traumatic stress disorder**
- **Generalized anxiety disorder**

With anxiety disorders, the underlying feature is rooted anxiety. This can be a general state where anxiety is present fairly consistently as in generalized anxiety disorder, where the anxiety is manifested in repetitive behaviors or chronic worries as in obsessive compulsive disorder, or the anxiety is generated by a trauma or extreme stressor has triggered other symptoms such as hypervigilance and nightmares as in post traumatic stress disorder.

Thought Disorders

- **Schizophrenia**
- **Psychotic disorder**

Thought disorders are those that interfere with coherent, rational thinking and the ability to process incoming information and events. There can be disturbances in thinking and the ability to make sense of things. There can also be additional symptoms, such as visual hallucinations, hearing voices, or believing things are happening when they are not.

Attention-Deficit and Disruptive Behavior Disorders

- **Attention-deficit hyperactivity disorder**
- **Conduct disorder**
- **Oppositional defiant disorder**

This group of disorders is rooted in the ability to manage one's behavior and attention. ADHD is related to the ability to pay attention, prioritize, and process information. Conduct disorder is essentially a disregard for rules and authority figures and may involve criminal involvement. Oppositional defiant disorder is generally a reluctance to follow caregiver rules or school rules.

Elimination Disorders

- **Enuresis**
- **Encopresis**

These disorders involve an inability to manage one's elimination of either urine or stool after successful potty training. The underlying issues often involve anxiety or trauma.

Other Disorders of Infancy, Childhood or Adolescence

- **Separation anxiety disorder**
- **Reactive attachment disorder**
- **Anorexia**
- **Bulimia**

Separation anxiety disorder is rooted in difficulty separating from a caregiver. Reactive attachment disorder reflects a traumatized pattern of relationships. Anorexia/bulimia are eating disorders that often first appear in adolescents.

Note: the DSM-IV-TR refers to the Diagnostic Statistical Manual of Mental Disorders IV, Text Revision

Children's Law Center of California

MEMORANDUM

TO: **Psychotropic Medication Committee**
FROM: **Children's Law Center of California**
DATE: **June 5, 2012**
RE: **Policy Recommendations to Promote Medical Decision-Making Readiness**

Dependents and wards must have the tools to make informed decisions about their health and mental health when they reach adulthood. For example, some child clients have severe diabetes and cannot survive without their insulin; others take psychotropic medication to enable normal functioning. It is critical that these clients develop an understanding of their medical conditions, and know how to continue treatment, access medication, etc. Below are initial recommendations regarding policy that can better prepare dependents and wards to make medical decisions once they reach age 18.

- Policy should ensure that youth have practical experience and can reach certain milestones.

  I.e.:

  - ✓ By age 14, youth knows which medications s/he is taking and can articulate why.
  - ✓ By age 15, with the youth's consent, a trusted adult is indentified (family, parent, caregiver, social worker, etc.) who can be made aware of the medical needs.
  - ✓ By age 16, youth should begin responsibility for taking meds, with caregiver assistance.
  - ✓ By age 17.5, youth should make medical/mental health appointments and refill prescriptions, initially with caregiver assistance, then with caregiver "check-ins."
  - ✓ By age 18, youth should:

    1. Understand that even if the case is open, s/he will be making decisions about health and mental health.
    2. Have copies of health and mental health history, and know how to have it transferred to a new doctor, therapist, etc. This should include:

       - Contact information for doctors
       - Therapist/psychiatrist contact information

- Medications
- Hospitalizations
- Diagnoses
- Evaluations

3. Know how to access regular treatment.
4. If check-ups beyond an annual physical are needed, youth should know why, where and with whom.
5. Know about the medications prescribed, including:
    - What medication(s)
    - Why it is prescribed
    - The correct dosage
    - Side effects and any red flags
    - How to refill prescriptions
    - How to make appointments to get new prescriptions
    - What do to if they wish to stop taking the medication and what the side effects might be

RESPONSIBILITIES

Children's Law Center of California

1) Collaborate with CSW/PO to ensure that youth have the opportunity to meet the goals/milestones identified above and are receiving the necessary information.
2) Communicate with youth about significance of consenting to medical treatment.
3) Bring to the court's attention any concerns.

CSW/Probation Officer

1) Identify goals/milestones in the case plan or TILP.
2) Work with caregiver, trusted adults and/or other relevant individuals (i.e. wraparound, FFA or group home case manager, etc.) to ensure they understand the goals/milestones and what, if any, role they will play in assisting the youth to reach those goals/milestones.
3) Assist youth in working with treating physician to ensure they are receiving the information detailed above.
4) If youth are not meeting the goals/milestones or do not have the information detailed above, provide linkage to adult services, such as regional center, adult mental health & systems of care. Collaborate with adult DMH, regional center workers or medial professionals to identify potential services, placements, etc
5) Inform the court and counsel of the status of the goals/milestones in court reports.

Court

1) Ensure case plan/TILP identify appropriate goals/milestones, and that youth are receiving assistance to meet such goals/milestones.

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CHAMBERS OF
MICHAEL NASH
PRESIDING JUDGE

August 7, 2012

TO: All Juvenile Court Judicial Officers
Department of Children and Family Services
Probation Department
All Juvenile Court Attorneys

FROM: Michael Nash, Presiding Judge
Los Angeles Juvenile Court

SUBJECT: PSYCHOTROPIC MEDS AND YOUTH REACHING THE AGE OF MAJORITY

The following memo shall be effective immediately.

Each year, hundreds if not thousands of youth under the jurisdiction of our Dependency and Delinquency Courts turn 18. Many of those youth transition out of our courts through termination of jurisdiction and some remain under court jurisdiction through AB12/212 or otherwise. Many of these youth are taking medication, including psychotropic medication. By virtue of reaching the age of majority, they have the right to make all important decisions concerning their lives, including medical decisions.

Currently, there is no policy, practice or procedure in place to ensure that these youth are prepared to deal with the myriad of issues they need to with respect to medications, especially psychotropic medications. This memo is intended to serve as a starting point for judicial officers, attorneys, social workers and probation officers and others as we attempt to deal with this issue.

Whenever a youth is before our courts for a hearing to terminate jurisdiction and the youth is 18 or older, or whenever a youth is before the court to determine whether the court will maintain jurisdiction through AB 12/212 or for other reasons and the youth is 18 or older, the court must determine if that youth is taking medication, including psychotropic medication. If the answer is yes, the following questions should be asked:

1. Is the youth aware of the specific medications being taken and the doses?

2. Is the youth aware of the reason for the medications?
3. Is the youth currently being seen by a doctor who prescribes and monitors the medication?
4. Is the youth participating in any therapy along with the medications?
5. Does the youth have medical insurance in place in order to continue taking the medications and maintaining the relationship with the prescribing/treating physician and therapist?
6. Does the youth know how and where to refill prescriptions?
7. Is the youth aware of any damages in stopping their medications?

If the answer to any of these questions is no, the court should consider continuing the case so that the attorney, probation officer or social worker can do whatever is necessary to work with the youth, caregiver, physician and any other necessary individual(s) to ensure that the youth has the ability to move forward with these issues. With respect to AB12/212 youth or youth remaining under court jurisdiction for other reasons, continuing the matter should not be a problem. With respect to youth leaving the system, it may take some persuasion to obtain consent for the continuance. However, even in the event of a refusal, the above individuals or entities should still attempt to work with the youth with respect to this issue.

Obviously, dealing with this issue should occur before the youth turns 18 and this will be our future task. However, as I said earlier, this is just our starting point in our process as we still have many youth who are turning 18 and others still in our system who have reached that age. Hopefully, we can begin to reach a good many of those youth immediately.

MN:ns

Glossary

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GLOSSARY

Abandonment: Act of a parent or caretaker leaving a child without adequate supervision or provision for his/her needs for an excessive period of time.

Abrasion: Wound in which an area of the body surface is scraped of skin or mucous membrane.

Adjudication: The process of rendering a judicial decision about whether the facts alleged in a petition or other pleading are true.

Admissible: Legally proper to be used as evidence. Admissible evidence is used by the trier of fact to decide a question of fact.

Admission: Voluntary statement that a fact is true.

Adoption: The social, emotional, and legal process through which children who will not be raised by their birth parents become full and permanent legal members of another family while maintaining genetic and psychological connections to their birth family.

Adoption Assistance & Child Welfare Act of 1980 (P.L. 96-272)
Federal law mandating that in order to be eligible for federal funds, states must document that they have when possible made reasonable efforts to provide preventive and reunification services to families when children have been placed out of the home. Removal of children from the home must be pursuant to a judicial determination and there must be periodic reviews of the case.

Advocacy: Intervention strategy in which a helping person assumes an active role in assisting or supporting a specific child and/or family or a cause on behalf of children and/or families. This could involve finding and facilitating services for specific cases or developing new services or promoting program coordination. The advocate uses his/her power to meet client needs or to promote causes.

Affidavit: A written statement of facts, which is sworn to (or affirmed) before an officer who has authority to administer an oath (e.g., a notary public). Before signing this statement, the person signing takes an oath that the contents are, to the best of his or her knowledge, true. It is also signed by the person administering the oath, to affirm that the person signing the affidavit was under oath when doing so. These documents carry great weight in courts to the extent that judges frequently accept an affidavit in place of the testimony of the witness.

After-court visit: Visitation between any person having a relationship with the child and a child that takes place immediately following a hearing.

Against Medical Advice (AMA): Going against the orders of a physician. In cases of child abuse or neglect, this usually means the removal of a child from a hospital without the physician's consent.

Allegation: An assertion or statement of a party to a legal action. In a child abuse case, the allegation forms the basis of the petition or accusation containing charges of specific acts of maltreatment, which the petitioner hopes to prove at trial.

Appeal: The attempt to have a final order of a trial court changed by seeking review of a higher court. Usually appeals are made and decided on questions of law only; issues of fact (e.g., did the minor suffer an accident, or was he intentionally injured?) are left to the trial judge or jury, and seldom can be decided in an appeal.

Arraignment: The formal presentation of allegations to the people the allegations are being made against. Parents and attorneys determine how they want to proceed (i.e., admit the allegations and enter a plea, agree to mediation (with a social worker's report), or deny the allegations and set the matter for adjudication) when they are arraigned.

Appearance Hearing: A hearing at which parties to the action are served with a notice advising them that a hearing will be held and they have a right to appear.

Attachment: The psychological connection between people that permits them to have significance to each other. An affectionate bond between two individuals that endures through space and time and serves to join them emotionally. A strong and enduring bond of love that develops between a child and the person(s) he or she interacts with most frequently.

Attention-Deficit Disorder With or Without Hyperactivity (AD/HD): A behavioral diagnosis in which children express or exhibit symptoms of inattention, distraction, restlessness, inability to sit still, and difficulty concentrating. Thought to be caused by both inherited and environmental factors. Treatable through behavior management and/or the use of medication.

Attorney Order: A document, which memorializes any order made by the Court. When Attorney Orders are generated at a hearing it is because the language of the orders are extensive and specific and cannot be captured by the clerk for inclusion in the Minute Order. Attorney Orders are also another way to get a court order without holding a hearing.

Autism: A developmental disability affecting verbal and nonverbal communication and social interaction. It is generally evident before age three. Some persons with autism are unable to speak at all, or if they do, use peculiar patterns of language. Autism is a physical disorder that distorts the way the brain processes information. Causes of autism include trauma at birth, prenatal viruses, encephalitis, spinal meningitis, tuberous sclerosis and rubella (German measles).

Bailiff: A law enforcement officer (in Los Angeles the Bailiff is a Los Angeles County Deputy Sheriff) assigned to a courtroom to keep peace and assist the judge, courtroom clerks, and witnesses. In dependency court the bailiffs are sometimes responsible for

checking in clients in the morning and making a list on the board in the court of all parties present. Their primary responsibility is to protect the safety of the courtroom and oversee clients who are incarcerated.

Battered Child Syndrome: A medical condition, primarily seen in infants and young children. Evidence of the syndrome includes repeated nonaccidental injury to the nerves, skin, or skeletal system. Frequently, the history given by the caretaker does not explain the nature of occurrence of the injuries. Also called parent-infant-trauma syndrome (PITS) or maltreatment syndrome.

Battered Women: Women who are victims of nonaccidental physical and psychological injury inflicted by a partner. There is often a relationship between partner abuse and child abuse, with both occurring in the same family.

Best Interest of the Child: The standard that the CASA volunteer uses in choosing a course of advocacy for every child.

Bias: A personal belief which impedes ones ability to exercise sound judgment.

Bifurcated: In two parts or sections. A hearing held in two parts is called a bifurcated hearing.

Bisexual: Attracted to both men and women.

Bonding: The psychological attachment of caregiver (usually mother) to child, which develops during and immediately following childbirth. The aptitude for bonding, which appears to be crucial to the development of a healthy parent-child relationship, may be observed immediately following delivery to help identify potential families-at-risk.

Borderline Personality: A psychiatric diagnosis with the essential feature being a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts.

Burden of Proof: A party's duty to prove a disputed assertion or charge; the duty to prove allegations of a petition in a court hearing. It is the petitioner's responsibility to prove the case. Neither the child nor the parents have the duty to explain unproven allegations.

Calendar: The court calendar is the list of cases to be called for hearing before a particular judge.

Calendar Call: A court session dedicated to determining the status of all cases awaiting hearing on that day, i.e., identifying presence of parties, receipt of reports, and readiness of attorneys.

Caretaker: Any person taking care of a child.

CASA: A volunteer child advocate who works to see that a child's best interest is served in a court case.

Cerebral Palsy: A disability resulting from damage to those parts of the brain that control and coordinate the muscles. This brain damage occurs before or during birth or in the first few years of life. Causes are lack of oxygen to the developing brain, infections or disease, physical injury, premature birth, or blood type incompatibility between parents. Cerebral palsy is neither hereditary nor contagious. About seven hundred thousand people in the United States have cerebral palsy. Specific characteristics, which may occur alone or in combination, include spasticity, marked by tense, contracted muscles; athetosis, involuntary exaggerated movements of the arms, legs, and head; and ataxia, poor sense of balance and depth perception. Cerebral palsy may occur with other handicaps.

Child Abuse Prevention and Treatment Act (CAPTA) (P.L. 93-247)
Act introduced and promoted in Congress by U.S. Senator Walter Mondale and signed into law on January 31, 1974. The act established the National Center on Child Abuse and Neglect in the HEW Children's Bureau and authorized annual appropriations. The purpose of the center is to conduct and compile research; provide an information clearinghouse; compile and publish training materials; provide technical assistance; investigate national incidence; and fund demonstration projects related to prevention, identification, and treatment. *See Chapter 2 for additional information.*

Child Advocacy: Strategy for intervention in which a helping person assumes an active role in assisting or supporting a specific child and/or family or cause on behalf of children and/or families. This could involve finding and facilitating services for specific cases, developing new services, or promoting program coordination. The advocate uses his or her power to meet client's needs or to promote causes.

CASA of Los Angeles: The name of the CASA program in Los Angeles County. CASA of Los Angeles recruits, trains and supports community volunteers to serve as Court Appointed Special Advocate volunteers.

Child Abuse: An intentional or neglectful physical or emotional injury imposed on a child, including sexual molestation or emotional abuse.

Child Protective Services (CPS): The agency with exclusive power to file abuse, neglect, or dependency petitions in court. In the County of Los Angeles it is the Department of Children and Family Services.

Child Sexual Abuse: Any sexual act inflicted on child. Any act which comports to the definition in WIC §300(d).

Child Sexual Abuse Accommodation Syndrome: A pattern of behavior in a child who is being sexually abused. The child victim will progress through five stages: secrecy, helplessness, entrapment and accommodation, delayed and conflicting disclosure, and retraction. Large numbers of children and their parents in proven cases of child sexual abuse exhibit this behavior pattern in order to maintain the child abuse victim within the family. However, such abuse tends to isolate the child from eventual acceptance and credibility within the larger society.

Children's Social Worker (CSW): A social worker employed by the Department of Children and Family Services.

Civil Proceeding: Also called a "civil action." Includes all lawsuits other than criminal prosecutions. Juvenile and family court cases are civil proceedings.

Clear and Convincing Evidence: Evidence indicating that the thing to be proved is highly probably or reasonably certain; this is a greater burden than preponderance of the evidence but less than beyond a reasonable doubt. This is the level of proof needed to grant emergency custody or to terminate parental rights (except in ICWA cases). See also **Standard of Proof**.

Community-Based Program: A program providing nonresidential or residential services to a juvenile in the community where his family lives. A community-based program may include specialized foster care, family counseling, shelter care, and other appropriate services.

Competency: The legal fitness or ability of a witness to be heard on the trial of a case. All persons are presumed to be competent witnesses, including very young children. A person challenging a witness's competency must show that either the witness cannot communicate information to the judge or jury or doesn't comprehend the difference between right and wrong.

Concurrent Planning: A permanency planning strategy for assuring an expedient permanent placement for a child. Planning for reunification occurs simultaneously with the development of alternative permanency plans, including adoption, to be used in the event that it is not possible for the child to return to his or her family of origin.

Concussion: An injury to the soft structure of the brain.

Confidentiality: The nondissemination of information that must be kept confidential. In child abuse and neglect matters, the CASA has access to all records pertaining to the child (unless federally protected), but may release such information to other parties only by court order or as designated by law.

Conflict Resolution: The capacity to resolve conflicts without having to resort to aggression. The process of conflict resolution may be done with the assistance of a neutral third party.

Congenital: Refers to any physical condition present at birth.

Consent Order: An official agreement by all parties to settle the case upon certain specified terms and submit it to the judge for approval.

Contempt: Any willful disobedience to, or disregard of, a court order or any misconduct in the presence of a court. An action that interferes with a judge's ability to administer justice or that insults the dignity of the court. Punishable by fine or imprisonment or both.

Continued or Continuance: Instance when a trial, hearing, or other court appearance is postponed to a later date. This is done by order of the court either upon agreement by the parties' attorneys or by one party's request and over the objection of other parties. In most cases, the new hearing date is set at the time of the continuance.

Contraindication: Reason for not giving a particular drug or prescribing a particular treatment, as it may do more harm than good.

Contusion: A wound-producing injury to soft tissue without a break in the skin, causing bleeding into surrounding tissues.

Corporal Punishment: Physical punishment inflicted directly upon the body.

County Counsel: In dependency court the county counsel is the attorney assigned to represent the Department of Children and Family Services (the Children's Social Worker).

Court Appointed Special Advocate (CASA): CASAs are volunteers appointed by Dependency Court judges to conduct independent investigations of children's circumstances in the foster care system and report their findings to the court.

Court Clerk: A court employee responsible for overseeing the courtroom's administration, especially to assist in managing the flow of cases through the court and to maintain court records and prepare Minute Orders.

Court Officer: A Department of Children and Family Services Children's Social Worker assigned to a courtroom. The Court Officer organizes and hands out DCFS reports and functions as a liaison between the Children's Social Worker in the field and the County Counsel.

Court Order/Judgment: Directive issued by the court, having the authority of the court, and enforceable by law.

Court Report: A written document presented to the court by the Children's Social Worker or CASA which usually states the needs of the child and makes recommendations.

Credibility: Believability of a person, especially a witness.

Criminal Prosecution: The process involving the filing of charges of a crime, followed by arraignment and trial of the defendant. Criminal prosecution may result in fines, imprisonment, and/or probation. Criminal defendants are entitled to acquittal unless charges against them are proven beyond a reasonable doubt. Technical rules of evidence exclude many kinds of proof in criminal trials, even though that proof might be admissible in civil proceedings.

Cross-Examination: The questioning of an opposing party's witness.

Cultural Awareness: A set of attitudes, beliefs, and actions based on continuing exploration of, understanding about, and respect for individual and cultural differences.

Culture: A learned pattern of customs, beliefs, and behaviors, socially acquired and socially transmitted through symbols and widely shared meanings. Culture is an organized group of learned responses—a system of ready-made solutions to the problems of people.

Custodian: The person or agency that has been awarded legal custody of a juvenile by a court. This may also be a person, other than a parent or legal guardian, who has assumed the status and obligation of a parent without being awarded the legal custody of a juvenile by a court.

Custody: The right to a child's care and control, carrying with it the duty of providing food, shelter, medical care, education, and discipline.

Cystic Fibrosis: A genetic disease characterized by severe respiratory and digestive problems. The disorder involves the body's inability to regulate salt secretions. This inability leads to damage of the lungs and pancreas. It also limits the child's ability to conserve salt. Children with cystic fibrosis have chronic lung infections, scarring on their lungs that leads to lung disease, and a pancreas that does not function well. The latter causes juvenile diabetes. The child may also dehydrate quickly during exercise. Children and teens suffering from cystic fibrosis require pulmonary therapy several times a day to clear their lungs.

Day Treatment: Program providing treatment as well as structured supervision for children with identified behavioral problems, including abused and neglected children, while they remain in their own, foster or group homes. Day treatment services usually include counseling with families or caretakers with whom the children reside.

Deficit Model: A method of assessing and treating family or individual problems that focuses on a family's weaknesses, and sets as the primary goal getting them off public services. In this model, it is the caseworker's role to find out what is wrong with the family and to decide how best to "fix it."

Delinquent Juvenile: Any minor who has been found by a court of law to have committed an act that would be a crime or infraction under state law or under an ordinance of local government, including violation of the motor vehicle laws, if committed by an adult.

Department of Children and Family Services (DCFS): The County of Los Angeles Department of Children and Family Services is the public agency charged with the duty maintaining the welfare of children and families of children who are exposed to child abuse and/or neglect.

Dependency: Referring to cases of children whose natural parent(s) cannot or will not properly care for them or supervise them so that the state must assume this responsibility. The general term used to categorize abused or neglected children. The specific term used to indicate that the court has assumed some form of responsibility for the child.

Dependent Juvenile: A juvenile in need of assistance or placement because the juvenile has no parent, guardian, or custodian responsible for the juvenile's care or supervision or whose parent, guardian, or custodian is unable to provide the care or supervision and lacks an appropriate alternative child care arrangement.

Depression: The oldest recognized and most prevalent emotional disorder; it afflicts about fifteen percent of adults and many children. Depression can be difficult to diagnose because of its various origins, manifestations, and degrees of severity. Endogenous depression results from biochemical changes in the brain; reactive depression seems to be triggered by a life event such as a death or loss of property. Symptoms include significant emotional changes, including a depressed mood, sadness, gloom; spells of crying; anxiety; irritability; feelings of guilt and remorse; inability to concentrate; indecisiveness and loss of interest; loss of self-confidence and self-esteem; and desire to commit suicide. Unrecognized depression in young children may be characterized by chronic fatigue or boredom; inability to achieve at their intellectual potential; reluctance to leave home to go to school; and hyperactivity. Treatment for both children and adults is typically a combination of psychotherapy and psychoactive drugs. Psychological testing may be needed to identify and treat the disorder.

Detention: The temporary keeping (by public authority) of a person. In child abuse and neglect cases, minors are often detained in shelter care facilities, foster homes, group homes, or hospitals pending trial in Juvenile Court, when it is believed unsafe for the minor to remain with his or her own parents. This term also refers to the initial court hearing held 72 hours after a child has been removed from their home. At his hearing the Department of Children and Family Services files a petition with the court alleging abuse and/or neglect. The Department of Children and Family Services must show that removal

from the home was necessary to protect the child and no reasonable means were available to maintain the child at home.

Developmental Disabilities: A severe, chronic disability of a person attributed to a mental or physical impairment or a combination of mental and physical impairments. A developmental disability is manifested before the person is eighteen years old. It is likely to continue indefinitely and results in functional limitations in three or more of these major life activities:

1. Ability to talk and express oneself, ability to understand and follow simple directives;
2. Ability to dress self, brush teeth, use the toilet, etc.;
3. Ability to learn colors, shapes, letters, words, foods, and the like;
4. Ability to walk, run, or sit in a manner that is acceptable;
5. Ability to make decisions or to do what is expected;
6. Ability to live independently; and
7. Ability to partially support self.

Some examples of developmental disabilities are the lifetime conditions of mental retardation, cerebral palsy, epilepsy, autism, and severe dyslexia.

Differential Diagnosis: The determination of which of two or more diseases or conditions a patient is suffering from by systematically comparing and contrasting clinical findings.

Direct Examination: The process by which an attorney questions his or her own witness in order to present information to the court necessary for that attorney's case. The questions are usually open-ended: "Tell the court about …" or "Describe the condition of the home."

Discipline: Training that develops self-control, self-sufficiency, orderly conduct. Discipline is often confused with punishment, particularly by abusive parents who resort to corporal punishment. Although interpretations of both "discipline" and "punishment" tend to be vague and often overlapping, there is some consensus that discipline has positive connotations and punishment is considered negatively. Some general comparisons between the terms are:

- discipline can occur before, during and/or after an event; punishment occurs only after an event.
- Discipline is based on respect for a child and his/her capabilities; punishment is based on behavior or events.
- Discipline implies that there is an authority figure; punishment implies power and dominance vs. submissiveness.

- The purpose of discipline is educational and rational; the purpose of punishment is to inflict pain, often in an attempt to vent frustration or anger.
- Discipline focuses on deterring future behavior by encouraging development of internal controls; punishment is a method of external controls, which may or may not alter future behavior.
- Discipline can strengthen interpersonal bonds and recognizes individual means and worth; punishment usually causes deterioration of relationships and is usually a dehumanizing experience.
- Both discipline and punishment behavior patterns may be transmitted to the next generation.

Discovery: The system of pre-trial procedures which enable the parties involved in a court proceeding to find out about the positions taken by the other parties and the facts which those parties believe support their positions.

Discretion: Power to act allowing some leeway for action. "Discretionary action" is action not mandated or compelled by some rule, order or guideline.

Dismissal: Action by the judge that removes a given case from the court.

Disposition: In juvenile dependency court, the order that determines the child's placement, and/or treatment plan for the child, as well as the court orders that have to be complied with in order to get a child back into custody.

Dispositional Hearing: The juvenile court hearing in which evidence is presented and arguments made to design the most appropriate treatment and choose the most appropriate placement for the child. In many courts, the dispositional hearing immediately follows the adjudicatory hearing. This type of hearing is not bound by the strict rules of evidence required in an adjudication.

Dissociation: An involuntary, natural mechanism present in infancy and continuing throughout adulthood through which a person physically and/or mentally separates himself or herself to guard against unpleasant situations. Because children are limited in their coping abilities, they commonly use dissociation to protect themselves from all or part of their painful experiences. Dissociation may become a preferred or automatic response in children who live in a chaotic, chronically stressful, or traumatizing environment. It is these children's loss of awareness that enables them to perform, or at least survive emotionally, in their respective environments; however, the use of protective dissociation may become so extreme that it interferes with the child's functioning and development. Children's sense of identity becomes fragmented when they regularly cope with stressful situations by disowning parts of their experiences. This fragmentation of the self may solidify into distinct patterns that are perceived by the child and others around him or her as separate personality states, or multiple personality disorder.

District Court: The name of one of the courts of the United States. It is held by a judge, called the district judge. Several courts under the same name have been established by state authority.

Docket: Schedule of cases on the calendar to be heard by a court.

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

Down's Syndrome: The most prevalent genetic abnormality associated with mental retardation. It accounts for about thirty-three percent of all forms of genetically based mental retardation. Each year in the United States, some seven thousand children of all races and socioeconomic groups are born with Down's syndrome, representing an average rate of one in eight hundred births. Down's syndrome most commonly results from the presence of an extra number twenty-one chromosome.

Dual Diagnosis: Diagnosis of two types, i.e., when a person has been diagnosed with both a mental illness and substance abuse; or mental illness and developmental disability.

Due Process: The rights of persons involved in court proceedings to be treated with fundamental fairness. These rights include the right to adequate notice in advance of hearings, notice of allegations of misconduct, assistance of a lawyer, and the right to confront and cross-examine witnesses.

Emancipation: When a minor achieves legal independence from his or her parents by court order or by getting married before reaching the age of majority. Within the context of juvenile dependency it means a series of activities which need to be completed by a child who is in Long Term Foster Care before their case can be terminated.

Emergency Custody: Residential placement of a child alleged to be abused, neglected, or dependent in a licensed foster home, facility operated by Child Protective Services, or other home or facility approved by the court. The court, pending the adjudicatory hearing, may order such placement if the judge finds that placement with the parents is unsafe.

Emergency Custody Hearing: Hearing to determine if the child's immediate welfare demands continued placement out of the home.

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, unworthy of friendship, unworthy of the natural birthright of all children: love and protection.

Epilepsy: Seizures are the primary symptom of all forms of epilepsy, which is characterized by convulsions of the muscles, partial or total loss of consciousness, mental confusion, or disturbances of bodily functions usually controlled automatically by the brain and nervous system. Epilepsy occurs in one percent of the general U.S. population. The disorder occurs more

frequently in children than in adults. In about eighty percent of cases, the first seizure occurs within the first decade of life. No one knows for sure why brain cells discharge abnormally and cause the symptoms of epilepsy.

Ethnicity: A group classification in which members share a unique social and cultural heritage and pass it on from one generation to the next. However, ethnicity does not have to have a biological or genetic foundation.

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

Evidence: Any sort of proof submitted to the court for the purpose of influencing the court's decision.

Exhibit: Physical evidence used in court. In a child abuse case, an exhibit may consist of x-rays, photographs of the child's injuries, or the actual materials presumably used to inflict the injuries. See also **Evidence**.

Ex Parte: Latin term that refers to situations in which only one party (and not the adversary) appears before a judge. Although a judge is normally required to meet with all parties in a case and not with just one, there are circumstances where this rule does not apply and the judge is allowed to meet with just one side (*ex parte*) such as where a plaintiff requests an order (e.g., to extend time for service of a summons) or dismissal before the answer or appearance of the defendant(s). In addition, sometimes judges will issue temporary orders *ex parte* (i.e., based on one party's request without hearing from the other side) when time is limited or it would do no apparent good to hear the other side of the dispute. For example, if a wife claims domestic violence, a court may immediately issue an *ex parte* order telling her husband to stay away. Once he's out of the house, the court holds a hearing, where he can tell his side and the court can decide whether the *ex parte* order should be made permanent.

Expert Witness: A person who testifies at a trial because he or she has special knowledge in a particular field that might be helpful to a judge (or jury). This person is permitted to state his or her opinion concerning those technical matters even though he or she was not present at the event. Non-expert witnesses are only permitted to testify about facts they observed and not their opinions about these facts. An example of an expert witness is a child psychologist or development specialist who testifies about the best interest of the child when custody or visitation is in dispute.

Failure to Thrive Syndrome (FTT): A serious medical condition most often seen in children under one year of age. An FTT child's height, weight, and motor development fall significantly below the average growth rate of normal children. It is presumed that this failure to thrive is a result of inadequate nurturing, bonding, and attachment.

Family Preservation Services: Intensive, short-term service delivery programs that provide in-home family therapy and skills education/training and help families obtain basic services, such as food and housing, to prevent removal of the children from their home and keep the family together.

Family Risk Assessment: A written evaluation, often in a checklist format, completed after an investigative report is substantiated and at various other times throughout the case. This assessment is completed to determine the present risk to the child of remaining with or being returned to his or her family.

Felony: Any crime punishable by a year imprisonment or more.

Fetal Alcohol Syndrome (FAS): A condition in infants resulting from heavy alcohol consumption by the mother during pregnancy. Because alcohol easily crosses the placenta, its concentration in fetal blood equals that in maternal blood. Heavy alcohol intake during pregnancy is associated with numerous adverse effects on the fetus, including mental retardation, hyperactivity, irritability, growth deficiencies, poor suck reflex in infants, and behavioral and learning disabilities. Children with FAS often have distinctive facial characteristics, such as small eyes, short noses, a flat, long upper lip area, and flattened mid-face. Following birth, the infant may suffer from alcohol withdrawal. The incidence of FAS in the United States is about one in 750 births. Nearly all of these cases involve mothers who drink heavily—more than 445 drinks per month or more than five drinks on any single occasion (Kruse, J. (1984) "Alcohol Use During Pregnancy," *Journal of Family Practice.*). A similar, but less severe manifestation is called fetal alcohol effect (FAE).

Fine Motor Function: Primarily eye-hand coordination—the ability to receive and utilize signals from your eyes to perform tasks employing the fingers (e.g., tying shoe laces, playing electronic games, or building a model). A component of neuromotor functioning.

Fost/Adopt Placement: The placing of a child who is not yet legally free for adoption (but likely to be at some future time) with a family who agrees to serve as a foster placement for the time being and an adoptive family should that possibility occur.

Foster Care: A form of substitute care, usually in a home licensed by a public agency, for children whose welfare and protection requires that they be removed from their own homes.

Fracture: A broken bone. One of the most common injuries suffered by battered children.

Fragile X Syndrome: An inherited genetic condition associated with mental retardation. It is identified by a break or weakness on the long arm of the X chromosome.

Since this is an abnormality of a sex chromosome, mothers are carriers and their sons are at risk of being affected. Daughters are at risk of being carriers and sometimes of mild infection. The disorder is not transmitted from father to son.

Gross Motor Function: The ability to facilitate and monitor feedback from the body's large muscles (e.g., during athletic activities). A facet of neuromotor functioning. Also called "large motor function."

Group Home: Residential placement in a non-family living arrangement for children with special needs.

Guardian Ad Litem: From Latin meaning "guardian at law." A guardian, usually a lawyer, appointed by the court to appear in a lawsuit on behalf of an incompetent adult or minor defendant.

Hearing Officer: The judge, commissioner or referee hearing the juvenile court matter.

Hearsay: Secondhand information that a witness only heard about from someone else and did not see or hear directly. Hearsay is not admitted in court because it is not trustworthy, as well as because of various constitutional principles, such as the right to confront one's accusers; however, there are so many exceptions that hearsay is often admitted more than excluded.

Hematoma: A swelling caused by a collection of blood in an enclosed space, such as under the skin or the skull.

Homophobia: Irrational fear of, aversion to, or discrimination against homosexuality or homosexuals.

Individualized Education Plan (IEP): A written, legal document mandated by federal law to be developed for all students identified as needing special education services. It is developed in a team meeting in which parents, teachers, specialists, and the student, if appropriate, participate. The main goal of the IEP meeting is to discuss and review the educational needs of the student and write a program that identifies goals and objectives for the year.

Independent Living Program (ILP): A DCFS program to provide foster youth with the skills, experiences and assistance that will enable them to lead healthy, productive, responsible and self-sufficient adult lives.

Immunity, Legal: Legal protection from civil or criminal liability. Some states have reporting statutes that confer qualified immunity upon persons mandated to report, if the report was made in good faith, giving them a defense against libel, slander, invasion of privacy, false arrest, and other lawsuits that the accused person might file.

Impetigo: A highly contagious, rapidly spreading skin disorder that occurs mainly in infants and young children. The disease, characterized by red blisters, may be an indicator of neglect or poor living conditions.

In Camera: Latin term meaning, literally, "in chambers." A hearing or judicial proceeding conducted in a judge's chambers or a private place where the public is not present.

In Loco Parentis: Latin term meaning a person, other than parents or legal guardian, who has assumed the status and obligation of a parent without being awarded the legal custody of a juvenile by the court. This term is often used to refer to the court itself taking over what should be parental responsibilities.

Incest: A sexual act between two persons who are related. Includes descent by blood or adoption, stepchild (while marriage creating their relationship still exists), brother, half-brother, sister, half-sister, niece, and nephew. Incest may occur between members of the same sex, but the most common form of incest is between father and daughter.

Indian Child: Any unmarried person who is under age eighteen and either (a) is a member of an Indian tribe or (b) is eligible for membership in an Indian tribe and is the biological child of a member of an Indian tribe. (Note: There is another definition in the service provisions that is wider and may give a child the opportunity to access services. This can be important where a child can be enrolled because of failure to meet a residency requirement of a specific tribe but could access culturally relevant services. The third definition is in the notice section, which requires for the purpose of noticing a tribe that notice happen whenever the court knows or has reason to know the child may be an Indian.)

Individuals with Disabilities Education Act (P.L. 94-142): A federal law passed in 1975 and reauthorized in 1990, mandating that all children receive a free, appropriate public education regardless of the level or severity of their disability. It provides funds to assist states in the education of students with disabilities and requires that states make sure that these students receive an individualized education program based on their unique needs in the least restrictive environment possible. All children ages three through twenty-one who need special education and related services because of a disabling condition are eligible.

Interstate Compact for the Placement of Children (ICPC): Agreement between all fifty states and the District of Columbia that has been passed as law by the states and been approved by Congress, governing out-of-state placements of children. It defines financial and supervisory responsibilities and guarantees constitutional protections. It requires that a court secure a home study from the local child welfare agency in any out-of-state jurisdiction where placement is being considered.

Judicial Review: A hearing in the juvenile court anytime after the disposition hearing, to determine whether court jurisdiction and/or out-of-home placement orders shall continue. Judicial reviews are held no less frequently than every six months.

Jurisdiction: The legal authority and power of the court to hear particular types of cases.

Juvenile: Any person who has not reached his or her eighteenth birthday and is not married, legally emancipated, or a member of the armed services of the United States.

Laceration: A jagged cut or wound.

Leading Question: A question that suggests an answer or puts words in the mouth of the witness. Allowable only when directed to the opposing party in a lawsuit or to an "adverse witness" during cross-examination. Often a leading question will begin, "Isn't it true that …?"

Least Restrictive Alternative: The principle that supports family autonomy, with in-home services provided by the child welfare agency only where necessary and then in the form that least intrudes on family autonomy. Consideration of placement outside the home should start at the least restrictive level: other family members, foster home, and then institutional placement, as most restrictive.

Legal Guardianship: Legal guardianship suspends, but does not terminate, the rights and responsibilities of the birth parents. The guardian becomes the legal caregiver and is entitled to make all decisions concerning the child's health, education and well-being. All guardianships terminate once the child reaches eighteen (18) years old.

Lesion: Any injury to any part of the body from any cause that results in damage or loss of structure or function of the body tissue. A lesion may be caused by poison, infection, dysfunction, or violence, and may be accidental or intentional.

Live-Scan: Live-Scan is inkless electronic fingerprinting. The fingerprints are electronically transmitted to the Department of Justice (DOJ) for completion of a criminal record check.

Long Term Foster Care: Explains the status of a child's dependency case when they are not reunifying with anyone, not in a legal guardianship, and have not been referred for adoptive planning. The child remains in foster care until the age of eighteen or graduation from high school. The rights and responsibilities of the birth parents are not terminated, but the care and control of the child is transferred to the Juvenile Court.

Malnutrition: Failure to receive adequate nourishment. Often exhibited in neglected children, malnutrition may be caused by inadequate diet (either lack of food or insufficient amounts of needed vitamins) or by a disease or other abnormal condition affecting the body's ability to properly process foods.

Maltreatment: Actions that are abusive, neglectful, or otherwise threatening to a child's welfare. Frequently used as a general term for child abuse and neglect.

Mandated Reporter: Person designated by state statutes who are legally responsible for reporting suspected cases of child abuse and neglect to the authorities. The persons so designated vary according to state law, but they are primarily professionals, such as pediatricians, nurses, school personnel, therapists, social workers and in the State of California, CASAs.

Mediation: An informal setting in which parties to the action attempt to resolve issues without a formal hearing.

Medicaid: A government sponsored health insurance program that provides care based on financial need.

Medi-Cal: Medi-Cal is California's Medicaid health care program. This program pays for a variety of medical services for children and adults with limited income and resources. Medi-Cal is supported by federal and state taxes.

Medically Fragile: A number of subgroups make up medically fragile infants and children, including infants weighing less than 1,500 grams at birth; infants, children, and teens who become medically fragile because of an illness after birth (e.g., lupus, renal disease); infants, children, and teens who sustain serious injuries or child abuse; infants born with multiple defects involving malformations in a number of organ systems (e.g., Down's syndrome); and infants born addicted to alcohol or drugs because of the mother's substance abuse during pregnancy.

Mental Retardation: Significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior. It becomes apparent during the developmental period, thus adversely affecting a child's educational performance, and is a lifelong condition.

Minor: A person under the age of 18 years old.

Minute Order: The official record of the orders and findings made by the court.

Misdemeanor: A category of crime, for which the authorized punishment is no more than one year imprisonment (usually in county jail rather than state prison) or a fine of $1000 or both. Distinguished from a felony, which has more serious penalties.

Molestation: Sexual act with a child which is usually progressive in nature, beginning with fondling and escalating over time.

Monitored Visit (or contact): Visit, telephone call or correspondence between a parent or other party and child that is overseen by another person who is present at all times. Usually, monitored contact is recommended to ensure the contact is safe and appropriate. Monitors may be the Children's Social Worker, the placement or any other DCFS approved monitored. CASAs may not act as monitors.

Munchausen Syndrome By Proxy (MSP): A form of child abuse in which the parent/caretaker relates fictitious illnesses in the child by either inducing or fabricating the signs or symptoms. As a result, the child is subjected to extensive medical tests and hospitalizations. The technical definition of MSP includes: (1) an illness in a child that is faked and/or produced by a parent or caretaker; (2) a parent or parent figure who presents the child for medical care persistently, often resulting in multiple medical procedures; (3) denial of the knowledge by the perpetrator as to the etiology of the illness; and (4) acute symptoms, which abate when the child is separated from the parent/caretaker.

Neurosis: Marked emotional disorder without loss of contact with reality and a history of relatively normal developments.

Non-Offending Parent: A parent who is not named in the petition.

Non-Respondant Parent: Parent not involved in the court case.

Notice: Receipt of the petition by the parents, the CASA volunteer, or other parties to the case, which gives them fair warning of specific allegations sufficiently in advance of court proceedings so that reasonable opportunity to prepare will be afforded.

Objection: A formal statement by counsel that he or she protests something that has occurred in court and seeks the judge's immediate ruling on the point.

Oppositional Behavior: A tendency to be defiant and noncompliant, possibly as a reaction to chronic learning difficulties.

Order: In legal practice, an order is a written directive of a court judge.

Overrule: A judge's rejection of an attorney's objection to a question to a witness (i.e., the question is legally proper). By overruling the objection, the trial judge allows the question to be answered or the evidence to be considered.

Panel Attorney: An attorney in private practice who has been approved by the court to be appointed for parties who do not hire their own attorney. The appointment of a panel attorney is provided under WIC §317.

Parens Patria: Latin term meaning "the power of the sovereign." Refers to the state's power to act for or on behalf of incompetents, such as minors or some developmentally disabled persons.

Parenting Skills: A parent's competencies in providing physical care, protection, supervision and psychological nurturance appropriate to a child's age and stage of development. Some parents, particularly those whose own parents demonstrated these skills have these competencies without formal training, but adequacy of these skills may be improved through instruction.

Party: Any person or entity that has standing to participate in court proceedings. A person making or responding to a claim in a court or other adversarial proceeding. A person or entity who sues or defends a lawsuit or any person or entity joined in a lawsuit, such as a regional center, is called a party. A party has the right to conduct discovery and receive notice of all proceedings connected with the lawsuit.

Paternalism: A system under which an authority undertakes to supply needs or regulate conduct of those under its control in matters affecting them as individuals as well as in their relations to authority and each other.

Paternity: The court needs to make a determination of paternity on each case. The court may find different types of legal fathers. Some examples are alleged father, biological father and presumed father.

Perception: The process by which sensory stimulation is converted into organized experiences. What appears to you; what you believe to be true.

Permanency Planning Hearing (PPH): A hearing that is designed to look at the child's placement options, amount of time in care, the current plan, and further resources for the child.

Personality Disorders: An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

Petition: A civil pleading filed to initiate a matter in juvenile court, setting forth specifically the alleged grounds for the court to take jurisdiction of the case and asking the court to do so and intervene. The document filed in Juvenile Court at the beginning of a neglect, abuse or delinquency case. A copy of the petition must be delivered to specified members of the

family involved. The petition sets forth allegations, which, if true, form the basis for court intervention.

Petitioner: The individual who initiates court action, whether by filing a petition or a motion for review alleging the matter for adjudication. For child abuse, neglect, or dependency cases in Los Angeles County, the petitioner is the director of the Department of Children and Family Services (DCFS), with the Children's Social Worker who signed the petition acting as a representative of DCFS.

Physical Abuse: Intentionally harming a child, use of excessive force, reckless endangerment.

Placement: The removal of a child from his/her natural home, placing him/her in a different custodial setting for more than a short period of time. Placement may be in a foster home, group home, relative's home or institution.

Plaintiff: The person who initiates a lawsuit by filing a complaint. When the document that initiates a lawsuit is called a petition rather than a complaint, the initiating person is usually referred to as the petitioner rather than the plaintiff.

Prejudice: Preconceived judgment or opinion.

Prima Facie: A Latin term approximately meaning "on the first appearance" or "on the face of it." In law, this term is used in the context of a "prima facie case," in which the presentation of evidence at a trial has been sufficiently strong to prove the allegations unless contradicted and overcome by other evidence.

Privileged Communications: Confidential communication that is protected by statutes and need not or cannot be disclosed in court over the objections of the holder of the privilege. Lawyers are almost always able to refuse to disclose what a client has told them in confidence. Priests, ministers, rabbis, doctors, psychotherapists, and spouses are all covered by privilege statutes, but their testimony can be compelled in many cases involving child abuse or neglect.

Probable Cause: A legal standard, used in a number of contexts that indicates reasonable grounds for suspicion of or belief in the existence of certain facts or allegations.

Probation: In criminal or delinquent cases, a disposition that allows the convicted criminal-defendant or the juvenile found to be delinquent to remain at liberty, under a suspended sentence of imprisonment, generally under the supervision of a probation officer, and usually under certain conditions. Violation of a condition is grounds for revocation of the probation.

Pro Bono*:* Latin term referring to attorney services rendered at no charge.

PRO SE (or PRO PER): Latin term meaning to act as one's own legal counsel.

Protective Custody: In child abuse and neglect cases, the emergency removal of a child from his home when the child would be in imminent danger is allowed to remain with the parent(s) or custodian(s).

Psychological Tests: Instruments of various types used to measure emotional, intellectual, and personality characteristics. Psychological tests should always be administered and interpreted by qualified personnel. Such tests have been used to determine potential for abuse or neglect, or psychological makeup of parent or children.

Psychotic Person: A person who suffers a major mental disorder impairing his or her ability to think, respond emotionally, remember, communicate, interpret reality, or behave appropriately, so as to interfere with his or her capacity to meet the ordinary demands of life. The term "psychotic" is neither very precise nor definite. It is estimated that significantly fewer than ten percent of all abusive or neglectful parents are psychotic.

Race: A subgroup of people possessing a combination of physical characteristics of genetic origin.

Racism: A belief that race is the primary determinant of human traits and capacities and that racial differences produce an inherent superiority of a particular race. Also, racial prejudice or discrimination.

Reasonable Efforts: The legal standard the Department of Children and Family Services is bound by in measuring their attempts to provide services to the family and child enabling them to be reunited.

Recant: To withdraw a statement.

Recross-Examination: After redirect or rebuttal is completed, the opposing counsel are permitted to ask the witness questions covering the issues addressed in the redirect or rebuttal examination.

Redirect Examination or Rebuttal: Upon conclusion of all cross-examination, the attorneys are permitted to ask the witness more questions. These questions are called "redirect" or "rebuttal" questions and they are designed to undo any damage to the attorney's case resulting from the cross-examination.

Reporting Laws: State law that requires specified persons to notify public authorities of cases of suspected child abuse and neglect. All 50 states now have reporting statutes, but they differ widely in what must be reported, persons who must report, manner of reporting (written, oral, or both), and the degree of immunity conferred upon reporters.

Review Hearing: A hearing conducted by a judge, within certain time frames, to review the status of a child's case.

Schizophrenia: A mental disorder that afflicts persons of all ages, races, and economic levels. The term refers to a group of disorders that have common characteristics but likely are caused by various factors— brain chemistry, hormonal imbalance, inherited predisposition, violent childhood, and highly stressful adult life. Basic to schizophrenia is a distorted thought pattern. Persons sometimes hear nonexistent voices or music or see nonexistent images. Their perceptions do not fit their reality, and they may react inappropriately or without any visible emotion at all. With the help of new medications aided by psychotherapy, schizophrenia can be controlled so that persons with the disorder can maintain employment and live with their families.

Shaken Baby Syndrome: A constellation of physical findings indicating a child was severely shaken including but not limited to edema (swelling of the head), cerebral hematoma (bleeding inside the brain) and retinal hemorrhaging.

Shelter Care: Children in out of home placement transported by the County to the court for their hearing wait in an area known as Shelter Care. There are scheduled activities and meals are provided while the child waits for their hearing to be called. After-court visits may also held in the shelter care visiting rooms.

Sickle Cell Anemia: A genetic defect of hemoglobin, the oxygen-carrying protein in red blood cells. Sickle cell anemia changes the shape of red blood cells, making them "plug up" small blood vessels and choke off the blood supply to the tissues. During periods of frequent sickle-cell crisis, children and teens can be incapacitated for weeks or months. The children experience severe pain, require frequent hospitalizations, and often require emergency care to obtain oxygen and fluids. Sickle cell anemia occurs in about 160 of each one hundred thousand live African American births.

Skeletal Survey: A series of x-rays that studies all bones of the body. Such a survey should be done in all cases of suspected abuse to locate any old, as well as new, fractures.

Social History: Also called social study, social report, or pre-hearing report. Information compiled by a caseworker about a child and/or family's functioning. This material may be presented for the juvenile court's consideration at the disposition hearing. Social histories often contain material that is hearsay.

Stand: The place where the witness sits while he or she is testifying. It is usually a chair beside the judge's bench, usually with a low "modesty screen." When called to testify, the witness "takes the stand."

Standard of Proof: In different judicial proceedings there are varying requirements of proof. Three of the most commonly used standards are:

1. **Beyond a Reasonable Doubt:** Evidence that is entirely convincing or satisfying to a moral certainty. This is the strictest standard of all and applies to all criminal proceedings. It is the standard applied to termination of parental rights that come under the provisions of the Indian Child Welfare Act (P.L. 95-608).
2. **Clear, Cogent and Convincing Evidence:** Less evidence than is required to prove a case beyond a reasonable doubt, but still an amount that would make one confident of the truth of the allegations. This is the standard applied to TPR cases (unless ICWA applies).
3. **Preponderance of Evidence:** Merely presenting a greater weight of credible evidence than that presented by the opposing party. This is the lowest standard of proof; used in most civil court proceedings. 51%

Statute: A law passed by the legislature.

Stereotype: Something conforming to a fixed or general pattern, especially in standardized mental picture that is held in common by members of a group and that represents an oversimplified opinion, prejudice, attitude, or uncritical judgment.

Stipulation: An agreement (oral or written, depending on the jurisdiction and nature of the proceeding) between the attorneys in a case that allows a certain fact to be established in evidence without further proof (e.g., the lawyers in a child abuse case may stipulate that the x-rays show a fracture so that the radiologist will not have to be subpoenaed to testify).

Subdural Hematoma: A common symptom of abused children, consisting of a collection of blood beneath the outermost membrane covering the brain and spinal cord. The hematoma may be caused by a blow to the head or from shaking a baby or small child. See also **Shaken Baby Syndrome.**

Subpoena: A subpoena is an order of the court for a witness to appear at a particular time and place to testify and/or produce documents in his or her control. A subpoena is used to obtain testimony from a witness at depositions (where testimony under oath is given outside of court) and at trial. Failure to appear as ordered by the subpoena can be punished as contempt of court if it appears the absence was intentional or without cause.

Subpoena *Duces Tecum:* Subpoena requiring the person subpoenaed to bring records to court.

Substantiation: A decision by the child protective services agency to confirm a report of abuse or neglect after an investigation. It is then the agency's responsibility to

determine if a petition should be filed or if the situation can be corrected with voluntary acceptance of protective services.

Sudden Infant Death Syndrome (SIDS): A sudden, unexpected death of any infant in whom a thorough postmortem examination fails to show a clear cause of death. Recent studies suggest that some infant deaths attributed to SIDS were related to other previously unknown causes.

Summons: A legal document issued by a court clerk or other court officer, usually handed in person by the sheriff to the person summoned, notifying the named person that a lawsuit or legal cause has been filed against or involves him or her, and notifying that person of any dates set for hearings and deadlines for responding to the complaint or petition.

Supervised Visitation: Visits between a person and child that are overseen by another person who is present at all times. Usually, supervised visitation is recommended when there is reason to believe a parent may seek information about the foster placement or influence a child to recant allegations or try to leave the area with the child. Supervision may be provided by the caseworker, a relative who is caring for the child, or by another responsible adult.

Supplemental Security Income (SSI): Monthly financial benefits provided to dependent, handicapped children whose families meet financial criteria and to disabled adults who are unable to be competitively employed and who meet income and asset criteria.

Sustain: A judge's agreement with an attorney's objection to a question posed to a witness (i.e., the question is not legally proper). By sustaining the objection, the judge does not allow the question to be answered or the evidence to be considered.

Sworn or Swear: To declare under oath that one will tell the truth (sometimes "the truth, the whole truth, and nothing but the truth"). Failure to tell the truth and to do so knowingly is the crime of perjury. A witness is given the option of swearing to tell the truth or affirming to tell the truth.

The System: In this context, either the child protective services system or the child protective services system and the court.

TANF (Temporary Aid for Needy Families): Welfare payments to families in need (formerly known as AFDC), which are now subject to two-year limits. Several million dollars of federal funding to implement reforms within the social services system for such things as sexual assault prevention, domestic violence grants, sex offender registry, and several other direct service projects.

Temporary Custody: Taking physical custody from the parent and providing personal care and supervision by the state until a court order for emergency custody can be obtained. State law defines how many hours a child may be held in temporary custody without an emergency custody order entered by a judge.

Title IV-D: A 1975 amendment to the Social Security Act. Provides greater assistance to the states in establishing paternity and enforcing child support orders. Also created the Child Support Enforcement program to oversee child support enforcement operations at the state level.

Title IV-E: An amendment to the Social Security Act that created a federally funded program for out-of-home placement of children.

Tolerance: An open and non-judgmental attitude towards beliefs or practices differing from or conflicting with one's own.

Tourette's Disorder: A hereditary, neurobehavioral disorder with symptoms including tics, obsessive-compulsive behaviors, dyslexia, confrontational behavior, sleep problems, phobias, depression and mood swings, panic attacks, short temper, inappropriate sexual behaviors, and alcohol, drug, food, and other addictions. Tourette's Disorder is sometimes misdiagnosed as attention-deficit/hyperactivity disorder, or the child is believed to be a victim of child physical or sexual abuse because the behavioral abnormalities are similar.

Transgender: Exhibiting the appearance and behavioral characteristics of the opposite sex.

Trauma: An internal or external injury or wound caused by an outside force. Usually trauma means injury by violence, but it may also apply to the wound caused by any surgical procedure. Trauma may be caused accidentally or, as in a case of physical abuse, non-accidentally. Trauma is also a term applied to the psychological discomfort or symptoms resulting from an emotional shock or painful experience.

Unmonitored Visitation: Visitation between a person and child that does not require the person to stay in one place and be watched by a creditable observer.

Unsubstantiated: The finding after investigation by the Department of Children and Family Services or law enforcement that no abuse or neglect is occurring.

Venereal Disease: Any disease transmitted by sexual contact. Presence of a venereal disease in a child may indicate that the mother was infected with the disease during pregnancy, or it may be evidence of sexual abuse.

Venue: Juvenile court venue refers to the county or counties within which a lawsuit may be initiated based on such factors as where the parents reside, where the child resides, or where the child is found.

Voir Dire: Latin term meaning "to speak the truth." The procedure during which lawyers question prospective jurors to determine their biases, if any. Also the procedure in which lawyers examine expert witnesses regarding their qualifications, before the experts are permitted to give opinion testimony.

Voluntary Family Maintenance: Agreement between a family and DCFS in which DCFS provides supervision and assistance to the family without filing a petition with the court**.**

Voluntary Placement: Act of a parent to relinquish custody of his or her child to the Department of Children and Family Services.

Waiver: The understanding and voluntary relinquishment of a known right, such as the right to counsel, the right to remain silent during police questioning, or the right to a separate hearing.

Welfare and Institutions Code (WIC): California code governing juvenile court law.

Witness: A person with direct knowledge of any fact.

Xenophobia: A fear of all that is foreign; a fear of people different from one's self or "foreigners."

ACRONYMS and ABBREVIATIONS

Au: Aunt

CASA: Court Appointed Special Advocate

CSW: Children's Social Worker

DCFS: Department of Children and Family Services

DCLS: Dependency Court Legal Services. The three law firms that contract with the County to provide legal representation for children in dependency court.

DMH: Department of Mental Health

FA: Father

FFA: Foster Family Agency

GAL: Guardian ad litem

HOP: Home of Parent. An order made by a court allowing a child to reside in the parent(s) home under the court's supervision.

IEP: Individualized Education Plan.

ILP: Independent Living Program.

ICPC: Interstate Compact for the Placement of Children.

ICWA: Indian Child Welfare Act. Federal law that places certain requirements on custody cases involving Indian children. Public Law 95-608.

JR: Judicial Review.

JT: Terminate Jurisdiction.

LTFC: Long Term Foster Care

MGF: Maternal grandfather

MGM: Maternal grandmother

MO: Mother

NPRG: Non-appearance progress hearing

PGF: Paternal grandfather

PGM: Paternal grandmother

PPH: Permanency Planning Hearing.

PRC: Pre-Trial Resolution Conference. At a PRC hearing the parties attempt to informally settle the case.

PRI: Pre-Release Investigation.

PROG: Hearing set for progress report.

RPP: Review of the Permanent Plan.

RUM Unit: Risk Utilization Management Unit

SCSW: Supervising Children's Social Worker

SISU: Special Immigration Status Unit.

SSI: Supplemental Security Income

Un: Uncle.

WIC: Welfare and Institutions Code

HEARINGS, NUMBERS and MISCELLANEOUS

.21(e) hearing: WIC §366.21(e). The 6-month review hearing after disposition.

.22(f) hearing: WIC §366.22(f). The 12-month review hearing after disposition.

.22 hearing: WIC §366.22. The 18-month review hearing after disposition.

.26 hearing: WIC §366.26. The hearing to select a permanent plan (adoption, legal guardianship, or long term foster care) and to terminate parental rights when adoption is the permanent plan.

241.1 hearing: Hearing in delinquency court to address whether a child belongs in the dependency or delinquency system. CASA, DCFS, Probation, and the Department of Mental Health file 241.1 reports.

364 hearing: WIC §364. The 6-month review hearing after disposition hearing and child was placed with one or both parents.

370 funds: County funding to obtain mental health services for children. The correct term is "funds pursuant to WIC §370."

387 hearing: WIC §387. Hearing upon filing of a 387 petition to determine whether a child should be removed from home of a parent, relative or friend and placed in a foster-home, private or public institution.

388 hearing: WIC §388. Hearing upon filing of a 388 petition requesting modification of an existing order.

602: WIC §602 is the section of the Welfare and Institutions Code that pertains to acts that if committed by an adult would be a criminal offense. If the court determines the child is a "602" the child becomes a ward of the juvenile delinquency court.

730 evaluation: A court ordered examination by a court-authorized expert under Section 730 of the Evidence Code.