Clearinghouse on Supervised Visitation

The Institute for Family Violence Studies

Florida State University

JULY EPRESS

NEWS

There will be a phone conference on **July 14th at 12ET/11CT** on the ***Overview Chapter*** *of the new Supervised Visitation Training Manual for Child Sexual Abuse Case Referrals.* The chapter is included at the end of this E-Press.

QUESTIONS FROM DIRECTORS

Is there a prohibition on putting the photographs and full names of our staff members, interns, or volunteers on our webpage or on social media?

No, there is no such prohibition in the Standards or Best Practices. However, the Clearinghouse has received complaints by programs in which clients or former clients followed program staff outside of the parameters of the visit and the program, left inappropriate messages for staff/volunteers, and otherwise exhibited stalking behavior toward program staff. Because of these incidents, the Clearinghouse recommends that programs limit the amount of freely available information about staff/volunteers. It is also why many programs only use the first name of the staff on name badges and IDs.

We have interns from local colleges that supervise visits. Are they required to have the full 24 hour training even if we only use them occasionally to monitor parent-child contact?

Yes. Anyone who supervises parent-child contact is required to have the full training. This is for the protection of the children, the vulnerable parents, and the monitor him or herself. The frequency of monitoring is irrelevant – even One visit creates a mandate that the monitor is trained. Frequent shadowing, where a monitor observes multiple visits supervised by a trained monitor, is not a substitute for thorough training, even though it does provide the new monitor with additional information. Remember, the Standards have always required training, and this mandate cannot be superseded. The only exception to this rule is if there is ALSO a fully trained monitor in the room with the intern, and that fully trained monitor is responsible for the visit.

If one family brings a toy to a visit, and a child from another family breaks that toy, is the program responsible for replacing the toy?

The question has never gone before a judge, and my advice is always to warn parents not to bring breakable or valuable items to visits. Things can happen quickly in group visits: children can run over to a different family and break something by mistake or with intent. Cell phones can fall out of pockets and shatter. Jewelry can go missing. Programs need to be sure that parents understand that staff are not responsible for such events. In thinking about this case scenario, I also suggest that if you notice that parents are wearing expensive watches, or earrings, etc., you repeat your admonition that the program is <u>not</u> responsible for ensuring the property of the family.

Are we allowed to recommend parenting coordinators or therapists or evaluators to clients?

I would avoid such recommendations, and instead direct parents to the list that most Court Administrators have on file. The issue is the appearance of favoritism – even if you know that a certain professional in the community has a good reputation, stay neutral and let the parents make their own decisions. Recommendations by parenting professionals can become highly divisive for the parents, and I see no benefit to becoming part of the conflict by making suggestions to the parties.

Discussing Culture with Families

Every family is different and monitors have a responsibility to take the time to understand how the families they work with are unique. Monitors may not have the same cultural background as the families they work with; cultural competence will help those monitors provide visitation in a non-judgmental and accepting way. An important way for monitors to be culturally competent is to be aware of different family's cultural backgrounds.

If programs do not learn how to acknowledge and appreciate cultural differences, families may feel overlooked or ignored. This E-Press will discuss the ways that visit monitors can ask questions to stay informed and learn about the cultural background of the families they work with. Through communication and acceptance, monitors can build a working knowledge about a family's cultural background and foster a strong connection.

Starting the Conversation

It is important to provide parents with the opportunity to express their cultural background at various points of service delivery (intake, during a visit, at the end of a visit). Different pieces of a family's cultural background may come to light at various points of visitation, and monitors can use conversation to learn more about what is important to a family.

During Intake

Intake is the first opportunity to ask questions about what cultural information parents want the program to know about themselves and their family. Programs can use the questions below to start the conversation with parents.

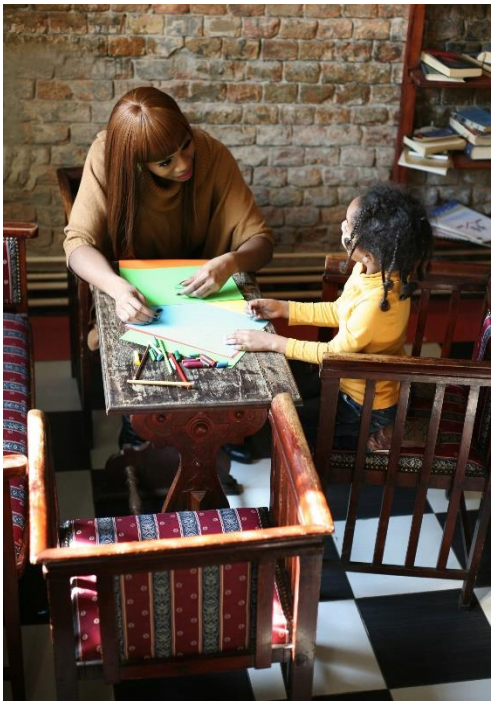
Questions to Ask

- Are there any important holidays that you celebrate that you want me to know while you are working with our program?
- Are there any important religious or cultural beliefs that you want me to know?
  If you are unfamiliar with something from a family's cultural background, it will be beneficial to do personal research after the visit to educate yourself about it
- Are the roles in your family specifically defined? If so, what are they?
- What pronouns do you use?
- Is there anything in your culture considered disrespectful that you want me to know? (ask the same question but use the word respectful instead)
- Is there anything in our program that makes your culture feel ignored or criticized?
- Tell me something that is important to you and your family that you want me to know as a visit monitor.

Monitors should never assume they know a family's cultural background due to their race, gender, or ethnic background. Intake provides a great opportunity for monitors to ask questions before making any assumptions. The only expert on a family's cultural background and practices is the family themselves.

During/After Visitation

During the visit, you should be making visual and audial observations by listening to the content the parent and child are discussing and noticing any reactions or mannerisms. Listening to the parent and child talk will provide you with details about what a family's culture is. In some cases, monitors will not receive all of a family's cultural background information during intake and will slowly begin to notice things as visits go on. Review the scenario below for an example.



The monitor is observing the third visit between Mr. Carter and his twelve-year-old son Demetri. During the first two visits, the monitor noticed that Demetri never looked his father in the eyes. The monitor assumed the child was afraid of his father, but hasn't observed other reactions to indicate Demetri was fearful.
The monitor decided to speak with Demetri alone to ask him about it.

Monitor: Hi Demetri, how are you feeling about your visit with your dad today?

Demetri: Pretty good, I really like getting to see him and telling him about baseball and school.

Monitor: That's good, I can tell by the big smile you have every time you're here that you enjoy seeing him which is why I wanted to ask you a question. I've noticed that you don't look at your dad in the eyes during your visits with him. Can you talk to me about why you don't look at him?

Demetri: Oh, I guess I don't really notice that I do that. I mean, a long time ago my parents told me to not look at the eyes of my elders because it's disrespectful so maybe that's why.

Monitor: Okay, I just wanted to make sure that you weren't feeling scared or anxious when you were with him.

Demetri: No, I'm not. I definitely do look at my dad sometimes, but I guess I just don't look at him a lot because of what they told me.

In the scenario above, the visit monitor was dangerously close to making a faulty assumption about why a child didn't look at his parent. In some cultures, not looking elders in the eyes is a symbol of respect and the visit monitor above was able to learn that by communicating with the child. The monitor could even go a step further and confirm that cultural practice with the parent as well.

During some visitations, a visit monitor might observe how a cultural belief is impacting a visit negatively between a parent and child. This does not mean that the cultural belief is negative necessarily, but that the parties involved are at a disagreement about the belief at hand. Instead of trying to change the view of a parent or child, it is better for the monitor to help the parent or child find ways to communicate with the other about their differences. Review the example below.

Monitor: During the visit today I heard you tell Theresa that she needs to stop playing soccer because as a girl she shouldn't be playing a sport that boys play. I know you mentioned to me during the intake that you want your daughter to be modest and not engage in sport activities, but I'm worried you might be pushing her away. After you told her to stop playing soccer she looked discouraged and wouldn't talk to you the rest of the visit. I think it's important that you talk to her about why you don't want her to play soccer, and also give her the opportunity to explain to you why she does.

Mrs. Mitchell: I know she stopped talking to me and she's upset with me, but I'm her mother and I know what is best for her.

Monitor: I understand Mrs. Mitchell, but I don't want to see her withdraw from you because I know you have worked so hard to strengthen your relationship with her. This visit was very different from the other ones you two have had. I think talking more about this with her will be important for your relationship. We can take a few minutes to talk about how you can have that conversation with her if you'd like?

Mrs. Mitchell: Okay, we can talk about it but that doesn't mean I'm going to change my mind.

Monitor: Okay. First, I want to ask you what makes Theresa not playing sports so important to you?

In the scenario above, the monitor mentioned an observation of how the mother's cultural belief was impacting her child without passing judgement. The monitor showed respect and acknowledgement of the mother's belief, but expressed concern in how the mother and daughter were functioning as a result.

Supervised visitation monitors should take the initiative to understand and engage with a family's culture by paying attention to what is said during the visit. If the monitor learns something new about the family's culture, he or she can follow up with the parent and child while the visit is wrapping up. Review the conversation below.

***Monitor**:* "I heard you and Fahim discussing Ramadan. Is there anything you want me to know leading up to or during Ramadan?

***Mr. Abdalla** (Father):* Yes, there is. During Ramadan we fast during the day and break the fast just after sunset for Iftar, and we eat again for Suhoor just before the sun rises. Since our visits are in the afternoon, Fahim might seem more tired than usual since he'll be up late to eat and then early to eat as well. I wanted to make sure you knew about that."

***Monitor**:* "Fahim, during Ramadan you get more tired around the afternoon?

***Fahim** (Son):* "I do feel a little more tired than normal in the late afternoon, but it's really not a huge deal. I've done it before, and it's summer time now so I have time to nap and rest."

***Monitor**:* "Okay, how long does Ramadan last for?"

Fahim(Son): About a month.

Monitor: I'll make a note of that so I can remember. Thank you both for sharing that with me.

In the scenario above, the monitor made an effort to ensure relevant cultural background was not ignored or overlooked. When monitors engage with parents and show a willingness to learn and accept, families will feel more comfortable during visitation.

Conclusion

The scenarios above make it clear how important it is for supervised visitation monitors to communicate with families about their culture. While intake is a key time to ask families questions about their beliefs, practices, and background, it is not the only time that monitors will learn about a family's culture. Monitors have a responsibility to engage, accept, and respect a family's culture throughout the visitation process.

This E-Press has provided monitors with questions on how to start the conversation with families, and case examples that show how those conversations may look during visitation. Programs can show they care about families by asking questions and recognizing their culture.

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Resources

The Clearinghouse has previously written E-Presses about different topics related to cultural competence before. You can find them here:

Cultural Awareness and Diversity for Supervised Visitation Workers- Page 9
http://familyvio.csw.fsu.edu/wp-content/uploads/2014/01/2014-01_EPress_web.pdf

Cultural Competence and Multiculturalism in Supervised Visitation- Page 19
http://familyvio.csw.fsu.edu/wp-content/uploads/2013/05/May13EPress_MB.pdf

Additionally, cultural competence is discussed in Chapter 7: Working with Culturally Diverse Families of the Supervised Visitation Training Manual.

Communicating with Families about Disabilities

Families from all backgrounds attend supervised visitation programs, and it is essential that monitors are equipped with the skills to work with each one. In some instances, programs may work with a parent or child who has a disability. When monitors are working with family members who have disabilities it is important to ensure that the program understands how they can accommodate that person's needs. This E-Press will discuss how monitors and programs can create a safe and supportive environment for families with disabilities through respectful language and asking questions.

People First Language

For individuals who do not have disabilities, they may not know or be aware of language that is outdated, hurtful, and even discriminatory towards people with disabilities. Before learning what questions are important to ask families regarding disabilities, monitors must first know how to use respectful disability language. The table below reviews language that is outdated and how monitors can replace it with its respectful language counterpart.

Outdated Language	Respectful Language
Crazy, insane, psycho, mental, maniac	A person with a mental illness A person with a mood disorder A person with an anxiety disorder
Crippled, crippled, lame, physically challenged	A person with a disability A person who uses a walker A person with a physical disability
Confined to a wheelchair, wheelchair bound	A person who uses a wheelchair
Autistic	A person with Autism/Autism Spectrum Disorder
Birth defect, deformity, congenital defect	A person with a disability since birth
Blind, visually impaired	A person with vision loss A person who is blind

Hidden disability, invisible disability: Learning disabled Mentally retarded, retarded, imbecile, feeble minded Midget, Dwarf Normal	Non-visible disability A person with a learning disability A person with an intellectual disability A person with a developmental disability A person of short stature A person who has a form of dwarfism A person without a disability A person who is not disabled

Important Reminders

Program monitors should never ask a parent “what happened to you” or “what happened to your child”. Asking questions like those can make the parent or child feel alienated and uncomfortable.

Monitors must remember that a person is more than their disability, which is why using respectful language puts the person first before their disability. Person-first language can be empowering and positive when working with individuals who have disabilities.

Communicating with Families

A key component of providing effective services as a program is understanding how the program and monitors can accommodate the different needs of families. During the intake process with parents, supervised visitation monitors have the opportunity to ask parents if they or their child has a disability.

The questions below are examples of questions that monitors can use during intake.

Questions to Ask

- How can our program accommodate you or your child's needs?
- Will you or your child need help getting to and using the restroom?
- Is there something you want us to know about you or your child's learning abilities?
- Is there specific language you would like us to use during your visits?
- Is there anything you want us to keep in mind or know about you or child during visitation?
- Was there any difficulty getting to our program today?

If parents disclose a disability that they or their child has, it is important that the program has an adequate understanding about that disability and how it might impact visitation

Monitors can assure parents that they have made a note of any important information and concerns regarding their own or their child's disability. It may also be helpful to inform parents that the program will do all that they can to accommodate their needs.

Conclusion

The most important thing to remember when working with parents or children that have disabilities, is that they are more than their disability. While it is often important and necessary information to know whether or not an individual has a disability, it is crucial that a monitor does not characterize them solely by their disability.

After reading this E-Press, monitors should have a better understanding of what kind of language to use to ensure that they are putting people first, and not disabilities. Additionally, monitors can use the example questions during intake as a starting point with families to learn if there is any information they or the program needs to know in order to adequately accommodate and address their family's needs.

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Kids as Self Advocates. (n.d.) Respectful Disability Langauge. Retrieved from http://www.fvkasa.org/resources/files/history-nyln-language.pdf

Ontario Education Services Corporation. (n.d.) Tips on Serving Customers with Disabilities. Retrieved from http://www.ddsb.ca/AboutUs/Accessibility/Documents/Accessibility%20Tips.pdf

Resources

The Clearinghouse has previously written E-Presses related to working with parents and children with disabilities. Some of these topics are below.

Working with Parents with Learning Disabilities- Page 8
http://familyvio.csw.fsu.edu/wp-content/uploads/2013/07/Aug13EPress_MB.pdf

Supervised Visitation and Special Needs Children- Page 4
http://familyvio.csw.fsu.edu/wp-content/uploads/2012/11/Nov2012_EPress_forWeb.pdf

The Opioid Epidemic

In the state of Florida, Governor Rick Scott has declared the opioid epidemic to be a public health emergency. The epidemic has plagued various parts of the country for several years, and Florida, particularly areas in South Florida, have witnessed the devastating effects of opioid addiction and overdoses for years.

This overview will provide a basic understanding of what opioids are, statistics about addiction and overdose rates, and risk factors for opioid addiction.

Florida's Opioid Epidemic

The Center for Disease Control and Prevention reported that in 2015, close to 3,900 people died across the state due to opioid abuse. **In 2016, an estimated 4,000 people died from opioid overdoses.**

In Palm Beach County in 2016, 525 people died by opioid overdoses. Continuing, in Delray Beach last year more than 900 individuals died from opioid overdoses.

Additionally, during 2016 in Miami-Dade County 220 individuals died due to a fatal combination of heroin mixed with fentanyl (which is significantly stronger than morphine) or carfentanil. In Broward County that same year, **90% of fatal drug overdoses included a mix of opioids such as heroin or fentanyl.**

Types of Opioids

1. *Natural Opioid and Semi-Synthetic Opioid Analgesics:* for natural opioids there are morphine and codeine, and examples of semi-synthetic opioid include oxycodone, and hydrocodone. These are commonly referred to as prescription opioids and have been used to treat moderate to severe pain in some patients. These drugs are commonly available by prescription.

2. *Synthetic Opioid Analgesics:* Besides methadone this includes drugs such as tramadol and fentanyl.

    - Fentanyl is man-made and is 50 times more potent than heroin and 100 times more potent than morphine. The first type of fentanyl is pharmaceutical which is primarily prescribed to advanced cancer patients in order to manage pain. Fentanyl can be prescribed as transdermal patches or lozenges. The second type is illegally made

and is non-pharmaceutical. This kind is often mixed with other drugs such as cocaine or heroin in order to enhance the drug's effects.

3. Heroin: An illegally made opioid created from morphine which can be a white or brown powder, or sticky black substance. This drug is highly addictive and is often used with other drugs and alcohol which increases the risk of overdose. Heroin can be injected, snorted, or smoked.

How Addiction Develops

Addiction to opioids can occur in a variety of ways. In some instances, an individual may be given prescription opioids to manage pain and then begin to develop a tolerance that can lead to physical dependence and then addiction. Some individuals may begin using heroin because it is cheaper and easier to obtain than the prescription opioids they are addicted to.

Research has also shown that some individuals are more susceptible to using and becoming addicted to opioids due to abnormalities in a person's brain structure. These abnormalities can affect the decision-making areas of the brain, making it more likely for a person to engage in compulsive and addictive behaviors. These behaviors include trying new drugs and having low impulse control.

Additionally, addictions to other substances can create abnormalities in the brain which can increase the likelihood for individuals to try opioids and continue using them to experience feelings of euphoria.

Opioids affect various parts of the central nervous system including the brain stem, the limbic system, and the spinal cord. It is important to understand the ways in which opioids affect a person's brain functioning, since those effects are primarily responsible for how dependence and addiction to opioids develop. Opioids can decrease breathing by changing the balance of different neurons and chemicals in the brain system, which is responsible for controlling vital body functions such as breathing and heart rate.

Opioids affects the part of the brain responsible for controlling emotions, the limbic system, by increasing feelings of pleasure and changing how that part of the brain typically functions. Lastly, opioids can block the feelings of pain from being sent through the spinal cord from the body. All of these effects combined provide insight as to why opioids can be addictive for many individuals.

When an individual develops a tolerance to opioids, they will experience withdrawal symptoms if they discontinue use of the drug. These symptoms can be incredibly uncomfortable and dangerous if not monitored by a medical professional. When a person becomes addicted to opioids by developing a tolerance and physical dependence, their brains have grown accustomed to functioning under the effects of the drug. When the opioid is no longer present, the body performs abnormally due to that dependence and addiction factor. During the withdrawal process, an individual may experience anxiety, muscle cramps, diarrhea, and jitters. The more severe the addiction is, the more difficult the withdrawal process will be for an individual. In addition to the pain relief and euphoric effects, the discomfortable withdrawal experience is a reason many avoid discontinuing opioid use.

Effects of Opioids

The effects of opioids can vary depending on which type it is. The following list describes the potential effects of prescription opioids on an individual:

- Higher tolerance to the drug- the longer you use the opioid the more you will need to provide the same effect.
- Physical dependence which leads to withdrawal symptoms after discontinuing opioid use.
- Increased sensitivity to pain
- Constipation
- Nausea, vomiting, and dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Itching and sweating

The following effects are specific to heroin use:

Short-Term Effects

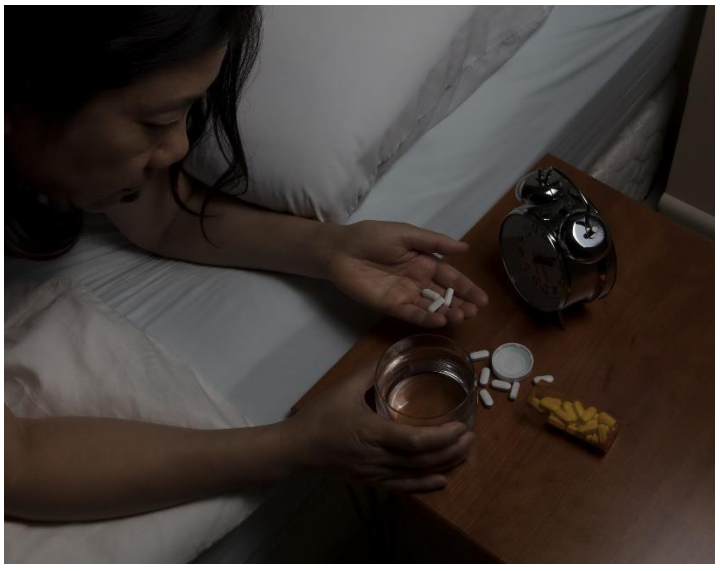
- A high or “rush”
- Decreased breathing
- Slower and cloudy mental functioning
- Nausea and vomiting
- Pain is blocked
- Spontaneous abortion if pregnant

Long-Term Effects

- Addiction
- Infectious disease (e.g., HIV, hepatitis B and C) due to unclean needles that may be used to inject heroin
- Collapsed veins
- Bacterial infections
- Abscesses
- Infection of heart lining and valves
- Liver and kidney disease

Addiction and Overdose Statistics

The following statistics have been found from research related to information about opioid addiction and overdose from around the United States.



- As many as **1 in 4 Americans who were prescribed opioids** long term to manage non-cancer related pain **struggled with addiction**.
- In 2014, over **two million Americans** abused or relied on prescription opioids.
- **Every day, over 1,000 people** are being treated for opioid abuse in Emergency rooms.
- The most common prescription opioids to cause overdose are **methadone, oxycodone (OxyContin), and Hydrocodone (Vicodin).**

Overdose Deaths

It is important to note that overdose does not always lead to death, but as an addict prolongs their abuse of heroin or prescription opioids, the amount they need to induce a "high" increases their risk of having a fatal overdose. A heroin overdose can cause very slow and shallow breathing which can result in coma or death. The startling statistics provide more information about the prevalence of overdose deaths due to opioid abuse.

- More than **six out of ten drug overdose deaths** in the United States involve an **opioid**.
- More than **500,000 people died** from drug overdoses from 2000 to 2015.
- **Every day, 91 Americans die from an opioid overdose**.

Research conducted from 1999 to 2014 found that among those who died from prescription opioid overdoses:

- People aged 25 to 54 years old had the highest overdose rates.
- Overdose rates were higher among non-Hispanic whites and American Indian or Alaskan Natives, compared to non-Hispanic blacks and Hispanics
- Men were more likely than woman to die from overdose, but that gap is beginning to close.

Risk Factors for Addiction

Research has found risk factors that may lead to prescription opioid and heroin addictions. As part of recognizing these addictions as a public health emergency in Florida, Governor Rick Scott **committed 54 million dollars in U.S. Department of Health and Human Services grant money** aimed towards prevention and intervention including equipping all EMS personnel with naloxone (and overdose reversal drug).

Prescription Opioids
Research shows that some risk factors make people particularly vulnerable to prescription opioid abuse and overdose, including:

- Receiving overlapping prescriptions from different doctors and pharmacies.
- Consuming high daily quantities of prescription pain relievers.
- Having a mental illness or history of alcohol or other substance abuse

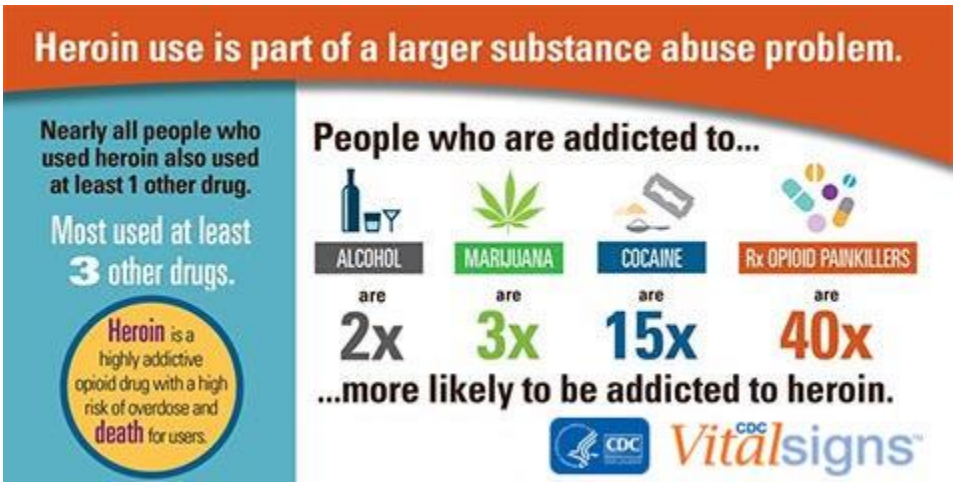
- Living in rural, isolated areas and having low income.

Medicaid Patients

- Inappropriate opioid prescribing rates are significantly higher among Medicaid patients than they are for patients who have private insurance.
- Based on 2010 data, 40% of Medicaid recipients with prescriptions for pain relievers had at least one of the following potential indicators of inappropriate use or prescribing:
    - overlapping prescriptions for pain relievers, and possibly benzodiazepine prescriptions,
    - long-acting or extended release prescription pain relievers for acute pain, and
    - high daily doses.

Heroin Addiction
Research has found that the following risk factors may make an individual more susceptible to developing a heroin addiction:

- Addicted to prescription opioid pain relievers or cocaine
- Uninsured or enrolled in Medicaid
- Non-Hispanic whites
- Males
- Addicted to marijuana and alcohol
- Living in a large metropolitan area



- Being between the ages of 18 to 25 years old.

  Additional Important Statistics:

  - More than **nine in 10 people** who have used heroin also used at least one other drug.
  - Among new heroin users, approximately **three out of four** reported **abusing prescription opioids prior to using heroin.**

Conclusion

Opioid addictions and overdoses are becoming more prevalent not only across the nation but in Florida as well. It is important to understand that as supervised visitation programs, you may work with parents who are struggling with a prescription opioid addiction or a heroin addiction. Many of those who have a heroin addiction were first prescribed an opioid to manage their pain which turned into abuse of the prescription drug then introduction to heroin.

This E-Press has provided supervised visitation programs with a basic foundation to understand the opioid epidemic and how it affects the individuals who have developed a dependence and addiction to the drug. It is important for all monitors to remember not to generalize or make assumptions regarding individuals with an opioid addiction. There are various ways that an individual may develop an opioid addiction, and each person has their own story.

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