CHAPTER 5

Understanding Families —Part 2

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CASA™
Court Appointed Special Advocates

CHAPTER 5

Understanding Families—Part 2

HOMEWORK RECAP

POVERTY—THE NUMBERS

In 2004, $15,219 was the federal poverty threshold for a three-person family. A three-person family earning less than $7,610 lived in "extreme poverty" (less than half the federal poverty level). In that year, more than 5.5 million children lived in extreme poverty. These families earned less than $634 a month, $146 a week, or $20 a day to meet all basic needs: food, clothing, shelter, health care, etc.

From *The State of America's Children 2005,* Children's Defense Fund, www.childrensdefense.org.

Consider the above information about the federal poverty level. Assume you have $15,000 a year to live on. Using the cost-of-living information the facilitator distributes and the Monthly Budget Worksheet, devise a monthly budget for $1,250 that includes expenses for housing, utilities, food, clothing, transportation, entertainment, childcare, and medical expenses. Think about what strengths or abilities a person needs in order to live on $15,000 a year.

COMMUNITY RESOURCES

Continue to gather information about the community resource you selected during a previous training session. You will present your reports on community resources during the session addressing Chapter 9.

GOAL

In this chapter, I will increase my understanding of families and my ability to assess the family situations of the children I will encounter as a CASA/GAL volunteer. In particular, I will consider the issues of substance abuse by parents/caregivers and poverty and how these issues impact families and children.

OBJECTIVES

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

✓ Identify how substance abuse/addiction impacts families and children

✓ Examine how my personal values and biases about substance abuse/addiction can affect my objectivity regarding the best interest of the child

✓ Explain why poverty is a risk factor for children

✓ Describe why the "minimum sufficient level of care" standard is in the best interest of the child

The Impact of Substance Abuse/Addiction on Children & Families

Activity 5A: Substance Abuse

Part 1: Think of friends, family members, or colleagues who abuse one or more substances. As you think of these people, make two lists:

- What are their strengths? Why do you like them?
- How does their substance abuse impact their lives?

Share your responses with a partner.

Part 2: Listen to the presentation on substance abuse and addiction. Afterward, the facilitator will inform you about the drugs most commonly abused in your community.

Substance Abuse/Addiction Issues

THE PROBLEM

- In 1999, 85% of states named substance abuse as one of the top two problems (the other was poverty) challenging families reported to child welfare agencies for child maltreatment.
- More than half of children in foster care have parents with substance abuse problems.
- In 80% of substance-abuse-related cases, the child's entry into foster care was the result of severe neglect.

Child Welfare League of America, *Alcohol, Other Drugs, and Child Welfare,* 2001.

DEFINITIONS

Psychoactive substances, whether legal (for instance, alcohol) or illegal, impact and alter moods, emotions, thought processes, and behavior. These substances are classified as stimulants, depressants, opioids and morphine derivatives, cannabinoids, dissociative anesthetics, or hallucinogens based on the effects they have on the people who take them.

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

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

CAUSES

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

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

TREATMENT

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

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

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

LEARN MORE!

For additional information on particular drugs, see the National Clearinghouse for Alcohol and Drug Information website at *http://ncadi.samhsa.gov.* The Chapter 5 Resource Materials contain information specifically on methamphetamine use because it is increasingly a problem in child welfare cases.

IMPACT ON CHILDREN

- Children whose parents abuse drugs and alcohol are almost three times likelier to be abused and more than four times likelier to be neglected than children of parents who are not substance abusers. Substance abuse and addiction are the primary causes of the dramatic rise in child abuse and neglect cases since the mid-1980s.

National Center on Addiction and Substance Abuse at Columbia University, *No Safe Haven*, 1999.

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

Commonly Abused Drugs

Substance Name	Examples of Commercial & Street Names	DEA Schedule*	How Administered**
***Substance Category:* CANNABINOIDS**			
hashish	boom, chronic, gangster, hash, hash oil, hemp	I	swallowed, smoked
marijuana	blaze, blunt, dope, ganja, grass, herb, joints, Mary Jane, pot, reefer, sinsemilla, skunk, weed	I	swallowed, smoked
Intoxication Effects: *euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination*	***Potential Health Consequences:*** *cough, frequent respiratory infections; impaired memory and learning; increased heart rate, anxiety; panic attacks; tolerance, addiction*		
***Substance Category:* DEPRESSANTS**			
barbiturates	Amytal, Nembutal, Seconal, phenobarbital; barbs, reds, red birds, phennies, tooies, yellows, yellow jackets	II, III, V	injected, swallowed
benzodiazepines (other than flunitrazepam)	Ativan, Halcion, Librium, Valium, Xanax; candy, downers, sleeping pills, tranks	IV	swallowed, injected
flunitrazepam***	Rohypnol; forget-me pill, Mexican Valium, R2, Roche, roofies, roofinol, rope, rophies	IV	swallowed, snorted
GHB***	gamma-hydroxybutyrate; G, Georgia homeboy, grievous bodily harm, liquid ecstasy	I	swallowed
methaqualone	Quaalude, Sopor, Parest; ludes, mandrex, quad, quay	I	injected, swallowed
Intoxication Effects: *reduced anxiety; feeling of well-being; lowered inhibitions; slowed pulse and breathing; lowered blood pressure; poor concentration* ***For barbiturates****—sedation, drowsiness* ***For benzodiazepines****—sedation, drowsiness* ***For methaqualone****—euphoria*	***Potential Health Consequences:*** *fatigue; confusion; impaired coordination, memory, judgment; addiction; respiratory depression and arrest/death;* ***For barbiturates****—depression, excitement, fever, irritability, poor judgment, slurred speech, dizziness, life-threatening withdrawal* ***For benzodiazepines****—dizziness* ***For flunitrazepam****—visual and gastrointestinal disturbances, urinary retention, memory loss for the time under the drug's effects* ***For GHB****—drowsiness, nausea, vomiting, headache, loss of consciousness, loss of reflexes, seizures, coma, death* ***For methaqualone****—depression, poor reflexes, slurred speech, coma*		
***Substance Category:* DISSOCIATIVE ANESTHETICS**			
ketamine	Ketalar SV; cat Valiums, K, Special K, vitamin K	III	injected, snorted, smoked
PCP and analogs	phencyclidine; angel dust, boat, hog, love boat, peace pill	I, II	injected, swallowed, smoked
Intoxication Effects: *increased heart rate and blood pressure, impaired motor function* ***For ketamine****—at high doses, delirium, depression, respiratory depression and arrest* ***For PCP and analogs****—possible decrease in blood pressure and heart rate, panic, aggression, violence*	***Potential Health Consequences:*** *memory loss; numbness; nausea, vomiting* ***For PCP and analogs****—loss of appetite, depression*		

**Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (unrefillable) and require a form for ordering. Schedule III and IV drugs are available by prescription, may have five refills in six months, and may be ordered orally. Most Schedule V drugs are available over the counter.*

***Taking drugs by injection can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis, and other organisms.*

****Associated with sexual assaults.*

Commonly Abused Drugs

Substance Name	Examples of Commercial & Street Names	DEA Schedule*	How Administered**
***Substance Category:* HALLUCINOGENS**			
LSD	lysergic acid diethylamide; acid, blotter, boomers, cubes, microdot, yellow sunshines	I	swallowed, absorbed through mouth tissues
mescaline	buttons, cactus, mesc, peyote	I	swallowed, smoked
psilocybin	magic mushroom, purple passion, shrooms	I	swallowed

Intoxication Effects: *altered states of perception and feeling*
For LSD and mescaline*—increased body temperature, heart rate, blood pressure; loss of appetite, sleeplessness, numbness, weakness, tremors*
For psilocybin*—nervousness, paranoia*

Potential Health Consequences: *nausea, persisting perception disorder (flashbacks)*
For LSD*—persistent mental disorders*

Substance Name	Examples of Commercial & Street Names	DEA Schedule*	How Administered**
***Substance Category:* OPIOIDS AND MORPHINE DERIVATIVES**			
codeine	Empirin with Codeine, Fiorinal with Codeine, Robitussin A-C, Tylenol with Codeine; Captain Cody, Cody, schoolboy; (with glutethimide) doors and fours, loads, pancakes and syrup	II, III, IV	injected, swallowed
fentanyl and fentanyl analogs	Actiq, Duragesic, Sublimaze; Apache, China girl, China white, dance fever, friend, goodfella, jackpot, murder 8, TNT, Tango and Cash	I, II	injected, smoked, snorted
heroin	diacetylmorphine; brown sugar, dope, H, horse, junk, skag, skunk, smack, white horse	I	injected, smoked, snorted
morphine	Roxanol, Duramorph; M, Miss Emma, monkey, white stuff	II, III	injected, swallowed, smoked
opium	laudanum, paregoric; big O, black stuff, block, gum, hop	II, III, V	swallowed, smoked
oxycodone HCL	OxyContin; Oxy, O.C., killer	II	swallowed, snorted, injected
hydrocodone bitartrate, acetaminophen	Vicodin; vike, Watson-387	II	swallowed

Intoxication Effects: *pain relief, euphoria, drowsiness*
For codeine*—less analgesia, sedation, and respiratory depression than morphine*
For heroin*—staggering gait*

Potential Health Consequences: *nausea, constipation, confusion, sedation, respiratory depression and arrest, tolerance, addiction, unconsciousness, coma, death*

Commonly Abused Drugs

Substance Name	Examples of Commercial & Street Names	DEA Schedule*	How Administered**
***Substance Category:* STIMULANTS**			
amphetamine	Biphetamine, Dexedrine; bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II	injected, swallowed, smoked, snorted
cocaine	cocaine hydrochloride; blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	II	injected, smoked, snorted
MDMA (methylenedioxy-methamphetamine)	Adam, clarity, ecstasy, Eve, lover's speed, peace, STP, X, XTC	I	swallowed
methamphetamine	Desoxyn; chalk, crank, crystal, fire, glass, go fast, ice, meth, speed, crystal meth	II	injected, swallowed, smoked, snorted
methylphenidate (safe and effective for treatment of ADHD)	Ritalin; Jif, MPH, R-ball, Skippy, the smart drug, vitamin R	II	injected, swallowed, snorted
nicotine	cigarettes, cigars, smokeless tobacco, snuff, spit tobacco, bidis, cloves, kreteks, chew	NA	smoked, snorted, taken in snuff and spit tobacco

Intoxication Effects: *increased heart rate, blood pressure, metabolism; feelings of exhilaration, energy, increased mental alertness*
For amphetamine*—rapid breathing*
For cocaine*—increased temperature*
For MDMA*—mild hallucinogenic effects, increased tactile sensitivity, empathic feelings*
For methamphetamine*—aggression, violence, psychotic behavior*

Potential Health Consequences: *rapid or irregular heartbeat; reduced appetite, weight loss, heart failure, nervousness, insomnia*
For amphetamine*—tremor, loss of coordination; irritability, anxiousness, restlessness, delirium, panic, paranoia, impulsive behavior, aggressiveness, tolerance, addiction, psychosis*
For cocaine*—chest pain, respiratory failure, nausea, abdominal pain, strokes, seizures, headaches, malnutrition, panic attacks*
For MDMA*—impaired memory and learning, hyperthermia, cardiac toxicity, renal failure, liver toxicity*
For methamphetamine*—memory loss, cardiac and neurological damage, impaired memory and learning, tolerance, addiction*
For nicotine*—adverse pregnancy outcomes, chronic lung disease, cardiovascular disease, stroke, cancer, tolerance, addiction*

OTHER COMPOUNDS			
anabolic steroids	Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise; roids, juice	III	injected, swallowed, applied to skin

Intoxication Effects: *no intoxication effects*

Potential Health Consequences: *hypertension, blood clotting and cholesterol changes, liver cysts and cancer, kidney cancer, hostility and aggression, acne; in adolescents, premature stoppage of growth; in males, prostate cancer, reduced sperm production, shrunken testicles, breast enlargement; in females, menstrual irregularities, development of beard and other masculine characteristics*

Substance Name	Examples of Commercial & Street Names	DEA Schedule*	How Administered**
inhalants	solvents (paint thinners, gasoline, glues), gases (butane, propane, aerosol propellants, nitrous oxide), nitrites (isoamyl, isobutyl, cyclohexyl); laughing gas, huffing, poppers, snappers, whippets, whipits	NA	inhaled through nose or mouth

Intoxication Effects: *stimulation, loss of inhibition; headache; nausea or vomiting; slurred speech, loss of motor coordination; wheezing*

Potential Health Consequences: *unconsciousness, cramps, weight loss, muscle weakness, depression, memory impairment, damage to cardiovascular and nervous systems, sudden death*

Adapted from material created by the National Institute on Drug Abuse, www.nida.nih.gov.

Activity 5B: Substance Abuse & Parenting

In the large group, brainstorm possible effects of substance abuse on parenting ability. The facilitator will list all responses on a flipchart page. Compare your answers to the list that follows.

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 may be emotionally and physically unavailable to the child.
- A parent's mental functioning, judgment, inhibitions, and/or protective capacity may be seriously impaired by alcohol or drug use, placing the child at increased risk of all forms of abuse and neglect, including sexual abuse.
- A substance-abusing parent may "disappear" for hours or days, leaving the child alone or with someone unable to meet the child's basic needs.
- A parent may spend the family's income on alcohol and/or other drugs, depriving the child of adequate food, clothing, housing, and healthcare.
- 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.
- Eventually, a parent's substance abuse may lead to criminal behavior and periods of incarceration, depriving the child of parental care.
- Exposure to parental abuse of alcohol and other drugs, along with a lack of stability and appropriate role models, may contribute to the child's substance abuse.
- Prenatal exposure to alcohol or other drugs may impact a child's development.

Activity 5C: What the Child Experiences

Individually, read the following section about children's experiences of a parent's substance abuse.

In your small groups, decide how you might respond to the following situations as a CASA/GAL volunteer:

- A 15-year-old child says, "My mom and her boyfriend smoke dope on weekends."
- You learn that the 10-year-old child for whom you advocate taught his foster sister how to smoke crack.
- A 4-year-old child, whose mother is in jail after a third offense for driving under the influence, asks you, "Why is Mommy in jail? Is she bad?"

Share a sample of your ideas for each situation in the large group.

What the Child Experiences

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

- **Broken Promises**
  Parents may break their promises to go somewhere with the family, do something with the children, not drink that day, or 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**
  Rules and limits may seem to change constantly, and parents may be loving one moment and abusive the next.
- **Shame & Humiliation**
  Alcohol or drugs may take over and suddenly turn an otherwise lovely parent into a loathsome embarrassment.
- **Tension & Fear**
  Because the children of substance-abusing parents never know what will happen next, they 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, their parents would not use alcohol/drugs.
- **Anger & Hurt**
  Children may feel neglected, mistreated, and less important in their parents' lives than the alcohol or drugs. They grow up with a profound sense of abandonment.

- **Loneliness & Isolation**
  Because the family denies or hides the problem and often will not even discuss it among themselves, 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**
  Children may feel they have to constantly cover for the failure of the parent, or account for his/her deviant behavior.
- **Feeling Responsible**
  Often children feel that it is their job to organize and run the home and care for younger siblings.
- **Feeling Obligated**
  Children feel they must 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, 1985.

Children in substance-abusing families need help to address these issues and begin to heal their wounds. The CASA/GAL volunteer can advocate for thorough assessment and treatment by a provider who has expertise in working with substance abuse issues.

Activity 5D: Finding a Balance

Part 1: Read the case summary below and then listen as the facilitator presents key points to consider in deciding whether to recommend that a child return home to his/her family.

One-year-old Amber has been in foster care since shortly after her birth. She tested positive for two illegal substances at birth and showed signs of withdrawal. Vanessa, her mother, has been in recovery for six months. She has had one known relapse, but has had negative drug screens and good reports for the last two months. Everyone involved in the case agrees that she is not yet ready to have Amber live with her. She started a new job two weeks ago and does not yet have stable housing.

Can the Child Return Home? Key Points to 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
- Treatment prognosis and/or length of sobriety

A dilemma that often arises is the conflict between the legal mandate (and the child's need) for permanence (ASFA) and the long-term treatment (including inpatient treatment) that substance-abusing parents may need. If a parent is in treatment, consideration should be given to placing the child with the parent rather than in foster care. Although 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 to punish the parent by withholding the child.

Part 2: The facilitator will divide you into two groups: One group is to make an argument for terminating Vanessa's parental rights so Amber can be adopted by her foster parents; the other is to make an argument for giving Vanessa more time to show she can parent Amber. Share your arguments in the large group.

What a CASA/GAL Volunteer Can Do

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

Services for which you might advocate include:

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

LEARN MORE!

For more information on making permanency recommendations for children when parental substance abuse is involved, see the article "The Treatment Perspective in Permanency Decisions for Substance Abusing Parents" in the Chapter 5 Resource Materials.

UNIT 2

Poverty—The Facts for Children

Socioeconomic status, or class, is a major factor that greatly defines how people live in the world. According to the Children's Defense Fund, at the end of 2004 more than 13 million US children lived in poverty.

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 5E: Children in Poverty

Listen as the facilitator shares information about how poverty affects children in the United States. Then fill in the blanks as the facilitator talks about children in your state or local community.

Key Facts About American Children

1 IN 2 . . .

- Will live in a single-parent family at some point in childhood
- Never completes a single year of college

1 IN 3 . . .

- Is born to unmarried parents
- Will be poor at some point during childhood
- Is behind a year or more in school

1 IN 4 . . .

- Lives with only one parent
- 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 3 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 childcare 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's *Kids Count Data Book,* 2001 and 2003.

KEY FACTS ABOUT CHILDREN IN MY COMMUNITY

______ children live in my state.

______ % of children in my state/community live in poverty, and

______ % live in extreme poverty, their families earning incomes less than half the federal poverty level.

______ % of children under age 5 live in poverty in my state/community.

______ % of teens in my state/community have dropped out of high school.

______ % of children in my state/community live in homes where no parent has full-time, year-round employment.

______ children in my state/community do not have health insurance.

______ adults and children in my state/community receive Temporary Assistance for Needy Families (TANF).

______ is the maximum monthly TANF cash assistance payment for a family of three in my state.

______ children in my state/community live in families that receive food stamps.

______ children in my state/community receive free/reduced lunch.

______ families in my state/community live in subsidized housing.

For more information on the effects of poverty on children in the United States, see *The State of America's Children,* available on the Children's Defense Fund website, at *www.childrensdefense.org*.

Activity 5F: Thinking It Over

Read the section "Why Are Poor Children More Likely to Be in the System?" Consider this material along with the information from the previous two activities. With a partner, pick three of the following questions to answer. There are many possible answers for each question.

- What effect might living in poverty have on access to education, healthcare, 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? Why are race and income level interconnected issues?

The facilitator will ask for a few volunteers to share in the large group.

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

The majority of children you will encounter as a CASA/GAL volunteer will be living at or below the poverty level. Developing a better understanding of the realities of poverty will assist you in being a better advocate. *Keep in mind, knowing people's socioeconomic status—like knowing their race, ethnicity, or other group membership—does not necessarily mean you can predict their attitudes or behavior.* 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 5G: Poverty vs. Neglect

Complete the sentences in each of the following examples:

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

Yes, if ______________________________

No, if ______________________________

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

Yes, if ______________________________

No, if ______________________________

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

Yes, if ______________________________

No, if ______________________________

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

Yes, if ______________________________

No, if ______________________________

In the large group, describe the factors you considered as you finished each sentence.

The Importance of Family to a Child

Activity 5H: The Importance of Family to a Child

Read the material below and share your responses to the following questions:

- Is there anything about the concept of minimum sufficient level of care (MSL) that concerns you?
- Why is the MSL standard in the best interest of children?

Why the Minimum Sufficient Level of Care (MSL) 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 the safety net that only the unconditional acceptance of family can provide. They need the knowledge of and connection to their cultural/ethnic heritage that is learned within the family.

Adapted from *Beyond Rhetoric: A New American Agenda for Children and Families*, National Commission on Children, Government Printing Office, 1991.

Most children you serve as a CASA/GAL volunteer will go home. It is your role to advocate for the services necessary so the child can go home safely. If the child cannot be returned home safely, what is in the child's best interest? This is not an easy question to answer. As a CASA/GAL volunteer, you start with the assumption that a child's 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 yours. 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.

As discussed in Chapter 1, 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, a community of faith, sports, Scouts, music lessons, 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 reunification as when considering removal.

The idea that a minimum sufficient level of care should be the standard for families is often difficult for CASA/GAL volunteers to embrace. It feels counterintuitive, as though it defies common sense. You may be 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 homes—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 terribly painful 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. 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 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., to seek substance abuse treatment or learn parenting skills) and those of the child protective services agency (e.g., to provide visitation, arrange counseling, 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. The steps in these agreements with parents need to be small and measurable. 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. If the steps are not measurable, success cannot be determined. For example, a parent can "attend parenting classes" for six months without ever making a change in behavior. If the agreement specifies that the parents are "able to describe and apply five ways to discipline their child without spanking," both the parents and any observer will be able to tell whether the task gets accomplished. As a CASA/GAL volunteer, you should routinely ask the question of both parents and case managers, "How will you know when this requirement is met?"

LEARN MORE!

A Question of Balance: Decision Making for CASA/GAL Volunteers, written by Janet Ward, is available online at www.shopcasa.org or from your local program.

Activity 5I: Understanding Families Wrap-Up

Consider the Harris-Price case in light of the material you've learned in the last two chapters. Imagine that Kathy Price doesn't show up for a hearing. Think of 10 legitimate reasons why she might have missed the hearing. In the large group, share your reasons.

Activity 5J: Michelle's Story

Watch Michelle's story from "Powerful Voices: Stories by Foster Youth," and respond to the following questions in the large group:

- What role did Michelle's family play in her life?
- How can you as a CASA/GAL volunteer help children maintain family connections?

Share any remaining questions you have about Chapters 4 and 5.

Homework

PSYCHOLOGICAL & EDUCATIONAL ISSUES

Read the descriptions in the Chapter 6 Resource Materials of common psychological and educational issues that affect children. Consider the following questions in preparation for the Chapter 6 session:

- How will this information assist you in your work as a CASA/GAL volunteer?
- What collaborations will you need to form in order to be a more effective advocate?
- What is one question you have about the reading?
- What more do you need to know about children?

COMMUNITY RESOURCES

Reminder: Earlier in training, you selected an agency to research. The facilitator provided a worksheet as a tool to assist you in gathering information about services provided, access to services, etc.

This activity was assigned early in training to allow time for you to gather the information. You will share the materials and information that you gather during the Chapter 9 training session, when community resources will be introduced.