JANUARY 2009 E PRESS

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The next statewide phone conference is on

THURSDAY, JANUARY 15, 2009.
Noon Eastern

(850) 644-2255

Bring your questions, comments, and feedback!

Please remember to check the Clearinghouse website for resources, reference material, training manuals, and other helpful aids for your Program! **Bookmark these sites!**

http://familyvio.csw.fsu.edu/ The Institute for Family Violence Studies at Florida State University (click on **Clearinghouse for Supervised Visitation**)

http://familyvio.csw.fsu.edu/CHV.php The Clearinghouse for Supervised Visitation (under *Information for Supervised Visitation Programs,* click on **Message Board and Archive**)

http://familyvio.csw.fsu.edu/phpBB3/index.php Board Index (click on **2008 New Standards for SV**)

http://familyvio.csw.fsu.edu/phpBB3/viewforum.php?f=15) 2008 New Standards for SV The electronic version of the **Report to the Legislature** is posted here, as is the **DCF Response** to the Report. The **Optional Compliance Forms** are filed under each Principle. Also posted here is the **Letter of Support** from the Florida Chapter of the Supervised Visitation Network and the letter received from the **Kansas Network of Visitation Providers**.

The Clearinghouse mailed two hardcopy versions of the formal *Report to the Legislature* to you on December 10th 2008.

The electronic version is posted on the Clearinghouse website under the forum "2008 New Standards for SV":
http://familyvio.csw.fsu.edu/phpBB3/viewtopic.php?f=15&t=165

The electronic version of DCF's Response to the Report is also posted on the Clearinghouse website under the forum "2008 New Standards for SV":
http://familyvio.csw.fsu.edu/phpBB3/viewtopic.php?f=15&t=166

Innovations and New Directions

What innovations has your program implemented? We want to publish your stories in the February Family Visitation Times. Click Reply to this E Press, and tell me when to call you. I will get all the pertinent information from you and even print a photograph, if you have one in jpeg.

If your program had a holiday party, let me know. I planned a spread in the newsletter on the various holiday events hosted by programs.

If you had a fundraiser – send pictures! I will run them with a short story. Remember, my number is 850-644-6303 (and I am in the office all week!)

Recession: The Economic Impact on Florida's Families

By Zachary Summerlin

As our state and nation have entered into a recession, Governor Crist has recognized that "Florida's families and businesses are faced with extraordinary economic times…"[1]. The sad truth is that in times of such economic stress many families and communities face the reality of the national stress level – it has risen over 14% in the last seven months [2].

With rising stress levels and tight economic times, many Floridians find themselves pinching the few pennies they do have, trying to work the extra job or pick up overtime in the job they have, or even some standing in the unemployment lines [3, 4]. These financial woes combined with the unstable housing market that is hitting Florida especially hard only increase stress in the household and no doubt affect each member in the respective families.

Statistically, job loss and sharp fluctuations in income are linked to unstable marriages (divorce, abuse, neglect, etc) and any instability between parents impacts children in areas far beyond the home [5, 6]. Kelly Smallridge, executive director of Haven of Lake and Sumter counties, a domestic violence shelter, is seeing an increase in victims of domestic violence seeking help by more than 30% a month since the economic downturn began.

The after effects of this economic downturn are appalling, especially when looking at families and children. Researchers in the Department of Sociology at Framingham State College in Massachusetts note that as distress affects parenting, harsher disciplinary actions are taken perpetuating domestic violence which in turn filters into the child's behavior at school [5]. Children who sense that their parents are more stressed take on that burden themselves internalizing it and are more vulnerable to depression [5].

With record numbers of foreclosures uprooting many of Florida's families it is estimated that more than 130,000 children in the state of Florida will be evicted from their homes in 2008 and 2009 [5]. Hundreds of thousands more children will move in the same time period causing them to fall behind in school [5]. Teens who move frequently are 77% more likely to have more behavior issues and 20% more likely to exhibit violent behavior in high school than their more residentially stable peers" [5].

Given these dire statistics, a heavy caseload at supervised visitation programs, and dwindling financial resources for social services, we ask that programs consider the following tips:

1. If you need to use volunteers because of poor funding, be sure they are trained properly.
2. Try to be as flexible as possible when parents have transportation problems and need to reschedule visits and other services because of work demands. **Consider suspending** your case rejection policies based on cancelled visits for a few months. Give people **even more** additional chances to show up when work issues interfere with visits.
3. Many families at visitation programs will not be able to bring birthday gifts for their kids – consider **asking a community group** for donations especially for this purpose.

4. Some families will need extra links to basic services for food and housing. Have these available. Also, make contacts with these agencies to ensure that they are still offering services. We have heard of several agencies that have placed limits on the amount of groceries they can give out and assistance they can offer. Know what help agencies can truly provide.
5. Go the extra mile when a parent or child is experiencing stress. Conduct your follow-up interviews often to see if there is anything you can do to help the family get services. Last month I had two calls from programs asking if they could make a phone call on behalf of a client to help cut through the red tape of getting supplies. The clients were numb from the bureaucratic red tape, and in one case, were tearful when asking for help over the phone. Yes, you can make that phone call.

1. Associated Press. (2008). Crist: State Can Meet Its Obligations Even In Hard Economic Times. http://www.charliecrist.com/index.php
2. Transitions Recovery Program (n.d.) Economic Stress Can Cause Addition Relapse. http://www.drug-rehabcenter.com/Treatment/2008/10/13/economic-stress-can-cause-addiction-relapse/
3. Santich, Kate. (2007). Florida's working families struggle to get by, report says. *Orlando Sentinel*. http://www.orlandosentinel.com/community/news/ucf/orl-poverty07nov21,0,357926.story
4. Associated Press. (2008). 'Sandwich generation' adults feeling new economic stress. *The Sacramento Bee.* http://www.sacbee.com/livinghere/v-print/story/1310717.html
5. Rutter, Virginia. (2008). Economic Woes = Family Stress. http://www.comtemporaryfamilies.org/subtemplate.php?t=briefingPapers&ext=EconomyandFamily
6. Rippel, Amy. (2008). Violence shelter finding less cash – and more need. *Orlando Sentinel.* http://www.orlandosentinel.com/news/local/lake/orl-ldomestic2808oct28,0,1496058.story

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Resource List by County

We are continuing to create the List of Resources by County and these are posted on the Clearinghouse Message Board "Announcements". *http://familyvio.csw.fsu.edu/phpBB3/viewforum.php?f=7*

As of December 19th, we have lists for the following counties completed and posted. These may help you link your clients to essential services.

County Lists Completed:

	County	*Date*
1.	Alachua	10/30/2008
2.	Baker	10/30/2008
3.	Bay	10/30/2008
4.	Calhoun	10/30/2008
5.	Charlotte	10/30/2008
6.	Citrus	10/30/2008
7.	Clay	10/30/2008
8.	Duval	10/30/2008
9.	Gilchrist	10/30/2008

10.	Holmes	10/30/2008
11.	Levy	10/30/2008
12.	Okaloosa	10/30/2008
13.	Santa Rosa	10/30/2008
14.	Lake	11/10/2008
15.	Marion	11/10/2008
16.	Sumter	11/10/2008
17.	Bradford	11/18/2008
18.	Brevard	11/18/2008
19.	Osceola	11/18/2008
20.	Glades	11/18/2008
21.	Hendry	11/18/2008
22.	Highlands	11/18/2008
23.	Leon	11/19/2008
24.	Union	11/19/2008
25.	Polk	12/09/2008
26.	Dade	12/09/2008
27.	St. Johns	12/09/2008
28.	Gulf	12/09/2008
29.	Hamilton	12/09/2008
30.	Jackson	12/09/2008
31.	Jefferson	12/09/2008
32.	Liberty	12/09/2008
33.	Madison	12/09/2008
34.	Monroe	12/09/2008
35.	Taylor	12/09/2008
36.	Columbia	12/10/2008
37.	Putnam	12/10/2008
38.	Washington	12/10/2008
39.	Wakulla	12/10/2008

Remember, this is created to help you identify agencies and groups in the community to refer clients to, and to help you meet the Community Standards of Principle Four!!!

This is the list for Charlotte County as an example.

CHARLOTTE COUNTY

DOMESTIC VIOLENCE SERVICES

Charlotte County Justice Center
http://www.co.charlotte.fl.us/CLRKINFO/information/domesticViolence.htm
350 East Marion Avenue
2nd Floor - Domestic Violence
Punta Gorda, FL
Phone: (941) 637-2162 / (941) 637-2264 / (941) 505-4751

Office Hours: Mon – Fri: 8:00 a.m. – 5:00 p.m.
Assists clients who want to begin a civil restraining order. Assistance in filing for an Injunction for Protection may be obtained by appearing in person at the Justice Center's office. Assistance is also offered for a Petition against Domestic Violence, Petition against Repeated Violence, Petition against Dating Violence, and Petition against sexual violence. There are no fees for these services and forms are available on-line.

Center for Abuse and Rape Emergencies (CARE)
http://www.geocities.com/Petsburgh/9711/CARE.html
Charlotte County Administration Annex
6868 San Casa Blvd.
Englewood, Florida 34224
Phone: (941) 475-6465 / (941) 627-6000
Provides a 24-hour domestic violence and sexual assault crisis hotline, support groups, counseling, and emergency shelter. CARE also provides support groups and counseling. In Englewood, the group meets Tuesdays at 6:30 at the office on San Casa Blvd. In Punta Gorda, the group meets Mondays at 6:30. Call (941) 627-6000 for directions to the Punta Gorda meeting. Child care is provided at both locations. All services provided by CARE are free.

Florida Coalition Against Domestic Violence
http://www.fcadv.org/
Phone: (850) 425-2749
Domestic Violence Hotline: (800) 500-1119
The 24-hour domestic violence hotline links people with domestic violence shelters and services throughout the state of Florida, and also provides translation services if needed. The website maintains a resource library that is available to volunteers and employees. Handbooks on Florida's legal rights for victims and confidentiality and privilege are also available on-line. There is no fee for the hotline or for the resource libraries.

Charlotte 211
http://www.charlottecountyfl.com/HumanServices/211.asp
26571 Airport Rd
Punta Gorda, FL 33982
Hotline: 211
Cell phone, TTY users and residents of Englewood, call: (941) 205-2161
Charlotte 211 is a 24- hour crisis hotline that can offer crisis counseling and referrals for a variety of issues, including domestic violence. There is no fee for the service.

Charlotte County Sheriff's Office
http://www.ccso.org/
Phone: (941) 639-2101
Emergency: 911

SEXUAL ASSAULT SERVICES

Florida Council Against Sexual Violence
http://www.fcasv.org/
Emergency Hotline: 1-888-956-RAPE (7273)

The emergency hotline connects the caller to the nearest rape/sexual violence crisis center. The website offers information for victims concerning crisis response, common emotions, and the healing process. There is no fee for the services.

National Sexual Violence Resource Center (NSVRC)
http://www.nsvrc.org/
Phone: 1-877-739-3895
TTY: 717-909-0715
NSVRC is a national clearinghouse of information, resources, and research related to sexual violence. The website provides a library of relevant readings. There are no fees.

Rape, Abuse, and Incest National Network (RAINN)
http://www.rainn.org/
Phone: 1-202-544-3059
Hotline: 1-800-656-HOPE (4673)
RAINN provides a national, free, and confidential hotline for those in need of crisis counseling and linkages to local resources. An on-line hotline is also available. Resources for learning about sexual violence and assault are also available on-line. These services have no fees.

See: Charlotte 211, Center for Abuse and Rape Emergencies, Charlotte County Sheriff's Office, Charlotte County Justice Center (Domestic Violence Services)

HOUSING/FOOD SERVICES

Charlotte County Homeless Coalition
http://cchomelesscoalition.org/
1476 Kenesaw St.
Port Charlotte, FL
Phone: (941) 627-4313
The Charlotte County Homeless Coalition's Lighthouse Outreach program provides hot meals at the Genesis Center at no cost. The Genesis Bishop House provides pregnant women with no place to go temporary housing, community support services, and enriching activities at no cost. Location: 112 Bishop St., Port Charlotte, FL. Phone: (941) 624-2721. The Genesis Chara House provides women with no more than 2 children temporary housing, community support, and enriching activities at no cost. Location: 509 Berry St., Punta Gorda, FL. Phone: (941) 833-0200.

Good Samaritans of Charlotte County, Inc.
265 E. Marion Ave, Unit 117-A
Punta Gorda, FL 33950
Phone: (941) 639-3335
Office Hours: Monday – Friday 10:00 a.m. to 12:30 p.m.
Offers emergency financial assistance, emergency prescriptions, transportation, housing, and maintains an emergency food pantry. You must visit the office to receive assistance.

Harry Chapin Food Banks
http://www.harrychapinfoodbank.org/
2126 Alicia Street,
Fort Myers, Florida 33901
Phone: (239) 334-7007

Offers emergency food services for those in need at no cost. Food is distributed to local churches and other organizations throughout SW Florida. Call the Harry Chapin Food Bank to find the nearest distribution center to you.

See Also: Charlotte 211 (Domestic Abuse Services)

CHILD SERVICES

Children's Advocacy Center of Southwest Florida
http://www.cac-swfl.org/
3900 Broadway, Suite B1
Ft. Meyers, FL 33901
Phone: (239) 939-2808
A crisis center that works with physically and sexually abused children, the center offers therapy, parenting education, offender and prevention programs. The Child Protection Team conducts forensic interviews, medical examinations, psychosocial family assessments, psychological evaluations, crisis intervention, and referrals for other services at no cost. Family Alliance provides individual and group therapy to child victims and survivors of abuse and neglect. There are minimal, sliding fees for these services. Nurturing Programs involve parenting classes that are designed to enhance and strengthen the family unit. The classes may be court-appointed or voluntary and require no fees.

Voices for Kids of Southwest Florida
http://www.voicesforkids.org/
Phone: (239) 997-5437
Ensures that children receive a court-appointed Guardian ad Litem. Children's Special Needs ensures that children receive any extraneous needs or services not provided by any other agency, including medical care, hygiene products, and car seats. My Closet ensures that children are able to receive adequate new clothing. Visits to My Closet must be scheduled through the Voices for Kids office. Beds for Kids ensures that children have appropriate bedding wherever they are. Availability varies. Requests can be made by calling the Voices for Kids office between 9:00 a.m. and 1:00 p.m. on weekdays.

Guardian ad Litem of Charlotte County
http://www.guardianadlitem.org/partners_c21.asp#map
21450 Gibralter Dr.
Port Charlotte, FL 33952
Phone: (941) 627-0643
The State of Florida Guardian ad Litem program is a network of professional staff and community advocates, partnering to provide a strong voice in court and positive systemic change on behalf of Florida's abused and neglected children.

See Also: Charlotte 211, Children's Advocacy Center of Southwest Florida

LEGAL SERVICES

Florida Rural Legal Services
http://www.frls.org/
350 E. Marion Avenue,
Suite A1017 and A1018
Charlotte County Justice Center

Punta Gorda, Fl. 33950
Phone: (941) 505-9007
Provides free civil legal assistance.

Human Services Department of Charlotte County
18500 Murdock Circle
Port Charlotte, FL 33948
Phone: (941) 743-1200
Legal assistance services are provided to assist clients to become aware of and protect their civil/legal rights through activities or direct intervention by attorneys or legal paraprofessionals.

Salus Services, Inc.
http://saluslegalservices.com/charlotte.aspx
Phone: (31) 274-4729
Offers a number of services related to civil procedure and service of process, including court filings, public records search, summons, medical records retrieval, etc.

See Also: Charlotte 211 (Domestic Abuse Services), Charlotte County Justice Center (Domestic Abuse Services), Guardian ad Litem of Charlotte County (Child Services), Voices for Kids of Southwest Florida (Child Services)

HEALTHCARE SERVICES

Fawcett Memorial Hospital
http://www.fawcetthospital.com/
21298 Olean Boulevard
Port Charlotte, FL 33952
Phone: (941) 629-1181 / Emergency: 911

Charlotte Regional Medical Center
http://www.charlotteregional.com/index_flash.php
809 E. Marion Ave.
Punta Gorda, FL 33950
Phone: (941) 639-3131 / Emergency: 911

Peace River Regional Medical Center
http://www.peaceriverregional.com/index_flash.php
2500 Harbor Blvd.
Port Charlotte, FL 33952
Phone: (941) 766-4122 / Emergency: 911

See Also: Charlotte 211 (Domestic Abuse Services)

SUPERVISED VISITATION SERVICES

These Programs are in the Twentieth Judicial Circuit but may not provide services in all counties within that circuit.

Family Safety Program
Gail Tunnock, Program Director
Children's Advocacy Center of Collier County
1036 6th Ave. North
Naples, FL 34102
239-263-8383, ext. 23 Fax: 239-263-7931
gtunnock@caccollier.org

Lutheran Services Supervised Visitation Program
Tom Desio, Director
2285 Victoria Ave
Ft. Myers, FL 33907
239-461-7640
tdesio@childnetswfl.org

Charlotte County Supervised Visitation Center
The Bill Reilly Center
Daryl Garner, Director
3440 Depew Cr.
Port Charlotte, FL 33952
941-255-0677 Fax: 941-255-0797
billreillycenter@embarqmail.com

Children's Home Society, Family Connection Center
Linda Bluhm, Program Director
1940 Maravilla Ave
Fort Myers, FL 33901
239-334-0222 Fax: 239-334-0244
Linda.bluhm@chsfl.org

Source of Light and Hope Visitation Center
Arvella Clare
3901 Dr. MLK Jr. Blvd.
Ft. Myers, FL 33902
239-334-3739
solvisit@earthlink.net

Twentieth Judicial Circuit - Programs In Progress

Institute for Youth and Justice Studies
Division of Public Affairs
Sandra Pavelka, Ph.D. Director/Associate Professor
Florida Gulf Coast University
College of Professional Studies
10501 FGCU Blvd. South
Ft. Myers, FL 33965-6565
239.590.7835 voice 239.590.7842 fax
sobrien@fgcu.edu

Plan ahead to join us for the February statewide phone conference on

MARK YOUR CALENDARS TODAY

THURSDAY, FEBRUARY 12TH, 2009

Noon Eastern

850) 644-2255

Supervised Visitation Database
Case and Client Report
3/1/2007 to 9/30/2008

The Clearinghouse on Supervised Visitation
Institute for Family Violence Studies
Florida State University
College of Social Work

December 18, 2008

Case and Client Statistical Analysis Results
3/1/2007 to 9/30/2008

Cases: 4,077 Clients: 7,001 Services: 53,289

Below you will find the results of the newest Clearinghouse on Supervised Visitation's Database Case and Client Analysis. This report covers March 1, 2007 to September 30, 2008, the **19 months** since the last report. The previous report covered 1/1/2005 to 2/28/2007, a total of **26 months**. A total of 43 of Florida's supervised visitation programs contributed information to the database during this time span. The tables allow for a comparison of the information across time.

Please note that there are two analysis options offered: "Percent" and "Valid Percent". "Percent" is the % of all cases, while "Valid Percent" is the % of only the reporting cases. In other words, "Valid Percent" does not include missing data. Both analyses are included here as they each hold their own value.

From 3/1/2007 to 9/30/2008 the total number of documented cases added to the database was **4,077**, the number of clients served was **7,001**, and the number of services provided was **53,289**.

This means that during that 19 month time period, over 53,000 services were provided to clients at Florida's supervised visitation programs. Divided by the number of cases, this means 4,077 cases/families received over 13 services each at programs in that time period.

Referral Source

		3/1/2007 to 9/30/2008			1/1/2005 to 2/28/2007	
Referral Source		Frequency	Percent	Valid Percent	Frequency	Valid Percent
Valid	Dependency Case	2227	54.6	57.7	2687	57.1
	DV Injunction	789	19.3	20.5	1219	25.9
	Dissolution of Marriage/Modifications	422	10.3	10.9	581	12.4
	Never Married/Paternity	80	2.0	2.1	130	2.8
	Self-Referred	24	.6	.6		
	Criminal Case	22	.5	.6		
	Other	294	7.2	7.6	87	1.8
	Total	3858	94.6	100.0	4707	100.0
Missing	System	221	5.4		494	
Total		4079	100.0		5201	

In the database, there are seven options for the variable Referral Source. This is now a mandatory variable in that database users cannot continue until this information is inserted. For the most part, the trends have remained steady as Dependency court continues to be the most common referral source, followed by domestic violence injunctions. Self-Referred and Criminal cases were not noted in the previous report but do consist of a small number of cases.

Reason for Referral Condensed

		2007-2008			2005-2007	
Reason for Referral		Frequency	Percent	Valid Percent	Frequency	Valid Percent
Valid	Child Abuse / Neglect	831	20.4	21.1	956	19.9
	Parental Substance Abuse	861	21.1	21.8	826	17.2
	Domestic Violence	1663	40.8	42.2	2534	52.7
	Parental Mental Health Issues	187	4.6	4.7	149	3.1
	Other Parental Misconduct	110	2.7	2.8	80	1.7
	Death of a Sibling	3	.1	.1		
	Parent Services	24	.6	.6		
	Other	263	6.4	6.7	260	5.4
	Total	3942	96.6	100.0	4805	100.0
Missing	System	137	3.4		393	0
Total		4079	100.0		5198	

For each case the database user is required to enter the primary reason for the referral. Death of a Sibling and Parent Services are newly included options. As in the previous years, domestic violence is the most often cited reason for a referral to supervised visitation, even for those referrals from dependency court. Note that the most cases originate in dependency court, as noted in the previous chart.

Primary Service Requested

Primary Service Requested		2007-2008			2005-2007	
		Frequency	Percent	Valid Percent	Frequency	Valid Percent
Valid	Supervised Visitation	3617	88.7	88.9	4820	92.9
	Monitored Exchange	194	4.8	4.8	367	7.1
	Parent Services	244	6.0	6.0		
	SV & ME	13	.3	.3		
	Other	1	.0	.0		
	Total	4069	99.8	100.0	5187	100.0
Missing	System	10	.2		11	
Total		4079	100.0		5198	

Each case lists a primary service requested with the available options listed above. In July of 2008, Parent Services was added as an option and quickly garnered 6% of the requests. Several programs are now offering this as a primary rather than additional service to families in need. However, Supervised Visitation remains by far the most highly requested service.

Person Providing Service

		2007-2008			2005-2007
		Frequency	Percent	Valid Percent	Valid Percent
Valid	Paid Staff	35,562	66.9	92.0	90.5
	Intern	348	.6	.8	.6
	Volunteer	2794	5.2	7.2	8.9
	Total	38,704		100.0	100.0
Missing	System	14,585	27.3		
Total		53,289	100.0		

Paid staff members continue to be the main provider of services in Florida's supervised visitation centers, followed by volunteers, and last, interns.

Child's Race

Race		2007-2008			2005-2007	
		Frequency	Percent	Valid Percent	Frequency	Valid Percent
Valid	Black	1275	17.5	19.5	1674	21.2
	White	4046	55.6	62.0	4970	62.8
	Hispanic	882	12.1	13.5	986	12.5
	Other	321	4.4	4.9	282	3.6
	Total	6524	89.6	100.0	7912	100.0
Missing	System	756	10.4		826	
Total		7280	100.0		8738	

According to the 2000 US census, approximately 69% of the US is white, 12% is black, and 15% is Hispanic. In comparison, blacks appear to be slightly overrepresented while Hispanics are somewhat underrepresented in the client profiles. However, the percentages have not changed significantly from the former report to the current report.

Child Gender

Gender		2007-2008			2005-2007	
		Frequency	Percent	Valid Percent	Frequency	Valid Percent
Valid	Female	3200	44.0	49	3973	49.3
	Male	3329	45.7	51	4084	50.7
					681	
	Total	6557	90.1	100.0	8057	100.0
Missing/Unknown	System	751	9.9		681	
Total		7280	100.0		8738	

This number remains steady, as nearly half the children who receive services are male; nearly half are female.

Visitor Gender

Gender		2007-2008			2005-2007	
		Frequency	Percent	Valid Percent	Frequency	Valid Percent
Valid	Female	1818	44.6	50.6	2601	50.0
	Male	1764	43.3	49.1	2530	48.7
	Unknown	8	.2	.2		
	Total	3590	88.0	100.0	5131	
Missing	System	488	12.0		67	.3
Total		4078	100.0		5198	100.0

The Visitor is the person who receives the service of supervised visitation with the child. Men and women continue to be almost equally represented as visitors participating in supervised visits.

Visitor Race

Race		2007-2008			2005-2007	
		Frequency	Percent	Valid Percent	Frequency	Valid Percent
Valid	Black	579	14.2	16.3	912	18.5
	White	2357	57.8	66.5	3331	67.4
	Hispanic	516	12.7	14.5	696	14.1
	Other	85	2.4	1.4		
	Total	3547	87.0	100.0	4939	100.0
Missing	System	531	13.0		259	
Total		4078	100.0		5198	

The majority of the visitors continues to be white, followed by black and then Hispanic visitors. There are only slight changes between the reporting periods.

Visitor Relationship to Child

Relationship	2007-2008			2005-2007	
	Frequency	Percent	Valid Percent	Frequency	

						Valid Percent
Valid	Grandparent	59	1.4	1.6	82	1.6
	Parent	3514	86.2	97.5	5082	97.7
	Sibling	7	.2	.2	11	.2
	Other Family Member	15	.4	.4	11	.2
	Other	9	.2	.2	11	.2
	Total	3604	88.4	100.0	5198	100.0
Missing	System	474	11.6			
Total		4078	100.0			

The most common visitor was by far a parent to the child client. This trend did not change over the reporting time periods.

Custodian Gender

		2007-2008			2005-2007	
Gender		Frequency	Percent	Valid Percent	Frequency	Valid Percent
Valid	Female	1522	37.3	72.2	3854	75.5
	Male	571	14.0	27.1	1249	24.5
	Unknown	15	.4	.7		
	Total	2108	51.7	100.0	5103	100.0
Missing	System	1970	48.3		95	
Total		4078	100.0		5198	

Clearly women were by far the most common custodian, the person having legal custody of the child client. Of note is the fact that there were 1970 cases for which this data was not entered. However, one can assume, based on the continued trend across time that women would be most highly represented among those missing cases. The fact that this category has the most missing data is significant, and may raise issues of database correction.

Custodian Race

		2007-2008			2005-2007	
	Race	Frequency	Percent	Valid Percent	Frequency	Valid Percent
Valid	Black	215	5.3	10.4	524	10.5
	White	1407	34.5	67.8	3518	70.3
	Hispanic	379	9.3	18.3	846	16.9
	Other	74	1.9	2.1	115	2.3
	Total	2075	50.9	100.0	5003	100.0
Missing	System	2003	49.1		195	
Total		4078	100.0		5198	

The majority of the custodians continues to be white, followed by black and then Hispanic visitors. There are only slight changes between the reporting periods.

Custodian Relationship to Child

		2007-2008			2005-2007	
	Relationship	Frequency	Percent	Valid Percent	Frequency	Valid Percent
Valid	Grandparent	220	5.4	10.4	365	7.0
	Parent	1646	40.4	77.8	4252	81.8
	Sibling	6	.1	.3	6	.1
	Other Family Member	89	2.2	4.2	170	3.3
	Other	155	3.8	7.3	405	7.8
	Total	2116	51.9	100.0	5198	100.0
Missing	System	1962	48.1			
Total		4078	100.0			

The most common custodian was by far a parent to the child client. This trend did not change over the reporting time periods. Following parents, grandparents were the next most common category.

Conclusion

This report shows remarkable consistency in the services provided at supervised visitation programs across the state. Unfortunately, the numbers do not reflect the total extent of the service, as there are a

number of programs who have not been reporting data. However, changes in DCF contracts with the individual agencies providing services have resulted in better data input. The value in the data collection is the tracking of a court or agency-ordered service across a large state.

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The new Report to the Legislature (December, 2008) recommends that programs be mandated to enter data (under Principle Two, Training). This requirement would close the gap of data entry within two years. Thus, our hope is for a full set of data reflecting every single court or agency-referred case by 2010. Having such a data set would be unprecedented for any state and would help justify the call for adequate resources.

Karen Oehme, Director

Program Closings:

In 2008, the Kids' First Visitation Program and the Salvation Army of Brevard County (Cocoa, run by Cindy Mitchell) closed their doors because of funding problems.

Subpoenas at Supervised Visitation

What is a subpoena?

A subpoena is a written, legal document that can be issued in a criminal or civil proceeding. In supervised visitation cases, a subpoena is generally used to require someone's appearance in court. Sometimes supervised visitation providers receive subpoenas in contested child custody litigation cases stating that the provider or staff must appear in court to provide information about a contested case. The subpoena itself usually describes the purpose of the subpoena.

What can a subpoena require supervised visitation providers to do?

A subpoena will usually require an individual to give testimony at a deposition, hearing or trial, or to produce documents like visitation reports or other records for inspection by the parties' attorneys. Sometimes the administrator or provider is subpoenaed, but other times the document requests that a specific monitor who observed visits, critical incidents, or other behavior come to court.

Who issues a subpoena?

Generally, one of the parties' attorneys issues the subpoena, but there may be other times when someone else, such as a States Attorney, attorney for the Child Protective Agency, or a local GAL attorney who issues the subpoena. Grand juries can also subpoena witnesses in criminal cases.

Can a subpoena be ignored?

No. When a supervised visitation provider receives a subpoena, he or she must either comply with its requirements or contest the document itself. Complying with the document usually means showing up at a certain hearing with records in a specific case. A subpoena asking for documents is called a subpoena ducas tecum. Contesting any subpoena requires the assistance of an attorney, because the attorney understands that any subpoena must meet several specific requirements before it is legally enforceable.

How can an attorney help?

Lawyers can ask that the subpoena be "quashed" – or vacated/invalidated. This can happen if the subpoena does not meet certain legal requirements defined by state law. If the subpoena is valid, the provider can receive specific guidance from the lawyer about meeting the requirements of the document. The issuance of subpoenas is one of the best reasons for ALL PROGRAMS TO HAVE A PRO BONO ATTORNEY to consult locally when a subpoena is received by the program! The Clearinghouse has always helped programs find ways to identify potential pro bono attorneys.

What happens if the person named in the subpoena does not show up?

If the person given a subpoena does not appear, some courts have the discretion to find the person in contempt of court. THIS IS A SERIOUS CONSEQUENCE, and it can impact the court's view of the visitation program. The court can either order the person's arrest or issue fines to him/her! If a provider decides that it is difficult or impossible to appear at the time and place indicated on the subpoena, the provider should contact the attorney or person who issued the subpoena. The person's name, address, and telephone number will usually appear somewhere on the subpoena. It may be possible to postpone the provider's appearance in court, or to arrange a more convenient time to appear. However, you should never ignore a subpoena.

At the January phone conference, we will discuss subpoenas, along with the questions you have raised over the last month. Please remember to join us.

Remember to give us a list of the program staff and volunteers who join us, so we have accurate records of training hours!

HAPPY NEW YEAR TO ALL!

February E Press

Greetings,

We have many announcements this month, so be sure to read this e press "cover to cover."

First,

Phone Training!

The Monthly Phone Meeting/Training is on Thursday, February 12 at Noon (EST)
Call in at 850-644-2255.
This month we are doing a tutorial on dependency cases. The pdf for that tutorial is attached. Please have it with you during the call. We will also have our usual "director asks" session.

Remember, do not put us on "hold." Mute your line. Send me and email to let me know you're joining us.

Second, the Winter Issue of the Family Visitation Times is attached in pdf. You will be receiving hard copies of this newsletter next week.

Third, there are several trainings coming up that you should know about. Here they are:

Training Information: Batterer Intervention

In association with the Florida Coalition Against Domestic Violence, the Department of Children and Families is pleased to once again offer a series of four regional training events. This year's topic is the Batterer As Parent and will be presented by DAVID ADAMS, ED.D, noted author and co-founder of Emerge Counseling Center in Boston, MA.

This training is open to all in the community including domestic violence centers, DCF staff and community-based partners, court personnel, law enforcement, county and state probation, supervised visitation centers, child welfare agencies, etc. Please pass this along to those you think may be interested.

This year's events are scheduled as follows:

February 25-Tallahassee Double Tree Hotel, 101 South Adams Street, Tallahassee, 1:00-5:00 p.m.

February 27-Daytona Beach-Hilton Daytona Beach Resort/Ocean Walk Village,
100 North Atlantic Avenue, Daytona Beach

March 11-Miami area (location pending)

March 13-St. Petersburg area (location pending)

Registration for the Tallahassee and Daytona events is available now. Please see attached registration forms or you may register on line at www.fcadv.org/registration/

(See attached file: Tallahassee 2-09 a.doc)(See attached file: Daytona 2-09
a.doc)

For more information, contact
Barbara A. Carter
Florida Department of Children and Families
Domestic Violence Program Office
1317 Winewood Blvd., Bldg. 3 Room 325
Tallahassee, FL 32399-0700
(850) 922-9327 Fax (850) 922-6720
E-Mail Barbara_A_Carter@dcf.state.fl.us

Supervised Visitation and GAL Training in Pasco in May – see pdf attached.

Mark your calendar for the FNCAC Multidisciplinary Conference in August. The Florida Network of Children's Advocacy Centers is having its annual meeting in Orlando again in August. The Florida Chapter of SVN is having its meeting and training in conjunction with that conference. Please see Fncac.org for more information!

Fourth, we offer more of our own trainings. Check out the in-service trainings below!

Fifth, it is time again for the annual performance survey. Please print it out and fax to 850-644-8331. You can also clip it out from the Visitation Times. I will be sending you reminders monthly. Please have your staff and volunteers fill out a survey as well!

In-Service Training for Your Staff!

Parents with Developmental Disabilities

By: Ericka Garcia

Introduction
There are many different obstacles that families deal with today. Parents with developmental disabilities have many obstacles, but these citizens and the needs of their families are often overlooked. This training piece can be used to introduce supervised visitation staff to the issues involved with parents with developmental disabilities.

Objectives:
1. Know the approximate number of Americans with a developmental disability;

2. Define four of the major life activities that developmental disabilities limit;

3. Know the removal rate of children from the home of parents with developmental disabilities;

4. Discuss what actions can be taken to assist parents with developmental disabilities in the visitation setting;

5. Identify different types of social support that can help these families.

Data

There are over 4 million individuals in the US that have a developmental disability[1]. In 2002, approximately 430,257 persons with developmental disabilities had children[2]. Most supervised visitation programs in Florida have dealt with the challenges of parents with disabilities. This brief article presents information about those and similar families.

To better understand the scope of developmental disabilities lets break it down into some simple categories.

What is a Developmental Disability?
Developmental disabilities result in substantial limitations in three or more areas of major life activities:

- Capacity for independent living
- Economic self-sufficiency
- Learning
- Mobility
- Receptive and expressive language
- Self-care

- Self-direction [1]

Although developmental disabilities can be solely of a physical nature, the term most often indicates an intellectual disability (in the past referred to as mental retardation). Many different diagnoses fall under the category of developmental disabilities. These are some of the most common disorders that people who are developmentally disabled have:

Autism Spectrum Disorders
Autism Spectrum Disorders are complex developmental disability that causes problems with social interaction and communication. Symptoms usually start before age three and can cause delays or problems in many different skills that develop from infancy to adulthood. [3]

Down Syndrome
Down Syndrome is set of mental and physical symptoms that result from having an extra copy of Chromosome 21 which changes the body's and brain's normal development. Even though people with Down syndrome may have some physical and mental features in common, symptoms of Down syndrome can range from mild to severe. Usually, mental development and physical development are slower in people with Down syndrome than in those without the condition. [3]

Fragile X Syndrome
Fragile X syndrome is the most common form of inherited mental retardation. Fragile X happens when there is a change, or mutation, in a single gene called the Fragile X Mental Retardation 1 (FMR1) gene. This gene normally makes a protein the body needs for the brain to develop. But when there is a change in this gene, the body makes only a little bit or none of the protein, which can cause the symptoms of Fragile X. [3]

History
For many generations in the US, persons with developmental disabilities were placed in mental institutions. This misunderstood population was blamed for all the problems of society and forced sterilization was used to prevent them from starting families. As the political and social climate has changed over the years so has the lifestyle that persons with developmental disabilities are capable of leading. Today with proper support, the developmentally disabled can live independently and have a family of their own if they so choose.

The sad history of the developmentally disabled in America leads to one inevitable truth for counselors and social service agencies; there is little information or protocol for working with parents who have a developmental disability. Another obstacle that parents with developmental disabilities face is stereotyping. Many social service agencies and child protective agencies have preconceived ideas about the ability of developmentally disabled parents. The removal rate of children from the home of parents with developmental disabilities ranges from 40-60%. [2] This means that these families are more

likely than not dealing with various social service agencies, including supervised visitation. [4]

Effects on Children

Children of parents with developmental disabilities are at a higher risk themselves for have developmental disabilities. Studies are not clear whether this higher risk is due to genetics or the early childhood environment in which the children are raised. To help these children have the best opportunity to thrive their parents should be provided with resources that are available to them.

It can prove difficult for parents with developmental disabilities to have a steady job and take care of their family, especially if they are a single parent. This leads to the issue of poverty among families headed by developmentally disabled parents. However, research has shown that parents with developmental disabilities can provide enriching environments for children when social support is present. Some examples of important social supports for developmentally disabled parents and their children include:

- Extended family
- Positive parenting role models
- Friends
- Financial assistance

Any of these supports can make the difference for the family by allowing the parents to retain or regain custody of their children. [5]

It is important to remember that although children of parents with developmental disabilities are taken out of the home at a very high rate, there is no evidence of this being a necessary or beneficial measure. These children, like most children, wish to remain with their parents. It is a common misconception that parents with developmental disabilities cannot be adequate parents. Parents with developmental disabilities who have their parental rights questioned can often learn the parenting skills they lack with specially designed programs to teach them efficiently. The true problem is that if there is not a program that understands the manner in which developmentally disabled persons learn, there is little hope of the skills being retained.

Things to Remember

Although the research and information on working with developmentally disabled parents is limited there are some guidelines and information to keep in mind that will help make working with these clients more effective for all parties involved.

Parent Characteristics

- May have deep rooted self-esteem issues
- Often have a lack of trust in others
- May lack problem-solving skills
- May have memory problems
- May be unable to apply knowledge from one situation to another

Tips for Supervised Visitation Providers

- If the case is a dependency case, know what the case plan requires
- Plan to do modeling for these parents; teach them how to interact with their children
- Take time to establish rapport
- Be genuine in interactions
- Avoid criticisms and advice giving, especially "You should…, You need to…"
- Remain patient: these parents need extra time and attention
- Find out from the case manager if there are other parenting resources in the community that can be offered to the family, in addition to the supervised visitation
- Prepare the staff/volunteers before the family arrives
- Repetition and modeling are the keys for interaction with the parents.[6]

Remember that these parents can learn new skills but it will take time and proper training.[5] By being aware of the challenges that these families face and some basic techniques for helping them, social service workers can feel more confident and comfortable working with parents that have developmental disabilities.

Exercise-

Imagine that a family is referred to your program with the following characteristics:

- Father has a diagnosis of Fragile X Syndrome, and an IQ of 70
- The child is 3 years old, and not on track with normal childhood milestones
- The father and child are very close but the father has difficulty interacting with the child because he seems to be overwhelmed by his child's energy

Break into small groups and discuss some of the techniques that could be used to facilitate quality interactions between father and child. Also discuss what type of social supports could help the situation.

Case Scenario

Alyssa Parker is a 28 year old mother of two with a developmental disability. Her oldest daughter, Amy, is 4 years old, and her younger daughter, Stephanie, is 2 years old. Stephanie has also been diagnosed with a developmental disability. Three months ago the girls' father, Richard, left Alyssa and the family and has not been seen since. DCF has the children in custody currently, due to neglect charges after a neighbor reported that Amy had started coming over to ask if they could help make Stephanie "stop crying." Alyssa has been scheduled to visit with the girls weekly while she is placed in parenting classes to attempt to improve her parenting skills.

Questions to Consider

1. How has the developmental disability affected the children in this case?
2. What techniques can staff use to make Alyssa and the girls feel comfortable?
3. What are obstacles that may keep Alyssa from fulfilling the objectives in her case plan?
4. What feelings does this case bring up for staff? Is there any hope of Alyssa being able to care for her children independently? Why or why not?

Quiz

1. Approximately how many Americans have a developmental disability today?

2. List at least 4 major life activities that developmental disabilities limit.

3. Briefly describe 2 conditions that cause developmental disabilities.

4. What are 4 techniques that supervised visitation providers should use when working with parents with developmental disabilities?

To Learn More

Visit the Administration on Developmental Disabilities website:
http://www.acf.hhs.gov/programs/add/Factsheet.html

For information on assisting clients with developmental disabilities visit the Parent to Parent of Georgia website:
http://www.parenttoparentofga.org/roadmap/parentsupport/familymembersparentswithdisabilities.htm

Through the Looking Glass provides direct services, information and referral for a diverse group of parents with disabilities and their families:
http://lookingglass.org/index.php

The Arc is the national organization representing people with developmental disabilities and their families: http://www.thearc.org/

References

[1] Administration on Developmental Disabilities,
http://www.acf.hhs.gov/programs/add/Factsheet.html

[2] Education Update, Dr. Levy, 2002,
http://www.educationupdate.com/archives/2002/feb02/htmls/speced_yai.html

[3] National Institute of Health, http://www.nichd.nih.gov/health/topics/

[4] Llewellyn, G., McConnell, D., Honey, A., Mayes, R., & Russo, D. (2003). Promoting health and home safety for children of parents with intellectual disability: A randomized controlled trial. *Research in Developmental Disabilities, 24*(6), 405-431.

[5] Taube-Schiff, M., & Serbin, L. A. (2006). The case of a 10-year-old boy presenting with cognitive delays and behavioral problems: Working with a developmentally challenged family. *Clinical Case Studies, 5*(4), 345-360.

[6] Natasha Green & Virginia Cruz "Working with Families with children/Parents with Developmental Disabilities" http://www.developmentaldisability.org/

Directors as Trainers:
Turning a "Think Piece" into a Training

We talk about curriculum design a lot at the Clearinghouse, and we provide you with a variety of materials to increase your staff's knowledge base. But sometimes directors have trouble turning a "think piece" or an article into a training. How do you do it? It's all about the curriculum design, and I'll give you an example. Look at the article on page 8 of the Family Visitation Times. It is all about anxiety and depression. You can give the article to your staff to read, OR you can create a short training by using the tool below.

First: The Overview. What should the person generally learn from the content?

Second: A few objectives. Tell your reader what specific pieces of knowledge will be communicated to him in the content.

Third: The content itself. This is the guts of the training.

Fourth: Exercises or case studies to apply what is learned.

Fifth: A quiz, to reinforce the curriculum and ensure that the reader absorbed the information you wanted him to understand.

You can do this with anything that you want your staff to learn. I have done it below to show you how easy it is! I used the article in the Times.

The Impact of Depression and Anxiety on Supervised Visitation

Introduction

As supervised visitation programs grapple with complex and difficult case loads and clients affected by a variety of problems and traumas, it probably comes as no surprise to learn that more than 25 million Americans struggle with some form of anxiety disorder. Just over 8% of the population (1 in every 12 people) suffers from panic disorder, social phobia, agoraphobia, posttraumatic stress disorder (PTSD), or obsessive-compulsive disorder (OCD). This brings the harrowing realization that anxiety disorders and depression are bound to affect many of the people with whom we come into contact on a regular basis.[1]

Objectives

Upon completion of this training, a visit monitor will be able to:

1. Identify major categories of anxiety and depression;
2. List common characteristics/symptoms;
3. Understand potential impact on children of parents suffering from anxiety and/or depression;
4. Recognize treatment options for persons dealing with anxiety and/or depression; and
5. Identify helpful resources to recommend for persons suffering with anxiety and/or depression.

Major Categories

Attempting to pinpoint all possibilities for the 25 million individuals in the United States who struggle with anxiety, and with numbers pushing almost 30 million when including depression, it would be impossible to determine each individual's identifying stressor.[2] Evaluating major categories (panic disorders, social phobias, agoraphobia, PTSD, OCD,

and depression) is beneficial in providing key identifying characteristics/symptoms to look for and aid in recognizing causal events and incidences. We provide the information below to educate readers, not to make them diagnosticians!

Panic Disorder: An anxiety disorder accompanied by unexpected and intense periods of fear and possibly chest pains, irregular heart beats, shortness of breath, dizziness, and nausea. Panic disorders usually develop in later adolescence and adulthood affecting nearly 4 million women and 2 million men in 2007 alone.[3]

Agoraphobia: Agoraphobia is defined as the fear of open places, yet the nearly 3.5 million (or 5% of adults) who suffer would better describe it as the "fear of not being able to escape when a panic attack occurs." Physical symptoms are similar to those of panic disorders and often develop co-morbidly in individuals in their twenties who experience panic disorders.[3]

Social Phobia: A common disorder in which individuals fear social events or functions of every day life. While this disorder manifests itself in a variety of ways depending on the person, those who suffer from it are aware of their irrational fears. They realize that their thoughts are not healthy; however they cannot help but have a sense of fear. Social phobias often manifest in childhood, but on occasion have been known to develop during adulthood, affecting more than 5 million each year.[1]

Posttraumatic Stress Disorder (PTSD): Five million Americans fight this debilitating disorder each year from causes ranging from having experienced serious physical, mental, or emotional stress. Because of such a wide-range of possible triggers, PTSD can reveal itself at any age and affect men and women at similar rates although it is presently seen in more men than women. Cautions to be aware of with individuals who suffer from PTSD are depression (with an incidence of more than 50%), substance abuse, and physiological problems similar to those of individuals with panic disorders.[1]

Obsessive-Compulsive Disorder (OCD): Affecting 3 million Americans in a given year, OCD is gender neutral, often seeing its onset in early childhood or adolescence. The extent to which it impacts each individual can vary, from mild in some cases to

controlling almost every aspect of other's lives. OCD is often accompanied by other disorders, including, but not limited to, depression, eating disorders, substance abuse, attention deficit disorder (ADD), hypochondria, and Tourette's syndrome.[1]

Major Depressive Disorder (depression): The characteristics of hopelessness, despair and anger effectively summarize depression. This major depressive disorder manifests itself in many ways, individually and co-morbidly with various forms of anxiety disorders. Clinical depression affects women much more so than men, and in most cases depression is recurrent.

Impact & Influence on Children

The far reaching impact of anxiety and depression affects everyone, from the person suffering from the illness, to his or her family member, and often to people who come into contact with the person. Children and adolescents impacted by a caregiver's anxiety and depression often begin to develop phobias, separation anxiety, behavior complaints, psychotic delusions, and low self-esteem.[7] Service providers are generally concerned about the ill caregiver's impact on the well-being and safety of a child who cannot fend for him or herself.

Case Example and Discussion Questions

Read the case example below and then answer the questions about the case.

Melissa finds it difficult to walk down the street because she is self-conscious and feels that people are watching her from their windows. Worse, she may run into a person on the sidewalk and be forced to say “hello” to them. She is not sure she can do that. She fears her voice will catch, her "hello" will sound weak, and the other person will know she is frightened. More than anything else, she does not want anyone to know that she is afraid. She keeps her eyes safely away from anyone else's gaze, praying that she can pick up her little girl from school and make it home without having to talk to anyone. Unfortunately, she remembers that she is supposed to take her child to a scheduled visitation with her father today. Her heart begins to race and her breathing becomes labored.

1. What specific type of anxiety disorder could Melissa be suffering from? Social Phobia
2. How might this parent’s behavior or symptoms impact her supervised visits? She may not show up for them, reschedule a lot, come late, have frequent panic attacks during them, her child may experience anxiety as a result of watching her, etc.
3. How might a visit monitor help the parent and child in this case? Refer parent to one of the listed resources that may be able to assist her with medication or therapy, talk with the parent about how she is feeling about brining the child to visit the father, Remember, do not diagnose people. Simply try to assist them find

resources and have a comfortable transition or visit.

Treatment

There exists a wide range of treatment options for anxiety disorders. The four categories that the majority of treatment options can be broken down into are (1) medications, (2) cognitive-behavioral therapy, (3) exercise and relaxation techniques, and (4) monitoring diet and nutrition.[1]

Treatment of all of the aforementioned illnesses and disorders has proven very successful using the four strategies listed above. Anti-depressant medications and cognitive-behavioral therapies (or some combination of the two) are most commonly used when treating anxiety disorders such as agoraphobia, social phobia, and panic disorders. Research tells us that medication can effectively alleviate depression's symptoms.[1]

Posttraumatic stress disorder is treated using a variety of cognitive-behavior therapies with the highest rates of success coming in group therapy and exposure therapy. Exposure therapy is also used in helping individuals confront and overcome obsessive-compulsive disorder. Many forms of anxiety disorder are treated using a variety of therapeutic models, but when multiple disorders and illnesses exist concurrently,

symptoms are usually more severe and thus treated with a combination of medication(s) and various therapies.[1,6]

For mild depression and anxiety, especially the kind related to situational stress, there are often holistic remedies recommended. This information is being offered as an overview about medical developments, not for diagnostic, treatment, or medical purposes. Well-respected institutions such as the Mayo Clinic are quick to note that while not considered a *cure* for depression and anxiety, exercise offers many psychological and physical benefits that can improve symptoms. Research shows that exercising only three times a week for as little as 30 minutes can significantly improve depression symptoms, and short-term gains are often reached with 10-15 minutes of activity. Exercise and other relaxation techniques (yoga and meditation) release endorphins, ease muscle tension, improve sleep, and reduce the levels of the stress hormone cortisol.[4, 5] Exercise offers the opportunity to build confidence, giving individuals a distraction from the stresses of life that often lead to anxiety and depression, build social networks, and introduce healthy coping strategies into a lifestyle that may not have been attuned to the array of options available.

Carefully monitoring of diet can also influence the physiological factors that often affect anxiety and depression. What was once considered an old wives' tale in using St. John's wart to ward off symptoms of depression is now endorsed by the **National Institute of Health** as a common natural remedy for fighting mild to moderate depression.[6] Closely watching daily intake of caffeine, sugar, and nicotine can all de-escalate the levels of anxiety in someone susceptible to these behaviors. Also, supplements and herbs such as B vitamins, and chamomile teas are all known to calm the nervous system, alleviating symptoms of anxiety and reducing symptoms of mild depression.[5] Again, this information is offered not as a diagnostic or medical tool, but as information about how the medical establishment views a common disorder.

Table 1.1 indicates major categories of anxiety disorders as well as characteristics associated with each one. Included in the table are the typical ages these disorders present themselves and the main treatments used in intervention. This list is not exhaustive and

does not incorporate all of the various ways in which they can manifest themselves. Instead, it gives an overview of a few of the major categories.

Table 1.1
Categories of Anxiety & Their Characteristics

Illness	**Symptoms/ Characteristics**	**Onset**	**Treatment**
Panic Disorder	Unexpected and intense periods of fear Possible chest pains Irregular heart beats Shortness of breath Dizziness Nausea	Late adolescence or adulthood	Medication Cognitive-behavioral therapy Certain forms of diet, exercise or meditation
Agoraphobia	Feeling of not being able to escape when a panic attack occurs Similar physical symptoms to that of panic disorder	20s	Medication Cognitive-behavioral therapy Certain forms of diet, exercise or meditation
Social Phobia	Fear of social events	Childhood	Medication

	or functions of every day life Belief that others are criticizing or judging them Awareness of irrational fears, but unable to respond differently Physical symptoms similar to that of panic disorder	Occasionally develops in adulthood	Cognitive-behavioral treatment
Post-traumatic Stress Disorder (PTSD)	Depression Substance abuse Physical symptoms similar to that of panic disorder	Any age	Variety of cognitive-behavior therapies (highest success with group therapy and exposure therapy)
Obsessive-Compulsive Disorder (OCD)	Recurrent, unwanted thoughts Repetitive behaviors	Early childhood or adolescence	Medication Exposure therapy
Major Depressive Disorder (depression)	Hopelessness Despair Anger Often found to accompany some forms of anxiety disorders	Various ages and often recurrent	Medication Certain forms of exercise and diet

Links to Depression & Anxiety Resources

If a client indicates that he or she is experiencing symptoms of anxiety and depression, consider recommending that the person talk with one or more of the resources listed below, as they can assist in making a referral to, or provide, diagnostic and treatment services:

- Case or Care Managers, if the case is a dependency referral
- Family doctors
- Mental health specialists, such as psychiatrists, psychologists, social workers, or mental health counselors

- Religious leaders/counselors
- Health maintenance organizations
- Community mental health centers
- Hospital psychiatry departments and outpatient clinics
- University- or medical school-affiliated programs
- State hospital outpatient clinics
- Social service agencies
- Private clinics and facilities
- Employee assistance programs
- Local medical and/or psychiatric societies

TO LEARN MORE

- For more about learning about anxiety and depression: http://www.pristiq.com/major_depressive_disorder.aspx?WT.mc_ID=DD647EE0-AAF7-4EEB-ABC5-BD687B4B8120&WT.srch=1&WT.mc_ev=click
- Depression & Crisis Center Hotlines http://www.healthyplace.com/Communities/Depression/suicide/crisis_centers.asp

QUIZ

1. Discuss the major categories of anxiety disorders.

2. Describe the potential impact on children of parents suffering from anxiety and/or depression.

3. List the major treatment options for the various forms of anxiety or depression.

4. Identify some of the helpful resources to which you can refer someone suffering from an anxiety disorder or depression?

Sources

[1] HealthyPlace.com Depression Center, *The Relationship Between Depression and Anxiety*, http://www.healthyplace.com.
[2] Roxanne Dryden-Edwards, & Dennis Lee, *Depression*, http://www.medicinenet.com.
[3] National Institute of Mental Health, *Panic Disorder*, http://www.nimh.nih.gov.
[4] Mayo Clinic, *Depression and anxiety: Exercise eases symptoms*, http://www.mayoclinic.com/health/depression-and-exercise/MH00043.
[5] Jeanie Lerche Davi, *Coping with Anxeity*, http://www.webmd.com/anxiety-panic/guide/coping-with-anxiety.
[6] National Institute of Mental Health, *Depression*, http://www.nimh.nih.gov.
[7] Carol E. Watkins, *Depression in Children and Adolescents*,

http://www.baltimorepsych.com

Parenting Assistance: Strategies

Researchers are suggesting that there are many 'environmental' strategies to improve parenting – activities that go beyond the traditional, structured parenting classes that you may be familiar with and incorporate parenting advice into everyday activities.

When you have access to families in crisis, use that access to help parents improve their parenting skills! Attached are several sheets to offer to parents who may need suggestions of activities with their children. You can offer these to the custodian, and then to the visitor after the court-order ends!

How to use them? In intake, offer the parent a sheet that matches his or her child's age/developmental stage.

But don't stop there! Make coupons for parents, like the one below, and hand them out after each service:

Coupon

Have fun with your child this week!

Take a walk with your child and name things that you see in alphabetic order.
…airplane, branch, car…
You can skip letters that are difficult, or make up silly answers if you can't find an example, like "X ray vision on that crossing guard" or "zebras running down the street."

What are some characteristics of a "positive" parent?

Parents make a difference in a child's life. A child's relationship with his or her parent may help that child avoid alcohol and substance abuse, may increase the child's positive outcomes at school, and may lead to a happier child. Researchers are often asked what a parent can do to be a "positive parent." Some of these answers are intuitive, and many of them could have been written by any number of people reading this at SV programs. Still, it is important to see what researchers say makes a positive parent.

Positive Parenting

Let your child know when he/she did a good job
Rewarded or gave something extra to your child for behaving well
Read books or stories with your child
Told stories to your child
Complimented your child when he/she did something well
Praised your child if he/she behaved well
Hugged or kissed your child when he/she did something well

Involvement

Had a friendly talk with your child
Volunteered to help with special activities that your child is involved in
Had a family meal together
Did fun things with your child
Sang songs with your child
Danced with your child
Played outside in the yard, a park, or playground with your child
Asked your child about his/her day in school or daycare
Helped your child with his/her homework
Drove your child to a special activity
Talked to your child about his/her friends
Had your child help plan family activities
Attended PTA meetings, parent/teacher conferences, or other meetings at your child's school
Looked at numbers, shapes, new words, etc. when on an outing with your child

March E Press

Upcoming Phone Conference

Thursday, March 12 Noon Eastern

850-644-2255

Dial in to network and learn! (Please mute your phone)

Questions of the Month

1. *We've had some confusion lately dealing with our local CBC. We have a grant manager and several administrators who each expect us to report to them about any changes in our program. But the CBC has its own internal politics, and differing personalities. So sometimes we feel we get mixed messages from our contacts, with one person calling us and saying one thing, and another person calling to say something completely different. What should we do?*

   The short answer to this predicament is simple. I recommend two things: first, a single point of contact, and second, putting everything possible in writing. The problem with that advice is that it's much easier to pick up the phone and hope that the person answering it conveys your message accurately.
   A single point of contact reduces the potential for confusion. Ask the CBC to guide you to one person for your inquiries. Stay consistent and call only that person, unless directed otherwise. Then be sure to send a follow-up email memorializing the conversation.

2. *Are there any rules that prevent my program from allowing a developmentally delayed adult use my program? He started here when he was 17, and now he's 18. His parents use my monitored exchange service.*

   No. If your program has the space, and you otherwise have no problem with the setup, I see no reason why they can't continue for a few months. The real issue is if your program wants to terminate the case because you have a waiting list, and other families are unable to use that visitation time slot because it is filled long-term. I always recommend that you ask the court to appoint someone – a GAL, a parenting coordinator, a therapist, – to assist with the case and help resolve it for the long term.

   Over the last several months, we have had many directors who have had problems with long-term cases. The basic scenario that has repeated itself over and over is when a director finally decides to terminate, the parents are very unhappy. In several of these cases, a parent has called the Clearinghouse, or other stakeholders, upset that the years-long service is disappearing. What has occurred is that the director allowed the parent to

assume that the case could be at the program forever. The parent adapted to the routine. The court stopped reviewing the case. The underlying issues that brought the family to the program were never resolved. Now the parent is outraged that the program wants to terminate services.

Avoid this problem now, so you won't have to deal with it later. Have clear guidelines for case time limits, and stick to them. Ask the court for help when you need it. Keep the familes informed of your policies, so everyone is on the same page. It's fine to make allowances for special circumstances from time to time, but be clear that no case can stay forever at your program.

3. *I know its important to work with the domestic violence community, but I am having a very difficult time getting my local DV director to work with me. I've heard rumors that this person does not approve of my program's location. Any suggestions?*

Don't give up! If you have really reached out – invited the director to your program, asked and offered cross-training, and kept the director informed about your program – my next suggestion is finding another person to act as a liaison for you. This person should be an ally of the director, someone the director trusts, so that you can bridge the current divide. You have mutual, common interests, and your community will benefit from a united front. Try again. Are you having an open house? Has your program changed its hours? Send invitations and notices to the director. It is likely that the ice will thaw if you make a sincere effort.

4. *What's the best way to deal with a parent who is seeking a social relationship with someone on my staff? Their kids go to school together, and the parent has invited my staff member over for coffee and wants to sit with her when they chaperone field trips. My staffer is not very assertive, and I'm uncomfortable with the situation.*

Your staffer should tell the parent clearly and firmly that she can not socialize with clients. Of course, you can also sit down with the parent and explain the boundary issues and conflict of interest rules yourself, but the staffer needs to be strong enough to do so as well. This issue may have exposed a deeper problem: your staffer may be too passive for work at an SV program. There is no shame in this: not everyone is cut out for SV work. A monitor must be able to intervene, and communicate firmly, respectfully,

and clearly. Your job as director is to make sure that monitors can carry out those responsibilities.

It's possible that the parent is just trying to be courteous. It's also possible that the parent is trying to sway the opinions of the staffer about some issue in the litigation. There's even a chance that the parent wants to make the other parent suspicious about the staffer's objectivity in the case. Regardless of the parent's intentions, there are ways to politely inform the parent of the ethical tenets of supervised visitation. Act quickly to set ground rules and create distance between the staffer and the parent.

Legislative Update:

Because of the severe budget crisis in the US and Florida, no legislator picked up any of the recommendations of the Legislative Report this year. Several legislators expressed interest and regret, noting that this year was an impossible situation for any new projects. This means that the old 1999 Supervised Visitation Standards are still in effect, but the new 2008 standards are *recommended*.

Use the following training with your staff after removing the answers to the quiz!

Issues in Infancy – Facts, Myths, and Interventions

Introduction

As supervised visitation monitors seek to understand families and the dynamics within them, it may be wise to look carefully at situations where a child may have been exposed to substances during his or her mother's pregnancy, as well as situations in which infants may be neglected or have troubling symptoms. Knowing the facts can help identify what types of interventions families may need. In addition, recent research has changed researchers ideas in ways which may surprise you.

Objectives

Upon completion of this training a visit monitor will be able to:

1. Recognize characteristics/symptoms of infants having *failure to thrive* (FTT).
2. Recognize characteristics/symptoms of infants having (FAS).
3. Understand treatment options that are recommended for FTT children.
4. Identify steps a visit monitor can take when suspecting a pregnant mother of alcoholism.
5. Identify the facts and myths about the so-called "crack baby syndrome."

Failure to Thrive

Failure to thrive (FTT) may vary in definition; however it is best described as a *condition* – not a disease – that applies to infants having weight, height, head circumference and psychosocial development that is significantly below normal for their age, causing concern for their health and well-being.[1] FTT is commonly brought on by malnutrition and neglect, and inadequate parenting is often at the root of these serious concerns.

It is important for visitation monitors to be able to identify risk factors that may trigger or perpetuate FTT if early intervention does not occur. These factors include the following: insufficient food intake; difficulty with feeding; poverty; minimal parental education and information; social isolation; maternal depression; and family stressors such as divorce/separation, abuse, substance misuse, single parenting, and poor mother/child interactions.[1] If the case is a dependency case, it is likely that the caseworker or care manager has identified the issue. Still, this may not be true, and SV workers should point out problems to the caseworker to ensure that the "extra set of eyes and ears" that an SV worker brings to a case are put to use!

Some FTT children have an insecure attachment to their mothers due to a deficiency in mother/child bonding. In these situations, a child's apprehension and fear in the presence of the mother is sometimes evident. The mother's sense of helplessness, anxiety, and anger is also observable.[1] Therefore, a visit monitor might suspect the potential existence of FTT when noting insufficient positive interactions between the child and mother, lower than normal infant body

weight, and delayed infant psychosocial development. Other issues may be at play here, like maternal depression, which can play a role in FTT.

The outcomes for children with FTT can be bleak if there is no recognition or treatment of the condition. Adverse outcomes can include short stature, behavioral concerns, and developmental delay. To decrease these potential effects, it is crucial for these children to receive intervention as early as possible.[2] There are typically two types of interventions for FTT cases: immediate crisis intervention and long-term therapy (for more difficult cases). Assessment may indicate a need for further resources, such as day time care where the child can have interaction and stimulation. Other resources might include assistance for the parents in regards to housing, welfare, medical attention, addiction treatment, employment, therapy, etc.[1] There have been very few studies done on the outcomes of FTT children, so it is hard to say what the long-term psychological effects of FTT are.[2] What *is* known is that early intervention can halt FTT, therefore visit monitors must be aware of the signs and risk factors and be able to refer families to resources as needed. If you suspect FTT, alert the caseworker to your concerns. Note in the case file any red flags that you notice. Or talk to the Guardian ad Litem about what you see at visits.

Case Example and Discussion Questions

Susan is a young mother who has an 11-month-old son, Brian. She has very little money and lives from paycheck to paycheck. She brings Brian to a scheduled visit with his father. The visit monitor notices that Susan does not speak directly to Brian, and he does respond to her. Brian appears to have a very low body weight for his age and seems delayed socially. There is very little interaction between Brian and his mother. The visit monitor suspects Brian may be a child with *failure to thrive*.

Discussion Questions:

1. How might the monitor approach this subject with the mother in order to gain more information? Ask certain types of questions that relay concern and not accusation. "You seem stressed today, how are things going at home? How stressful are you finding your role as a mother?" etc. It is also acceptable for you to note developmental issues to a parent at intake and visits. "Oh, Brian is 11 months old. He needs you to hold him and cuddle him." (Model this behavior for the parent.) "You can even sing to him, he may like that a lot. Babies are so wonderful; they really want to interact with the people around them!" These kinds of statements will may lead to an opening for you to express to Susan your concerns for Brian's health as well as her own emotional well-being.
2. What types of interventions and referrals could the monitor set up for Brian and Susan? Physical examination for Brian, parental education for Susan, services that will help Susan financially so she can afford food for both of them, children's programs which will help with social stimulation, etc. Contact caseworker, GAL, make notes of behavior in file.

Fetal Alcohol Syndrome

Fetal Alcohol Syndrome (FAS) is a condition that results when a woman consumes alcohol while pregnant. Prenatal alcohol exposure places the baby at risk of permanent birth defects which may include mental, physical, and behavioral issues of various kinds, depending on the child and the severity of alcohol use.[3]

The most common results of FAS involve diminished growth, impaired physical performance, lowered intelligence, and facial and skeletal irregularity.[4] Some of the facial characteristics of an FAS child are "short eye openings, sunken nasal bridge, short nose,

flattening of the cheekbones and midface, smoothing and elongation of the ridged area between the nose and lips, and smooth, thin upper lip." [4]

Many ask the question "what is a safe amount to drink while I'm pregnant?" The answer given by most medical professionals is "none." Due to the seriousness of the repercussions of too much alcohol exposure while in utero, this approach is the safest and surest way of protecting the child from developing FAS. [3] If a visit monitor suspects that a mother who is pregnant is struggling with alcohol, the sooner they are able to refer the parent to a program in which she can receive help and intervention, the better the chances will be for the baby. There are several programs, some that are non-profit, to which a visit monitor can refer a pregnant mother struggling with this issue (NOFAS, FASCETS, FAS Family Resource Institute, for example). These organizations have websites which are listed at the end of this article.

Case Example and Discussion Questions

Theresa is coming to a supervised visitation to visit her 1-year-old daughter, Lisa. Her ex-husband, Mark, has told the staff that Lisa has fetal alcohol syndrome, which staff suspected upon seeing Lisa. He has relayed that Theresa is an alcoholic and is pregnant again with their second child. He is worried that this child will have the same issues as Lisa because Theresa will not get the help she needs.

Discussion Question:

How should a visit monitor handle this situation? Answers may vary: Check with the GAL or caseworker if this is a dependency case. If this is not a dependency case, make note of Mark's comments in the file, and in your summary report to the court. (Remember that you may not have any independent evidence of his claims.) Offer Theresa a referral to an intervention program that is designed to help pregnant mothers to get educated and overcome their addictions. Remember that she does not have to accept the referral. If you do have independent evidence that there is a problem, you should call the Clearinghouse to discuss the possibility of other actions. If, for example, Theresa shows up at visits under the influence of alcohol, you may have to alert the abuse hotline and the court. These cases must be staffed carefully – keep good records, and be sure that staff are trained to behaviors that may indicate a parent's impairment.

Crack Baby Syndrome

Crack was introduced to the streets in the mid-1980's, and with its inception came alarming stories of babies born from mothers who were addicted to crack cocaine. These infants were said to have a myriad of issues that would last a lifetime, leaving little to no real hope of a functional life for these children.[5] It became a media frenzy as the rate of newborns exposed to crack while in utero drastically increased in the early 1990's. Behavioral abnormalities were reported in these infants, leading to a label that would stick with them forever – "crack baby syndrome."[6]

Over a decade later, researchers and medical professionals are disputing the existence of such a syndrome. Longitudinal studies have been and are continuing to be conducted on these children who were labeled at infancy. The evidence now suggests that "crack baby syndrome" is a myth which was perpetuated by the media.[5, 7] Also a myth is the idea that these infants are born addicted to cocaine. Research has suggested that this is scientifically false and that babies cannot be born addicted to cocaine. Not only have these babies grown up to become functioning members of society, they are now fighting the stigma that followed them throughout their school careers and their entire lives.[5]

It is important to note, however, that there is clear evidence that cocaine is unquestionably harmful for a fetus. Some symptoms are slow fetal growth, typically smaller in size in infancy, and born with smaller heads (these symptoms tend to rectify themselves as children grow and eventually catch up). There is also evidence suggesting that cocaine-exposed children have subtle differences in I.Q. scores (an average of 4 points lower than unexposed children at 7 years old).[7] There are certainly detrimental effects of prenatal exposure to cocaine. However, they are comparable to those of tobacco use, and actually far less severe than those of alcohol abuse – both of which are substances that are legal and used far more often by pregnant women. Experts are asserting that substances of any kind (including tobacco and alcohol) should absolutely be avoided during pregnancy, not that one is more "acceptable" than another.[6]

Research further suggests that children who were exposed to cocaine in utero run a high probability of being raised in an unhealthy and potentially unstable **environment**, which may be risk factors that are not often taken into consideration. Teachers, doctors, and visitation

supervisors could be more inclined to blame certain behaviors on the child's previous exposure to drugs as opposed to environmental causes, such as abuse.[7] Remember that a parent who is addicted to illegal substances may be neglectful, abusive, or incapable of caring for a child.

Any of these issues may present themselves in families who use supervised visitation services. Staff should familiarize themselves with the risk factors and symptoms of each; not for the purpose of labeling the parents or the children, but rather to provide them with the resources they will need for their family.

QUIZ

1. What are some possible causes of failure to thrive in children? poor mother/child interactions; commonly brought on by malnutrition and neglect.
2. What are the symptoms or characteristics of a child with failure to thrive? Weight, height, head circumference and psychosocial development that is significantly below normal for age.
3. What are the symptoms or characteristics of a child with fetal alcohol syndrome? Diminished growth, impaired physical performance, lowered intelligence, and facial and skeletal irregularity;
4. What are some common myths regarding "crack baby syndrome? Issues that would last a lifetime, leaving little to no real hope of a functional life; born addicted to cocaine.
5. What are some facts regarding the potential effects of cocaine transmitted by a mother to her child? Slow fetal growth, typically smaller in size in infancy, born with smaller heads; average of 4 points lower IQ
6. Discuss what types of interventions can be offered to parents with these issues? Answers will vary

For more information regarding these issues relating to infants, try visiting the following websites:

Failure to Thrive:

http://kidshealth.org/parent/growth/growth/failure_thrive.html

http://www.nlm.nih.gov/medlineplus/ency/article/000991.htm

http://www.sage-ereference.com/humandevelopment

Fetal Alcohol Syndrome:

http://kidshealth.org/parent/medical/brain/fas.html

http://www.fetalalcoholsyndrome.org

http://www.fascets.org

http://www.nofas.org

[1] Dorota Iwaniec, *Failure to Thrive*, Encyclopedia of Hum. Dev. (2005) Retrieved February 18, 2009, from http://www.sage-ereference.com/humandevelopment/Article_n251.html

[2] Scott D. Krugman & Howard Dubowitz, *Failure to Thrive*, 68 Am. Fam. Phys. 879 (2003)

[3] Mayo Foundation for Medical Education and Research, *Fetal Alcohol Syndrome* (2007), http://www.mayoclinic.com/health/fetal-alcohol-syndrome/DS00184#

[4] David Perlstein, *Fetal Alchohol Syndrome*, MedicineNet, Inc. (2009), http://www.medicinenet.com/fetal_alcohol_syndrome/article.htm

[5] Mariah Blake, *The Damage Done: Crack Babies Talk Back*, 42 Columbia J. Rev. 10, 11 (2004)

[6] Julia S. Noland, *Crack Baby Syndrome*, Encyclopedia of Hum. Dev. (2005) Retrieved February 17, 2009, from http://www.sage-ereference.com/humandevelopment/Article_n164.html

[7] Susan Okie, *The Epidemic That Wasn't.(Science Desk)(Using Crack Cocaine During Pregnancy)* 158.54568 The N.Y. Times (Jan 27, 2009) Retrieved February 17, 2009, from <http://find.galegroup.com/ips/start.do?prodId=IPS>

Please be sure to have your staff and volunteers fill out the Performance Measure Survey that we included in the Family Visitation Times. Thank you!

Another Example of the Dangers of Off-site Visitation:

http://www.kvue.com/news/top/stories/021709kvue_amber-alert-eh.24c1b39a.html

Kidnapped Conroe Girl Found Safe

Annabelle Williams-Forlano, 5, who was the focus of an Amber Alert issued Tuesday after her biological parents abducted her during a supervised visit in Conroe, has been found safe in Ohio.

Sheriff's deputies found the girl Friday morning and arrested her parents.

Authorities said the parents, who do not have legal custody of the child, had driven with her from Texas in an 18-wheeler.

Angela Williams, 46, and Carl Forlano, 57, both of New Hartford, N.Y., were in the Fayette County, Ohio Jail Saturday on fugitive of justice and kidnapping charges pending extradition proceedings.

The girl was taken to Fayette County Children Services pending her return to Texas.

The girl disappeared around 8:30 p.m. Monday during a supervised visit at a Chuck E. Cheese restaurant in Conroe.

Police say the girl's aunt and uncle, Joyce and Kurk Nielsen, took her to the restaurant to see her parents, who requested the visitation.

The Nielsens said they were recently awarded custody of the girl.

Community Fundraising Strategies

Everyone is worried about the economy, and SV programs want to find create ways to shore up dwindling budgets. Community fundraising may help.

Remember, program directors can not "do it all." The first step to community fundraising is to find someone in the community with a friendly personality, good networking and event planning skills, and a lot of extra time to fill the position of your event coordinator. This person should be creative and fully committed to your program's mission. Finding someone to volunteer for this position would be ideal but there are other ways to keep this position low-cost. Woman's Trust, a small charity organization that provides free counseling and advocacy services for women affected by domestic violence, staffs a fundraiser who only works four or five full days a month. This is how they receive virtually all of their funds from the community and they've been growing strong as an organization for ten years.

When developing fundraising strategies, come up with creative and original ideas, or put your own "spin" on a popular fundraiser. Be sure that everyone understands the mission of your program. Engage the community's interest, keep in mind what your community would and would not get involved in, understand the basics of event planning, and most of all, have fun!

List of Fundraising Idea Sites

http://charitymile.com/
Fundraising through athletic events

http://www.industrymailout.net/Industry/Home/206/700/link5510/2Elements%20of%20a%20Fundraising%20Plan.pdf
Elements of a fundraising plan

www.grassrootsfundraising.org
Grassroots fundraising training

www.help4nonprofits.com/
Provides several articles on many topics including fundraising/resource development and community engagement

www.stepbystepfundraising.com/finding-professional-help-nonprofit/
This is a great website with fundraising ideas and events for different causes

List of Fundraising Events/Strategies from other Organizations

http://www.refugehouse.com/about_events.html
Here are Tallahassee's Refuge House fundraising strategies and events

http://www.nccadv.org/pdf/Wise%20Women%27s%20Favorite%20Fundraising%20Strategies_b.pdf
The North Carolina Coalition against Domestic Violence published successful fundraising strategies from various domestic violence programs.

http://www.amcalfamilyservices.com/files/2004-2005%20Annual%20Report.pdf

This is the 2004/2005 annual report for the West Island Youth Project. The projects' fundraising strategies are provided starting on page 13.

http://www.childandfamilypolicy.duke.edu/evalsvcs/files/FundingReport-CCFP.pdf
Fundraising and venture strategies for local agencies are provided starting on page 19.

Fundraising Examples

1. Homeless Shelter: The shelter ran a promotion where they sent tea bags in fancy wrapper to potential donors, with an engraved card that invited them to have a tea party at home. Donors were then encouraged to donate the money they would have spent on going out for drinks. Self-addressed stamped envelopes were included in the packet. The Shelter made a handy profit from almost no overhead.
2. Unseen Stories: A non-profit created to raise awareness about human trafficking in Benin, Africa has gotten Chik-fil-a to sponsor them by giving 15% of anyone's total order to the organization if they mention Unseen Stories when they order.
3. Will County Children's Advocacy Center
   http://www.willcountychildadvocacy.com/html/fundraising_events.html
   a. "Men Who Cook" Fundraiser: Local men in the community will be able to demonstrate their culinary skills at a new fundraising event. Ticket price is $35. At this event, guests will be able to sample appetizers, side dishes, entrees and desserts, and then vote for their favorite in each category. Prizes will be awarded for the best dish in each category. They anticipate 30-40 cooks.
   b. "Kids Helping Kids" Art Fundraiser: Will County's Regional Office of Education held its first Annual Charity Art Fair "Kids Helping Kids" in 2008. This charitable Art Exhibit of works by kindergarten through fifth grade students allowed the younger students to display their talents, while at the same time providing a service to the community. All proceeds from the exhibit were donated to the Will County Children's Advocacy Center.
   c. "Champions for Children Walk": Forty-five people participated in a 10-mile walk to raise awareness and funding for the Will County Children's Advocacy Center.
   d. Will County Children's Advocacy Center hosted an evening of fun for a serious cause: the protection of sexually abused children. This year's event featured a silent auction that included Bulls tickets, golf foursome packages, a football signed by Chicago Bears players as well as numerous gift baskets containing computer items, car care items and jewelry. All items were sold during the auction. The guest speaker for the evening was Detective Ken Simpson of the Bolingbrook Police Department. Simpson shared his experiences as a member of the center's multi-disciplinary team for the past seven years.
4. Law Enforcement Torch Run Fundraising Events for Special Olympics Florida
   http://www.specialolympicsflorida.org/community/law-enforcement/letr-fundraising-events-and-promo.html
   a. Local law enforcement agencies are selling hats and t-shirts to promote the torch run and raise funds for the Special Olympics.
   b. Law enforcement personnel volunteer their time as "celebrity waiters" in restaurants throughout Florida and use their tips to raise funds for the Special

Olympics. These officers work closely alongside the regular wait staff, serving coffee and water, and acting as hosts.

c. One extremely successful event is the polar plunge. Tons of ice will be added to a swimming pool to a temperature of 35 degrees, making this a memorable experience. Plungers are asked to donate a minimum of $25.00 for the cause. Awards will be given to the individual with the highest fundraising, the team with the highest fundraising, best costume, and largest team membership. Team competition is encouraged among local businesses & government, swim clubs, police, correction and fire academy classes.

Other Fundraising Ideas

1. Find out if there are any musical groups within your nearby University. Florida State University has several a cappella groups who put on free or inexpensive concerts every semester. Last spring, three a cappella groups put on a benefit concert and gave the proceeds to the non-profit, Invisible Children. New musical groups are always looking for ways to get their name out there. All new local bands start off by putting on free shows. Ask a newer local band to host a benefit concert.
2. Holidays are great fundraising opportunities:
   Plan an Easter event for children with egg hunts, candy, food, an Easter bunny and fun family games. Suggest a small donation to attend and explain what the money will support.
3. Advertisement companies pay website owners for putting advertisements on their websites. Also, you can put a donation portal on your website.
4. Auctions are generally the major source of fundraising used by various organizations. Some examples of auctioning events are: dinner prepared by a private chef for "x" amount of people in the winner's home, tickets to a local or national sporting event, custom built playhouse, girl's day out, guided tours, student hot lunch for a period of time, party at the fire station, restaurant gift certificates, customized gift baskets, concert tickets, helicopter ride with the local police department, photo session for the family... (http://www.middletonauctions.com/charity.html)
5. Ask a church or other house of worship to 'adopt' your program at one service. Explain what your program does, and have the basket passed for the benefit of your program.

Questions? Comments? Need help with something? Call the Clearinghouse at 850-644-6303. My cell phone number is 850-567-9464.

Highlighting your program's value in times of trouble for families

I have heard sporadic reports of higher crime, and higher numbers of arrests for DV and child abuse in communities. Be sure to ask your law enforcement liaison about your community's arrest records. Are the numbers going up; has there been a spike in crime? These are the kinds of things that visitation programs should know about when they request continued funding. There are more stressors on families than ever. Here's how to make that case for your program.

Examples for a Community Fact Sheet: (try to get as many as you can)

Number of DV petitions filed, compared to last year
Number of arrests for violent crimes
Number of arrests for child abuse
Number of arrests for domestic violence
Number of Dependency petitions filed
Number of foreclosures in your area
Number of businesses closing
Number of divorces file (and in comparison to last year)
Other facts relevant to stress on families
Then add the number of services you provided this year, last year, and overall
Emphasize your value!

You need to emphasize how important your programs are to the community. If you use volunteers, highlight how these volunteers add to your program's value. If you collaborate with other agencies, note that collaboration is essential in hard times. Go to law enforcement, the city/county, the clerk of court, and get these statistics. Use a volunteer or intern to help.

For March phone conference:

Working with Faith-based Community Organizations: A Primer

I. Data related to faith-based involvement

II. Federal outreach to faith-based organizations

III. What issues intersect for Supervised Visitation
- Infrastructure
- Fundraising
- Community support
- First responders
- Child abuse
- Domestic violence
- Substance Abuse

- IV. Faith-based Initiatives

- V. Obstacles to Collaboration

  - Secular histories of some SV
  - Narrow inclusion of religious groups (*my* faith, *my* church)
  - Lack of cross training
  - Lack of sense of mutual purpose
  - Some religious doctrines

VI. Ways to reach out
- Service on community boards
- Choose liaison within SV community
- Actively seek outreach
- Mutual projects with MOUs

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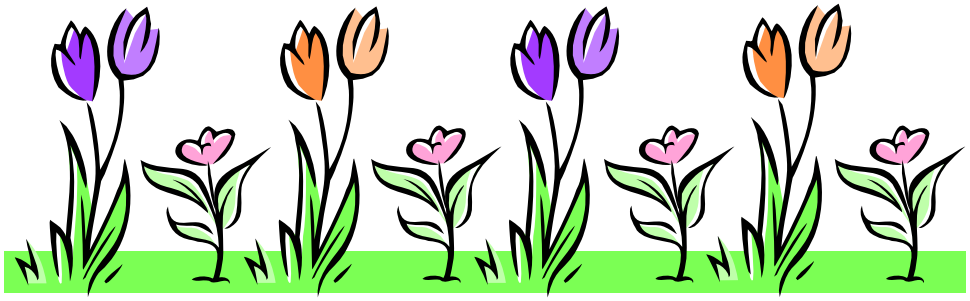

Greetings!

Spring is both a beautiful and busy time of year. There are many announcements, so please read this e press "cover to cover."

First,

The next statewide phone conference is on
THURSDAY, APRIL 16, 2009.
Noon Eastern
(850) 644-2255

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"**New Administrator's**" Training Phone Conference
MONDAY, APRIL 6, 2009
Noon Eastern
(850) 644-2255
Topics include: working with local judges, ways to improve safety, recruiting a pro bono attorney, and creating and sustaining an advisory board. (You must RSVP) New Directors/lead staff only, please.
Please rsvp to koehme@fsu.edu or fsuvisit@aol.com

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Database Issues Phone Conference w/ Kelly O'Rourke
TUESDAY, APRIL 7, 2009
Noon Eastern
(850) 644-2255
This is for anyone who has questions about how to effectively use the database, including Access and Visitation Reporting.
Please rsvp to koehme@fsu.edu or fsuvisit@aol.com

Second, a Disaster Preparedness, Response and Recovery guide for CAC's is attached in pdf. Hurricane season is fast approaching! This guide will help you prepare for, survive and recover from a natural disaster.

Third, the Florida Coalition Against Domestic Violence will be hosting a training:

- Florida Coalition Against Domestic Violence
- Embracing Diversity: Bridging the Cultural Divide
- May 11-14, 2009
- See the description of the training at www.fcadv.org

Fourth, please be sure to have your staff and volunteers fill out the Performance Measure Survey. It is included in this e press on the following page, and it is also included in the Family Visitation Times.

Annual Performance Measure Survey

Please indicate the extent to which you agree that the information provided by the Clearinghouse on Supervised Visitation assists you in performing your job. The usefulness scale is indicated below for each product. Please indicate Not Applicable if you do not use a specific tool or product.

1. How useful was the newsletter: *The Bar & Bench Visitation Report*?

☐ Not Applicable ☐ Not Useful ☐ Very Much Useful

2. How useful was the newsletter: *The Family Visitation Times*?

☐ Not Applicable ☐ Not Useful ☐ Very Much Useful

3. How useful was the Monthly E Press?

☐ Not Applicable ☐ Not Useful ☐ Very Much Useful

4. How useful was the Memorandum to Directors?

☐ Not Applicable ☐ Not Useful ☐ Very Much Useful

5. How useful was the ("meet me") Monthly Phone Conferences?

☐ Not Applicable ☐ Not Useful ☐ Very Much Useful

6. How useful was the Institute's Website (with training materials, archive, and message board)?

☐ Not Applicable ☐ Not Useful ☐ Very Much Useful

7. How useful was the Database (and data reports)?

☐ Not Applicable ☐ Not Useful ☐ Very Much Useful

8. How useful was the Report to the Florida Legislature?

☐ Not Applicable ☐ Not Useful ☐ Very Much Useful

Thank you for completing this survey. You may return it by email (clearinghouse@fsu.edu or fsuvisit@aol.com) or by fax (850-644-8331) or by regular mail (Clearinghouse on Supervised Visitation, Florida State University, Room C2501 UCC, 296 Champions Way, Tallahassee, FL 32306-2570).

WORKING WITH FAITH-BASED GROUPS

This is a new topic that we began discussing in the last phone conference. I sent you an outline to get you started.

Religious organizations can reach the large numbers of people who may not be connected to other groups with messages of safety, parent education, child advocacy and support for families. It is important to be familiar with local religious organizations in your area, as well as issues that could impact working and collaborating with faith-based groups. Faith Based groups may also be able to help with program development, advisory assistance, and funding issues.

FAITH in FLORIDA

Florida is a very religious state. Statistics from 2000 indicate that with a population of over 15 million, over 8 million people report attending church regularly. There are 527 Catholic congregations with over 2.5 million attendees. The Evangelical Protestant congregations number 6,657 with attendance of over 2.2 million people. While substantially smaller, the Jewish and Muslim faiths are also represented in Florida, with 346 and 37 congregations, respectively, which represents over 670,000 Jewish worshippers and over 30,000 Muslim worshippers. http://hirr.hartsem.edu/megachurch/megastoday_profile.html

Here is another representation of the religious nature of Florida:

Evangelical Protestants	2,245,241	Mainline Protestants	943,157
Catholic	2,596,148	Orthodox	42,198
Other	749,461	Unclaimed	9,406,173

From the Association on Religious Data Archive website at http://www.thearda.com

There are 95 megachurches or congregations with a sustained attendance of over 2000 people per week in Florida. Based on this information Florida has a minimum of 190,000 people

attending megachurches each week. These churches have been found to be fairly conservative regarding theology. Forty eight percent of the megachurches in the country are in the South. Large Catholic churches are not included in the category of megachurches, as they appear their internal structures appear to differ dramatically from those of the other megachurches. The megachurch is generally dependent on a charismatic leader and a very organized group of church employees who organize a complete schedule of social events every night of the week, as well as retreats and specialty workshops and seminars. These churches are generally considered to be Protestant in nature, however listed below is the actual breakdown of Florida's megachurches and their affiliations:

Assemblies of God	13
Baptist (Unspecified)	8
Missionary Baptist	3
Southern Baptist Convention	23
Episcopal	1
Calvary Churches	4
Church of God	1
International Church of Christ	1
Presbyterian Church of America	2
United Methodist Church	8
United Pentecostal Church of America	1
Seventh Day Adventist	2
Nondenominational	19
No listing	9

While the Jewish and Muslim faiths are mainly represented in Southern Florida, the megachurches are scattered across the state, but a majority are located in metropolitan areas. Jacksonville has the largest number of megachurches with eleven, representing over over 40,000 worshippers. There are five megachurches in each of these Florida cities: Pensacola, Lakeland, Tampa and Miami. There are two in Fort Myers, six in Fort Lauderdale and even one in Tallahassee. http://hirr.hartsem.edu/megachurch/megastoday_profile.html

The Clearinghouse has drafted some forms for you, to edit as appropriate.

1. Want to recruit a Liaison to assist with your faith-based efforts? The Clearinghouse has drafted a "job description" for you:

FAITH LIAISON VOLUNTEER NEEDED

☑Skills needed:

Our supervised visitation program is looking for a volunteer to work three to five hours a week on outreach to religious groups in the community. Our Faith Liaison must be willing to work with people of diverse beliefs, have strong organizational skills, have a thorough understanding of our own program's mission and goals, and must be open to recruiting a few other people to assist him or her as necessary.

☑Goals of the Faith Liaison:

- To meet with area faith groups
  - Introduce the supervised visitation program
  - Offer information sheets relating to SV programs
  - Learn about the congregation and the group's interests in collaborating with local agencies
  - Find common ground on issues such as family health and function

- To determine mutual interests
  - Develop projects such as using the faith group's space for SV functions
    - Meetings, monitored-exchange, or visitation
    - Fundraising opportunities
    - Service on SV's Advisory Board
    - Attract volunteers from the faith group to work at SV
    - Solicit invitations to speak at sub-groups within the faith agency: women's groups, social action groups

☑Tasks Include:

*Becoming familiar with the SV program's mission, goals, policies, procedures
*Writing introduction letters
*Scheduling and keeping appointments
*Learning about existing faith groups
* Developing relationships with those groups, and/or their own liaison
*Speaking at faith groups to leaders and group workers/volunteers
*Being creative in outreach goals: service on committees
* Working with the SV Program's fundraiser or Community Advisory Board to create proposals for fundraisers
* Finding mutual interests of the SV program and the faith group.

☑Other Possibilities:

- Establish ongoing opportunities for collaboration, cross training, technical assistance, and joint programming with religious organizations.

- Attend conventions and conferences organized by religious, faith-based, and spiritual organizations as participants, exhibitors, and presenters to raise awareness about the issue and available community resources.

- Collaborate with religious, spiritual, and faith-based groups and organizations to develop or adapt materials for their members that describe your missions and goals.

- Develop alliances with interreligious groups, ecumenical groups, or other linking groups to seek common goals.

- Seek to serve on community task forces.

- Work with religious organizations to secure appropriate funding for their participation in projects relating to child protection, violence against women, family support and facilitation, and parent education.

Getting Organized

A good idea to help keep organized about faith-based groups in your area is to create forms with all necessary contact information in your files. At least three separate forms should be created, with three available entries per form: one for churches, one for temples and one for mosques. This method allows for easy reference and information retrieval.

EXAMPLE FORM FOR CHURCHES

1. NAME OF CHURCH: _____

DENOMINATION: _____

ADDRESS: _____

PHONE/EMAIL: _____

RELIGIOUS LEADER: _____

PROGRAM LIASION OR CONTACT: _____

NOTES: _____

_____

2. NAME OF CHURCH: _____

DENOMINATION: _____

ADDRESS: _____

PHONE/EMAIL: _____

RELIGIOUS LEADER: _____

PROGRAM LIASION OR CONTACT: _____

NOTES: _____

_____

3. NAME OF CHURCH: _____

DENOMINATION: _____

ADDRESS: _____

PHONE/EMAIL: _____

RELIGIOUS LEADER: _____

PROGRAM LIASION OR CONTACT: _____

NOTES: _____

_____

FUNDRAISING is an issue that intersects Supervised Visitation and faith-based groups. Collaborating with faith-based groups in fundraising activities can be a great way to build a broad foundation of community support.

A good example:

The Salvation Army Family Focus Program in Sanford
is hosting a
GOSPEL CONCERT
featuring local church choirs

- Friday, April 17, 2009
- 7:00pm-9:00pm
- Sanford Civic Center
- Tickets: $10.00 (admission at the door is $15.00)

For tickets and information, contact The Salvation Army Family Focus Program (407) 323-6848

*** * * ***

One way SV programs and faith-based groups can work together is by embarking on a mutual project or effort. Often, issues that can negatively impact a community are layered and complex. More information about faith-based efforts will be in the Memo to Directors next month.

April SV Training

The Impact of Prescription Drug Abuse on Supervised Visitation

By Christie Corbitt

Introduction

Prescription drug abuse is a growing problem in America, and the abuse of prescription drugs among the general population has risen markedly in the past decade. Prescription drug abuse can involve the use of prescription drugs without obtaining a prescription, taking more than the prescribed dose, or taking medication more frequently than prescribed. Many people who misuse prescription drugs do so to numb, alter, or heighten their senses, mood or mind. Parental abuse of prescription drugs can lead to neglect and abuse of children, which can have long-lasting effects on them.

Overview

Information in the training provides visit monitors with basic information about the kinds of prescription drugs that are often abused and how to identify an abuser. Additionally, information is presented on the effects of parental prescription drug abuse on children and visitations. This training will

give monitors some techniques to use in a visitation situation with a parent under the influence of non-prescribed prescription drugs or abusing prescription drugs.

Objectives

After reading this training, a visit monitor will be able to:

1. Identify the most commonly abused prescription drugs and the effects of each;
2. Describe the possible effects of a parent's prescription drug abuse on children;
3. Discuss how identified behaviors of controlled substance abusing parents can affect supervised visits; and

4. Identify effective techniques that can be used when supervising visits involving parents who abuse controlled substances.

Snapshots

- In 2009, prescription drugs replaced other illicit substances as the **leading cause of drug abuse fatalities in Florida.**
- The negative effects of prescription drug misuse can include harmful physical side effects, medical complications and even death.
- The most common teen demographic group to misuse prescription drugs is Caucasian and female.

Background and Scope of the Problem

It can sometimes be difficult to tell the difference between *use* and *misuse* of prescription drugs, but for our purposes, we will define *misuse* as "nonmedical use of a prescription drug without a doctor's prescription" (Twombly & Holtz, 2008). This can include both recreational use and self-medication. In 2003, the number of people who admitted abusing controlled prescription drugs was over 15 million. According to the DEA, it is unlawful to knowingly possess a controlled substance (prescription drug) unless the substance was obtained with a valid prescription directly from a practitioner. Consequences of

breaking the laws pertaining to prescription drugs can include incarceration and heavy fines. The problem affects citizens in all socioeconomic groups: in 2002, Noelle Bush, the governor's daughter, was arrested in Tallahassee for trying to purchase Xanax illegally.

Commonly Abused Prescription Drugs

Some of the most commonly abused prescription drugs are central nervous system depressants, stimulants, tranquilizers, opioids and pain relievers. Opioids and pain relievers include such drugs as Vicodin and Oxycontin. A common stimulant is methylphenidate (Ritalin) and common tranquilizers are Valium and Xanax. Opioids block the transmission of pain signals to the brain, produce a sense of heightened pleasure, and can be highly addictive. Examples of central nervous system depressants, which have sedating or calming effects, are Valium and Xanax. Central nervous system depressants can be addictive as well. Central nervous system stimulants include Adderall and Dexedrine, which can enhance brain activity, increase alertness, energy and attention and elevate blood pressure, heart rate and respiration. Stimulants also create feelings of euphoria.

Impacts of Parental Prescription Drug Abuse on Children

Research indicates that children living in homes where a parent abuses prescription drugs can suffer from a variety of physical, emotional, and mental health problems at a rate greater than the general population. Problems with abuse of controlled substances can negatively affect a parent's capacity to raise a child, which can threaten the child's safety. Specifically, addiction can have the following effects on a parent's abilities:

- Interfere with a parent's judgment and mental functioning.
- Reduce a parent's sensitivity to a child's daily needs.
- Cause parents to neglect a child's basic needs.
- Increase aggression and the threat of physical violence towards a child.

A parent's prescription drug abuse can copied by his/her children and lead to a child's greater risk for subsequent drug abuse.

Prescription Drug Abuse in Teens

Prevalence of the abuse of prescription drugs among teens has been increasing dramatically. In 2003, it was reported that 2.3 million teens ages 12 to 17 used a controlled prescription drug in the past year. Many teens misuse prescription drugs because the underestimate the harm the drugs can do. Teens are a highly impressionable population that can be influenced by multiple sources, such as family, peers, community, culture and the media, and they often have access to prescription drugs in there house hold medicine cabinets. Abuse of prescription drugs by teens can have adverse affect on a teen's school performance, social relationship, emotional wellbeing and overall health. The prescription drugs most commonly abused by teens are opioids.

Identifying Signs of Prescription Drug Abuse at Supervised Visitation

The signs of prescription drug abuse can be manifested in many different ways during a visitation, depending on the drug being used. A parent under the influence of opioids or pain relievers may seem drowsy ("nodding off"), have slurred speech or mood changes. Someone may be under the influence of central nervous system depressants may also appear drowsy or have slowed reaction times. Parents under the influence of central nervous system stimulants may appear to be hyper vigilant, irritable, nervous or restless. Visitation supervisors should be aware of **these behaviors**, but they should also be aware that parents may be nervous, drowsy, etc. for other reasons besides drug use. Visitation staff should always note **behavior that is inappropriate.** Monitors should not be diagnosing problems.

Case Example & Discussion Questions

Ms. Jones is a 35 year old mother who works the night shift at a convenience store. She has been abusing central nervous system stimulants to stay awake through her night shift and abusing central

nervous system depressants to help her escape the stresses after work. Upon intake, Ms. Jones was asked if she was taking any medication and if the medication might adversely affect her supervised visitation. Ms. Jones disclosed that she was currently taking medication to help her relax after work, but that she did not think it would affect the visits with her child. While attending a supervised visitation with her 8 year old daughter, Ms. Jones was under the influence of depressants. Although she never displayed any concerning behavior on during previous visitation, today her reactions were delayed and she was having trouble concentrating on a game with her daughter. She slurred her words. She asked directions three times, and seemed not to hear the answer. The visitation supervisor suspected the behavior might be symptoms were of prescription drug abuse.

1. What were some of the signs that Ms. Jones was having reactions to medications?
2. How might Ms. Jones' drug use/abuse have affected her daughter during the visitation?
3. What would your staff do after suspecting that Ms. Jones is under the influence of prescription drugs?
4. Why is it important to focus on behavior, and refrain from writing down a diagnosis?

(We will discuss the answers during the next phone conference!)

Quiz

1. What is the leading cause of drug related fatalities in Florida?
2. What is the most commonly abuse prescription drug among the general population?
3. What are some ways that parental prescription drug abuse can affect a child's welfare?
4. What are some possible signs that a parent is under the influence of prescription drugs?

References

Wilson M. Compton, Nora D. Volkow, Abuse of prescription drugs and the risk of addiction, Drug and Alcohol Dependence, Volume 83, Supplement 1, Drug Formulation and Abuse Liability, June 2006, Pages S4-S7, ISSN 0376-8716, DOI: 10.1016/j.drugalcdep.2005.10.020. (http://www.sciencedirect.com/science/article/B6T63-4JJ87VP 1/2/c588d7abe7072a9f06fe9700473aeeed)

Keywords: Prescription drug abuse; Drug dependence; Addiction; Opioid analgesic

Twombly, E, Holt, K, & Teens and the Misuse of Prescription Drugs: Evidence-Based Recommendations to Curb a Growing Societal Problem. The Journal of Primary Prevention, 29, Retrieved 3/15/09, from http://www.springerlink.com/content/q5585742gu205628/.

Research Update: Shaken Baby Syndrome (SBS)

By Brittany Gedeon

For years there have been several campaigns aimed at addressing the Shaken Baby Syndrome (SBS) issue. Experts have believed that bleeding behind the eyes probably indicates that an infant has been physically abused, especially when there are also signs of brain damage and bleeding in the brain. Now, a growing number of skeptics are claiming that some of the evidence for the syndrome is cloudy. Still, no one should ever shake a baby. That must remain clear. This research is only being offered so that SV providers know of the complexities of the issues surrounding referrals to SV.

Although many infants are hospitalized with life-threatening conditions, such as convulsions, an inability to eat or to be awakened, or difficulty breathing, it is only on closer examination—CT or MRI scans of the infant's head and examination of the infant's eyes—that a diagnosis of shaken baby syndrome comes into play. A CT or MRI shows intracranial bleeding, between the brain and the skull and in 90 percent of the cases there are also retinal hemorrhages. The symptomatic triad of bleeding between the brain and skull, bleeding behind the retinas and brain swelling is both the core of an SBS diagnosis and the point of departure for the syndrome's skeptics. The medical proof that shaking alone can cause these internal head injuries is questionable, the skeptics say, when many other things, from

infections to malnutrition to falls onto a hard surface, are known to be causes of similar symptoms in infants.

Shaken baby proponents say that people confessing to shaking babies proves that violent shaking had to cause the injuries. Critics charge that the problem with this conclusion is that agreeing to confess to shaking the child would considerably reduce any sentence. There are also several other factors regarding perpetrator's confessions that makes this evidence seem less legitimate.

Certainly some SBS cases bring an abusing parent to justice and save children in the process. But those who deal with dysfunctional families should be aware of the controversy in this subject. Still, please remember, no one should ever shake a baby.

Anderson, M. (2008). Does shaken baby syndrome really exist?. Retrieved March 30, 2009, from Discover Web site: http://discovermagazine.com/2008/dec/02-does-shaken-baby-syndrome-really-exist

BBC News (2004). Doubt over shaken baby diagnosis. Retrieved March 30, 2009, from BBC News Health Web site: http://news.bbc.co.uk/2/hi/health/3564605.stm

NEWS ABOUT PARENTING

Below is an article that appeared in the New York Daily News. It reveals how much help parents sometimes need to be able to care for their children. As we have mentioned on the phone conferences, parent education may be a source of funding in your communities. There may be time for you to incorporate more parent training into your SV time.

Working to put a 'Dad!' into young fatherhood

Monday, March 23rd 2009, 12:44 AM

Several State University of New York Downstate nursing graduate students in Brooklyn teamed up with a program out of Far Rockaway, Queens, to make some young Bronx men better fathers.

Downstate Medical Center College of Nursing Clinical Associate Profs. Sheryl Zang and Natasha Nurse teamed up with David Jones, director of Family Support Services for the Visiting Nurse Service of New York, to help nearly a dozen new noncustodial fathers ages 16 to 24 learn how to parent.

The motivation was simple.

"We wanted to present a program to a population whose needs were not being met," Zang said. "There are a lot of programs for teen mothers. We thought that in order to get teen fathers more involved with their children, we needed to come together with some form of education for them."

Research took them to Jones, who created and has coordinated the Fathers First program in Far Rockaway, Queens, for Visiting Nurse Service of New York (VNSNY) since 1997.

"It was based on my observations of our community," Jones said. "I saw a lot of children with no positive male role models. The fathers were sort of present, but absent from the children's homes."

Jones said he discovered fairly quickly in Far Rockaway that education was a means of increasing an absent father's involvement in a child's life.

"There is very strong judgment about teenagers to begin with," Jones said. "They need a tremendous amount of support about learning how to take care of a newborn. It is so easy for a young father to run away from that responsibility when you have not had positive role models in your life."

Zang, her students and Jones created the Bronx Fatherhood Program, a week-long program that ran 10 fathers through a gamut of basic baby and motherhood information last spring.

"So when Sheryl approached us," Jones said, "it was a perfect fit."

"We did not want to reinvent the wheel," Zang said. "These were young men who already had an interest in fatherhood and wanted to be the best they could be."

The program covered everything from nutrition to Lamaze childbirth. Dads were taught, for example, that giving an expectant woman a baked potato was better for her than a bag of potato chips.

"We presented a program that taught them about changes in the fetus, changes in the mother, labor and delivery, newborn and other anticipatory guidance," Zang said.

"The idea is that even if they don't bring money to the table, and they don't bring education and they don't bring a relationship, at least they can bring something to the baby."

Jones said health-care facilities, educational settings such as primary, secondary and high schools, and social service programs "are really conducive to dealing with the female population. They were neither flexible or fluid in dealing with the male population.

"It was really hard, because when you are teaching parental skills and they don't have the physical custody of the child, we have to sometimes set up supervised visitation, and sometimes even interact with the courts to get them visitation.

"But the information is essential, because when they do interact with their child, they have some competency," he said.

"We want these fathers to be a physical part of their children's lives," Zang said.

The group is seeking funding to hold more classes. For information, see the Web site at www.VNSNY.org.

crichardson@nydailynews.com

In other news...

Domestic Violence Tragedy.

Child dies, another hurt in domestic violence

Sara K. Clarke | Sentinel Staff Writer
March 16, 2009

Police say Miguel Alejandro Torres-Delarosa nearly strangled his two-year-old child to death. (March 15, 2009)

A Lakeland toddler died and another boy was nearly choked to death in two domestic-violence incidents in Central Florida during the weekend.

Lakeland police said they arrested 32-year-old Matthew Robert Wyrosdick on Sunday in the aggravated manslaughter of a child after he admitted he violently shook his 17-month-old nephew and repeatedly dropped the child on the floor.

Wyrosdick initially told authorities the boy fell from a Fisher-Price picnic table Thursday and hit his head, but a doctor said the child's injuries didn't match the story his uncle told.

The toddler, Zachary Johnson, was pronounced clinically brain dead at Tampa General Hospital. An autopsy showed that his injuries were consistent with "shaken baby syndrome or a blow from an offender," but a medical examiner said he could not officially determine the cause of death without further investigation, according to an arrest affidavit.

Palm Bay police said another child nearly died Friday when his father choked him with a belt after the 2-year-old soiled his diaper right after he had been changed.

Miguel Alejandro Torres-Delarosa, 23, told the child's mother he didn't know why the boy's eyes were swollen or why he had marks around his neck. The mother brought the child to the emergency room, where doctors confirmed that he had been choked or strangled.

Torres-Delarosa is being held at the Brevard County Detention Center without bail on charges of attempted murder and aggravated child abuse.

These and other domestic-violence incidents involving children are a concern for authorities and children's advocates. Last year in Orange County alone, at least four children were killed. In 2007, more than 6,800 children wound up living in domestic-violence shelters in Florida.

The recession's effect on domestic violence is significant. Escalating unemployment and foreclosure rates add extra strain on relationships that already may be volatile. One of the leading risk factors for violence, according to national research, is whether the batterer is jobless — as authorities said Wyrosdick was.

Wyrosdick was arrested and taken to the Lakeland Police Department after he was videotaped while showing police how his nephew was injured. He said he was angry at Zachary for not sitting down at the picnic table. He said he shook the boy violently, causing his head to snap back and forth. He put the boy violently back in his seat and the child fell from the picnic table, striking his head on a coffee table.

Wyrosdick said he shook him a second time before he grabbed the child by his arm and walked quickly toward the front door, striking the toddler's head on a railing twice during the process. He then demonstrated how he dropped him three times on the floor, shook him again and dropped him again, Lakeland police said.

Sara K. Clarke can be reached at skclarke@orlandosentinel.com or 407-420-5664.

Amber Alert Canceled After Abducted Infant Found

Police Find Baby, Mother In Yonkers; Mother Arrested (Supervised Visitation involved)

NEW YORK (CBS) —

New York police issued an Amber Alert for Carmen Lopez, a 10-month-old baby apparently abducted by her mother, who is mentally disturbed.

An Amber Alert issued for a 10-month-old girl abducted by her mother in Manhattan was canceled after police found both the suspect and victim in Westchester County, CBS 2 has learned.

The child, identified as Carmen Vidamya Lopez, was found in good condition with her mother, Katherine Mora Ruiz, who was captured by police and arrested in Yonkers. Lopez was safely turned over to child services.

Lopez was reportedly taken by her Ruiz -- who does not have custody of her -- around 11 a.m. during a supervised visitation at 305 Seventh Ave. in Manhattan at .

Ruiz, 31, is said to be mentally disturbed, suffering from chronic paranoid schizophrenia and bipolar disorder. She has refused medication and has been deemed by a court to be a danger to her child.

It's unclear what prompted to Ruiz to take the child and run.

Culturally Diverse Toys

Many thanks to Trish Waterman for her tip on where to find toys, games, and other culturally diverse materials good for SV Programs:

http://www.discountschoolsupply.com/product/productdetail.aspx?product=23154

Items on the site include dolls, early childhood curriculum resources, musical instruments, arts and crafts, books, etc.

MAY E PRESS

May's Phone Conference is on

Thursday, May 14 at Noon eastern

Call 850-644-2255 to join us!

TRAINING ANNOUNCEMENT

The Florida Network of Children's Advocacy Centers will host its 6th Annual Multidisciplinary Conference on Child Abuse in Orlando on August 12-14. August 13 will be a special track for Supervised Visitation!

The FNCAC will hold its Sixth Annual Multidisciplinary Conference on Child Abuse in Orlando, Florida at the Caribe Royale Orlando Hotel & Convention Center. The Conference is a three-day event beginning on Wednesday, August 12, 2009 and ending on Friday, August 14, 2009. The goal of the Multidisciplinary Conference is to provide the multidisciplinary professionals who attend the Conference the instruction, information and strategies they need to protect and treat child abuse victims and their families and to hold offenders accountable.

This annual event has become a favorite for many professionals around the country - including medical professionals, attorneys, therapists, counselors, law enforcement personnel and social workers. Over 300 participants are expected at this year's conference. And, with more than 25 speakers and workshops, there will be something for everyone. Faculty includes presenters who are recognized for their passion and expertise.

The combination of high quality training and vast networking opportunities along with the excitement of Orlando brings an experience that is sure to challenge and inspire everyone who attends.

Speakers include

Lt. Governor Jeff Kottkamp

Secretary of DCF, George Sheldon

Special Agent Al Danna, FDLE

On August 13th, a Supervised Visitation track of trainings will be provided. Also on August 13, there will be a meeting of the Florida Chapter of the Supervised Visitation Network.

Registration Fees

Before July 13, 2009: $300 for individuals and $275 each for groups of 4 or more. Between July 13, 2009 and August 5, 2009: $325 for individuals and $300 each for groups of 4 or more. Registrations after August 5, 2009 must be made on-site at the conference.

Groups of 4 or more wishing to receive the discount must register by mail/fax using the registration form.

Registration payments are transferable, but will not be refunded.

Registration Deadlines

Registrations after July 31st must be faxed or submitted online.

Registrations after August 5th will only be accepted on-site at the conference.

We will also have on-site registration and early check-in at the Caribbean Registration Desk on August 11, 2009 from 1:00 - 4:00pm in the Convention Center.

Hotel Information

The Caribe Royale Orlando is an all-suite hotel so you will have plenty of room to comfortably enjoy your stay in Orlando. Each of the one-bedroom suites will be completely renovated as of April 2009 and you will appreciate the many enhancements in these beautiful new suites, including 37" and 42" flatpanel HDTVs.

$125 Double Queen One-Bedroom Suite
$125 Standard King One-Bedroom Suite
$145 King Deluxe One-Bedroom Suite
$250 Two-Bedroom Villa

Call 1-800-823-8300 to speak with a Reservations Specialist.

Location

Caribe Royale Orlando Hotel
8101 World Center Drive
Orlando, FL 32821

The last day to book your suite and receive the group rate is Sunday, July 12, 2009.

Lunch-Time In-Service Training for Staff

CHILDREN WITH ADHD

Introduction

Many of the children referred to supervised visitation programs, in both dependency and in family law cases, are affected by the Attention-Deficit/Hyperactivity Disorder (ADHD). ADHD is a condition that becomes apparent in some children in the preschool and early school years. It is hard for these children to control their behavior and/or pay attention. Problems generally associated with ADHD include inattention, hyperactivity and impulsive behavior. They can affect nearly every aspect of life. Children with ADHD often struggle with low self-esteem, troubled personal relationships and poor performance in school.

Overview

This chapter provides current information and research findings about child ADHD in order to assist visit monitors in their roles.

Objectives

Upon completion of this chapter, a visit monitor will be able to:

1. State the prevalence of child ADHD;
2. Recognize the inattention and hyperactivity symptoms of the disorder
3. Identify the causes of ADHD
4. Recognize the various complications involved with ADHD
5. State the various treatments and medications for ADHD

Snapshots

- Boys are most likely to be diagnosed ADHD.
- The National Center for Gender Issues (NCGI) reports: “For girls and women, ADHD is often a hidden disorder, ignored or misdiagnosed by the educational and medical communities causing these girls and women to suffer in silence.”
- 40 % of children with ADHD have a parent with ADHD.
- 50% of children with ADHD also have trouble sleeping.
- Children with ADHD develop 30% slower than non ADHD children.
- 65 % of children with ADHD have discipline problems.
- 25% of children with ADHD have a serious learning disability.
- One half of ADHD children have poor listening comprehension.
- Parents of a child with ADHD are three times as likely to divorce.
- LD online, the world’s leading website on learning disabilities and ADHD, states, “It is estimated that between 3 and 5 percent of children have ADHD, or approximately 2 million children in the United States.”

Symptoms of ADHD

In general, children are said to have ADHD if they show six or more signs or symptoms from the two broad categories of the disorder, inattention and hyperactivity-impulsive behavior, for at least six months. These symptoms must significantly affect a child's ability to function in at least two areas of life — typically at home and at school. This helps ensure that the problem isn't with only a particular teacher or with only parents. Children who have problems in school but get along well at home or with friends are not considered to have ADHD. The same is true of children who are hyperactive or inattentive only at home but whose schoolwork and friendships aren't affected by their behavior.

Inattention

Signs and symptoms of inattention may include:

- Often fails to pay close attention to details or makes careless mistakes in schoolwork or other activities
- Often has trouble sustaining attention during tasks or play
- Seems not to listen even when spoken to directly

- Has difficulty following through on instructions and often fails to finish schoolwork, chores or other tasks
- Often has problems organizing tasks or activities
- Avoids or dislikes tasks that require sustained mental effort, such as schoolwork or homework
- Frequently loses needed items, such as books, pencils, toys or tools
- Can be easily distracted
- Forgetful often

Hyperactivity-impulsiveness
Signs of hyperactivity-impulsive behavior may include:

- Fidgets or squirms frequently
- Often leaves his or her seat in the classroom or in other situations when remaining seated is expected
- Often runs or climbs excessively when it's not appropriate or, if an adolescent, might constantly feel restless
- Frequently has difficulty playing quietly
- Always seems on the go
- Talks excessively
- Blurts out the answers before questions have been completely asked
- Frequently has difficulty waiting for his or her turn
- Often interrupts or intrudes on others' conversations or games

Most healthy children are inattentive, hyperactive or impulsive at one time or another. For instance, parents may worry that a 3-year-old who can't listen to a story from beginning to end may have ADHD. But preschoolers normally have a short attention span and aren't able to stick with one activity for long. Even in older children and adolescents, attention span often depends on the level of interest. Most teenagers can listen to music or talk to their friends for hours but may be a lot less focused about homework. The same is true of hyperactivity. Young children are naturally energetic and they may become even more active when they're tired, hungry, anxious or in a new environment. In addition, some children just naturally have a higher activity level than do others. Children should never be classified as having ADHD just because they're different from their friends or siblings.

Causes

Parents may blame themselves when a child is diagnosed with ADHD, but researchers increasingly believe that causes have more to do with inherited traits than parenting choices. At the same time, certain environmental factors may contribute to or worsen a child's behavior. These are factors that may play a role:

- Altered brain function and anatomy. While the exact cause of ADHD remains a mystery, researchers have discovered important differences in the brains of people with ADHD. For example, neurotransmitters aren't used properly in people with ADHD. Additionally, there appears to be less activity in the areas of the brain that

control activity and attention in people with ADHD. Brain scans have revealed that, on average, children with ADHD have up to 4 percent smaller brain volumes than do children without ADHD.

- Heredity. ADHD tends to run in families. About one in four children with ADHD have at least one relative with the disorder.
- Maternal smoking, drug use and exposure to toxins. Pregnant women who smoke are at increased risk of having children with ADHD. Alcohol or drug abuse during pregnancy may reduce activity of the nerve cells (neurons) that produce neurotransmitters. Pregnant women who are exposed to environmental poisons, such as polychlorinated biphenyls (PCBs), also may be more likely to have children with symptoms of ADHD. PCBs are industrial chemicals that were widely used in the past.
- Childhood exposure to environmental toxins. Preschool children exposed to certain environmental toxins, particularly lead and PCBs, are at increased risk of developmental and behavioral problems, many of which are similar to those found in children diagnosed with ADHD. Exposure to lead, which is found mainly in paint and pipes in older buildings, has been linked to disruptive and even violent behavior and to a short attention span. Exposure to PCBs in infancy may also increase a child's risk of developing ADHD.

Difficulties Associated with ADHD

Children with ADHD often struggle in the classroom, which can lead to academic failure and ridicule from both other children and adults. Children with ADHD are also more likely to be injured than are other children.

In addition, although ADHD doesn't cause other psychological or developmental conditions, as many as one in three children with ADHD are affected by other disorders, including:

- Oppositional defiant disorder (ODD). Generally defined as a pattern of negative, defiant and hostile behavior toward authority figures, ODD occurs in as many as half of all children with ADHD. This condition is more common in boys.
- Conduct disorder. A more serious condition than ODD, conduct disorder is marked by distinctly antisocial behavior: stealing, fighting, destroying property, and harming people and animals. Children with conduct disorder need immediate help.
- Depression. Depression may occur in both children and adults with ADHD.
- Anxiety disorders. Anxiety disorders tend to occur fairly often in children with ADHD and may cause overwhelming worry and nervousness as well as physical signs and symptoms, such as a rapid heartbeat, sweating and dizziness. Although anxiety disorders can cause severe signs and symptoms, most people can be helped with therapy or medication. Once anxiety is under control, children are better able to deal with the problems arising from ADHD.

- Learning disabilities. Children with both ADHD and learning disabilities are the children most in need of special education services.
- Tourette syndrome. Many children with ADHD also have Tourette syndrome, a neurological disorder characterized by compulsive muscular or vocal tics.

Treatment and Medications

Standard treatments for ADHD in children include medications and counseling. Other treatments to ease ADHD symptoms include special accommodations in the classroom, and family and community support.

Medications

Currently, stimulant drugs and the non-stimulant medication, atomoxetine, are the most commonly prescribed medications for treating ADHD.

Stimulant medications for ADHD include:

- Methylphenidate (Ritalin, Concerta, Daytrana)
- Dextroamphetamine-amphetamine (Adderall)
- Dextroamphetamine (Dexedrine)

Although scientists don't understand exactly why these drugs work, stimulants appear to boost and balance levels of the brain chemicals called neurotransmitters. These ADHD medications help improve the core signs and symptoms of inattention, impulsivity and hyperactivity — sometimes dramatically. However, effects of the drugs wear off quickly. Additionally, the right dose varies from child to child, so it may take some time in the beginning to find the correct dose.

Stimulant medication side effects may include:

- Decreased appetite
- Weight loss
- Problems sleeping
- Irritability as the effect of the medication wears off

A few children may develop jerky muscle movements, such as grimaces or twitches (tics), but these usually disappear when the dose of medication is lowered. Stimulant medications may also be associated with a slightly reduced growth rate in children, although in most cases growth isn't permanently affected. However, there has been some concern about using stimulants to treat preschoolers who have ADHD.

Although a rare occurrence, several heart-related deaths have occurred in children and adolescents taking stimulant medications. The American Heart Association has said that every child should have a heart test called an electrocardiogram (ECG) before getting stimulant medications for ADHD, while other organizations such as the American

Academy of Pediatrics say that a thorough history and physical exam is enough to screen for heart problems.

Non-stimulant medication

Atomoxetine (Strattera) is generally given to children with ADHD when stimulant medications aren't effective or cause side effects. In addition to reducing ADHD symptoms, atomoxetine may also reduce anxiety.

Non-stimulant side effects may include:

- Nausea
- Sedation
- Decreased appetite
- Weight loss

Atomoxetine has been linked to rare side effects that include liver problems. If the child is taking atomoxetine and develops yellow skin (jaundice), dark-colored urine or unexplained flu symptoms, their doctor should be contacted right away.

There has also been some concern that children and adolescents taking atomoxetine have an increased risk of suicidal thinking. Although atomoxetine has never been linked to an actual suicide, the child’s doctor should be contacted if there are any signs of suicidal thinking or other signs of depression.

Other medications

- Antidepressants. These medications are generally used in children who don't respond to stimulants or atomoxetine or have a mood disorder as well as ADHD.
- Clonidine (Catapres) and guanfacine (Tenex). These are high blood pressure drugs shown to help with ADHD symptoms. They may be prescribed to reduce tics or insomnia caused by other ADHD medications, or to treat aggression caused by ADHD.

ADHD counseling and therapy

Children with ADHD often benefit from counseling or behavior therapy, which may be provided by a psychiatrist, psychologist, social worker or other mental health care professional. Some children with ADHD may also have other conditions such as anxiety disorder or depression. In these cases, counseling can help both ADHD and the coexisting problem.

Counseling types include:

- Psychotherapy. This allows older children with ADHD to talk about issues that bother them, explore negative behavioral patterns and learn ways to deal with their symptoms.
- Behavior therapy. Teachers and parents can learn behavior-changing strategies for dealing with difficult situations. These strategies may include token reward systems and timeouts.
- Family therapy. Family therapy can help parents and siblings deal with the stress of living with someone who has ADHD.
- Social skills training. This can help children learn appropriate social behaviors.
- Support groups. Support groups can offer children with ADHD and their parents a network of social support, information and education.
- Parenting skills training. This can help parents develop ways to understand and guide their child's behavior.

The best results usually occur when a team approach is used, with teachers, parents, and therapists or physicians working together. You can help by referring them to reliable sources of information to support their efforts in the classroom.

Home Remedies, Life Style, and Alternative Medication

Children at home/Advice for parents:

- Show your child a lot of affection
- Be patient
- Be realistic in your expectations for improvement
- Take time to enjoy your child
- Try to keep a regular schedule for meals, naps, and bedtime
- Make sure your child is rested
- Try to avoid situations that are difficult for your child (i.e. sitting through long presentations)
- For children with ADHD, a timeout from social stimulation can be very effective. Timeouts should be relatively brief, but long enough for your child to regain control.
- Help your child organize and maintain a daily assignment notebook and be sure your child has a quiet place to study.
- Find ways to improve your child's self-esteem and sense of discipline. Children with ADHD often do very well with art projects, music or dance lessons, or martial arts classes, especially karate or tae kwon do.
- Use simple words and demonstrate when giving your child directions.
- Take a break yourself

Children in school:

- There may be special programs in a child’s school for children with ADHD. As with other disabilities, schools are required by law to have a program in place to

make sure children who have a disability that interferes with learning are getting the support they need. The child may be eligible for additional services offered under the federal laws Section 504 or the Individuals with Disabilities Education Act (IDEA). These can include curriculum adjustments, changes in classroom setup, modified teaching techniques, study skills instruction, and increased collaboration between parents and teachers.

- Close communication between teachers and parents is a key factor in an effort to support the child in the classroom. Parents should make sure teachers closely monitor their child's work, provide positive feedback, and are flexible and patient. Teachers should be very clear about their instructions and expectations.
- Children with ADHD often have trouble with handwriting and can greatly benefit from using a computer or a typewriter.

Examples of alternative medicine discussed in the media:

- Yoga. There's growing evidence yoga may help alleviate symptoms of ADHD.
- Special diets. Most diets for ADHD involve eliminating foods thought to increase hyperactivity, such as sugar and caffeine, and common allergens such as wheat, milk and eggs. Some diets recommend eliminating artificial food colorings and additives. So far, studies haven't found a consistent link between diet and improved symptoms of ADHD, though a limited number of studies suggest diet changes might make a difference.
- Vitamin or mineral supplements. While certain vitamins and minerals are necessary for good health, there's no evidence that supplemental vitamins or minerals can reduce symptoms of ADHD. "Megadoses" of vitamins — doses that far exceed the Recommended Dietary Allowance (RDA) — can be harmful.
- Herbal supplements. The verdict is still out on whether taking hypericum, ginseng, ginkgo, traditional Chinese medicine formulas or other herbal remedies may help with ADHD.
- Essential fatty acids. These fats, which include omega-3 oils, are necessary for the brain to function properly. Researchers are still investigating whether these they may improve ADHD symptoms.
- Glyconutrients. The term "glyconutrients" refers to eight specific sugars that theoretically reduce symptoms by helping form important compounds called glycoproteins. While sugars are necessary for brain function, it isn't clear whether glyconutrient supplements have any effect on ADHD.
- Neurofeedback training. Also called electroencephalographic biofeedback, this treatment involves regular sessions in which a child focuses on certain tasks while using a machine that shows brain wave patterns. Theoretically, a child can learn to keep brain wave patterns active in the front of the brain — improving symptoms of ADHD. More research is needed to see whether this treatment works.

Case Example

Instructions: Read the following case study. Discuss or express in writing how this visit should be handled.

A mother is visiting her seven-year-old son. When she tries to talk to him or play a game with him, he seems completely zoned out and isn't paying attention to her. He can't sit still and constantly roams around finding other things to do. His mother feels he can't stand to be around her and blames herself for his behavior and poor progress at school. Out of frustration, she then ridicules him for his behavior.

Questions to Consider

1. **What are some of the possible causes of this child's behavior?**
2. **What is the impact of the child's behavior on the visit?**
3. **What kind of notes should be taken about this behavior?**
4. **If this is a DCF/CPS case, should the case worker be consulted?**
5. **Who else should be consulted about this case?**
6. **How can a monitor offer a quality visit in this case?**

Quiz

1. Describe some of the signs and symptoms of inattention and hyperactivity-impulsive behavior and how it may interfere with a child's life.
2. Identify the common medications used to treat ADHD and any side effects of these drugs.
3. Discuss the types of therapies used to treat children with ADHD.
4. Give examples of advice for parents with children who have ADHD.
5. What are some efforts schools and teachers can make to accommodate children with ADHD?

Resources

http://www.mayoclinic.com/health/adhd/DS00275

http://www.adhdchild.org/

http://ldonline.org

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You ask: we answer!

Multigenerational/Intergenerational Households

Nearly 10% of the kids in the US live in multigenerational households

When you read the information below, think about the potential impact on SV! Can you accommodate a multigenerational family?

Statistics

-Types of multigenerational households in the United States in 2000 (year of the most recent census):

- 3 generations – grandparent headed: 65%
- 3 generations – parent headed: 33%
- 4 generations or more: 2%

-Multigenerational households grew from 3 million (3.2% of families in America) in 1990 to 4.2 million (3.9%) in 2000.

-Multigenerational family households are more common in parts of the country where housing shortages or high costs force families to double up their living arrangements.

-Hawaii had the highest percentage of multigenerational family households, 8.3 percent of all households. These households are also more common in locales with a high number of immigrants.

-Between 1990 and 2000 the percent of children living in multigenerational households increased from 7.3 percent to 9.6 percent in the U.S.

-The number of heads of households who share their homes with their parents, brothers and sisters, and other relatives grew 42 percent from 2000 to 2007. The census finds a 75 percent increase in parents under the age of 65 who are now living with their adult children. Some of these may be multi-generational households while others contain only two generations.

Reasons for multigenerational/intergenerational households

- Financial: The high cost of living, especially high housing costs and higher education costs
- Situational: Unemployment, divorce, or military deployment of a spouse
- Cultural: In many cultures, such as those of some immigrants, American Indians and Alaskan Natives, families may believe in living with multiple generations and find it

quite natural. These and other groups may desire to stay connected to roots and to share rituals, holidays, and other special events. Also, some individuals believe it is healthier to live in age-integrated communities where young can benefit from the wisdom of elders and older adults feel connected to the future.

Rewards of multigenerational living

- Parents of young children may receive help with childcare from grandparents. The grandchildren obtain gifts of time, unconditional love, and attention from their grandparents. In turn, grandparents get emotional satisfaction from frequent interaction with their grandchildren and from the responsibilities of helping them.

- Positive outcomes for older adults who engage with children including less depression, taking better care of themselves physically and reporting a sense of purpose.

- Children are less likely to fear aging or stereotype older adults.

Challenges of multigenerational living

- Members of the middle generation may feel stress balancing the needs of their parents and children.

- Many times there are renovations necessary to accommodate the physical needs of all family members – such as a ramp for wheelchairs or strollers or child-proofed rooms.

- Providing privacy for all household members

Resources

http://www.gu.org/documents/A0/FS_MultiGen_Households_2009.pdf

http://muse.jhu.edu/journals/future_of_children/v016/16.2beller.html

Kearny, M.S. (2006). Intergenerational mobility for women and minorities in the United States. *The Future of Children, 16*(2), 37-53.

Nam, Y. (2004). Is America becoming more equal for children? Changes in the intergenerational transmission of low and high-income status. *Social Science Research, 33*, 187-205.

More about our Faith-based Discussion:

Florida Muslims: Faith and Community

Editor's note: The Clearinghouse has been hosting a conversation about how SV programs can learn about and engage the faith community. This brief article is another part of that discussion, based on questions from directors.

Florida is home to a diverse array of cultures, ethnicities, and religions. The most asked-about group here at the Clearinghouse is the Muslim population in Florida. Along with many other groups, the Muslim population continues to grow and flourish across the state. The southeastern coast of Florida has the highest concentration of Muslims, with more than 70,000 followers of Islam in Palm Beach, Broward, and Miami-Dade counties. Other significant enclaves can be found in the Tampa Bay area and Central Florida. Muslims across Florida are contributing to their communities everyday, yet the rich history and traditions of this religion is often misunderstood.

About Islam

Islam, the religion of practicing Muslims, has been in existence for over 1,400 years. It is one of the fastest growing religions in the world. Muslims can be found in the Middle East, Southeast Asia, Africa, Europe, and the Caribbean, among other notable places. Their religious teachings are based on the holy book the Qu'ran, and the prophet of Islam is Muhammad. Islam is upheld by the Five Basic Pillars: declaration of faith, praying five times a day, giving money to charity, fasting, and completing a pilgrimage to Mecca. Mecca is considered to be the birthplace of Islam. Places of worship are called mosques and religious leaders called *imams* conduct services.

In addition, Muslims observe many holy days. Ramadan is a holy month in which Muslims are required to complete a 30-day period of fasting, as well as to spread charity

and give back to the community by offering food, money, and time. At the end of the holy month, family and friends celebrate with the festival of Eid al-Fitr. It is a time of togetherness and forgiveness.

Muslims Giving Back to the Community

Muslims around Florida are doing their part to give back to the community. The Crescent Clinic in St. Petersburg is a free medical-care facility ran primarily by Muslim doctors and staffed with volunteers. The medical chief of staff, Husan Abuzarad, opened the clinic because he saw a need in the community to provide free medical care to those with no health insurance. Since its opening, the Crescent Clinic has received close to 1,000 patients. Patients' health complaints include everything from the common cold to cuts requiring stitches. An agreement with Florida Cancer Institute-New Hope allows the clinic to provide treatment to cancer patients as well. Due to the high demand of clinic services, the facility is hoping to expand its hours and staff to accommodate even more patients.

In South Florida, Muslims have participated in community beautification projects and supplying food to the homeless. Mosques have also teamed up with churches and synagogues to provide aid to Haiti and other countries in the Caribbean, as well as to educate the community about the Muslim faith. As the state of Florida continues to become more diverse, it is an opportunity for all Floridians to educate themselves and give back to the community.

CRESCENT CLINIC WANTS TO EXPAND, HELP EVEN MORE
St. Petersburg Times (FL) - Monday, November 17, 2008
Author: BETH N. GRAY, Times
http://docs.newsbank.com/s/InfoWeb/aggdocs/AWNB/1248CD705094B488/0D0CB4F723A99D0A

Muslims celebrate faith, family during Eid al-Fitr
==========
Pensacola News Journal (FL)-October 3, 2008
Author: Anthony Cornealius
http://docs.newsbank.com/s/InfoWeb/aggdocs/AWNB/1239DEAA22F0BF78/0D0CB4F723A99D0A

Muslims in South Florida, Some find their religion can hinder assimilation, By Ruth Morris, August 19, 2006, South Florida Sun-Sentinel

Ida Rivera's program sponsored a Gospel Concert with many area churches this month. She shared several photos with us. Contact us or Ida if you would like to see the pictures!

Power Point Presentation: During the May phone conference, we will discuss an SV self-study relating to diversity. Be there!

When you RSVP to the phone call, we will send you a PowerPoint guide to the discussion.

Questions from Directors

We see a lot about living below the poverty line. What does this mean?

I've attached the newest poverty guidelines for 2009. As you can see, if you have four people in your family, and you make less than $22,000 per year, your family is living below the poverty line. The SV Database indicates that the majority of people receiving services in Florida have incomes at or below the poverty line.

Poverty Guidelines

The U.S. 2009 Poverty Guidelines	
Persons in family	**Poverty guideline**
1	$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010
For families with more than 8 persons, add $3,740 for each additional person.	

How can I help a parent understand his or her child better to improve the visit and the relationship? Do you have any ideas?

That's a great question. As a result of this particular question, we did some research and offer this training piece on multiple intelligences, below.

Multiple Intelligences in Children: A Strengths-Based Approach

Introduction

As supervised visitation programs seek to embrace a family-centered practice and to provide families with optimal resources, it is crucial that they do everything within their power to understand how children learn and develop. Often times we are tempted to use "cookie cutter" type techniques to address children's learning issues, but children learn in diverse ways. A "one size fits all" approach to learning will not work; instead, it may cause a child to feel inadequate in his/her own abilities and diminish feelings of self-worth. **Teaching a parent to focusing on the strengths of a child and the ways in which that particular child excels can be helpful.** One such method, and perhaps one answer to the growing awareness of children's diverse learning issues, is Howard Gardner's Theory of Multiple Intelligences (MI).

Objectives

Upon completion of this training, a visit monitor should be able to:

1. Identify the eight different intelligences and how they evolved;
2. Identify characteristics for each intelligence;
3. Understand the potential positive impacts of implementing the Multiple Intelligences Theory;
4. Recognize the different populations which can benefit from using the MI theory; and
5. Recommend helpful resources and strategies for families with children who may have learning exceptions.

Evolution of Multiple Intelligences Theory

Many of us are familiar with Alfred Binet and his introduction of the test which measures intelligence, resulting in one's "intelligence quotient" or "IQ." The Scholastic Aptitude Test (SAT) is yet another test which attempts to measure intelligence, specifically that of high school students looking to apply to colleges. Both of these tests look largely at two types of intelligence: verbal and math.[1] However, if a person a) does not excel in either or both of these rather specific areas, or b) does not feel he or she is skillful at taking tests, then a lower score results. Consequently, he or she is branded as unintelligent.[1] The social work profession is vehemently advocating for service providers **to focus on the strengths of the individuals** who are being served. Overall, this is called a strengths-based approach.

In the early 1980's, Howard Gardner attempted to address the issue of limited and narrow perspectives on intelligence with his Multiple Intelligence (MI) theory, which proposed that there are several other forms of intelligence which ought to be considered. He began with seven intelligences, but has more recently added an eighth (naturalist). **The eight intelligences that Gardner presents are the following: linguistic, logical-mathematical, spatial, bodily kinesthetic, musical, interpersonal, intrapersonal, and naturalist.[2]**

Types and Descriptions

Linguistic – Good with words. May enjoy being read to regularly or reading books themselves. May be well-spoken. Good at remembering words and/or telling stories.[2]

Logical-mathematical – Good at logical thinking. May enjoy puzzles or other games where they have to think logically. Typically good at math and working with computers. Enjoy problem solving and critical thinking.[2]

Spatial – Good at images and pictures. May enjoy drawing or painting. May be good at mazes, building blocks, or puzzles. May have interest in machines or things they can take apart and put back together.[2]

Bodily Kinesthetic – Good at sports and/or other movement activities. Display good gross and fine motor skills. May enjoy swimming, dancing, building, or participating in competitive sports.[2]

Musical – Enjoy music and/or singing. May play musical instruments or sing. May be good at discerning sounds around them. May enjoy listening to music and remember songs easily.[2]

Interpersonal – Very social and good in social settings. May settle conflicts and enjoy group activities. Seem to be more aware of other people's feelings.[2]

Intrapersonal – Strong sense of independence. May enjoy playing by themselves more than playing with others. May have a strong sense of self-confidence. May be goal-oriented.[2]

Naturalist – Strong interest in nature or animals. Prefer to play outdoors rather than in. May enjoy playing with rocks, sticks, water, sand, snow, leaves, or animals.[2]

Note: There is a potential ninth intelligence that Gardner is exploring, which is called "existential intelligence." This refers to the sensitivity to deeper concepts and tackling

big questions about human existence. However, since there is little information on this intelligence, it will not be discussed here.

Potential Impact on Diverse Learning Populations

While a traditional IQ test may, by its approach, ask the question "how smart are you?" the MI theory asks "*in what ways* are you smart?" Many children experience learning disabilities and/or the discomfort of testing poorly**. The MI theory suggests that they are likely to have other areas in which they can feel accomplished and intelligent.** Since children are gifted in diverse and varying ways, it stands to reason that there should be diverse and varying opportunities for growth. Some schools have begun to incorporate the MI theory into their curriculum due to its effectiveness with children who are gifted learners as well as those who have disabilities.[3, 4, 5] The MI theory has been shown to be a valuable tool in working with children on extreme ends of the learning spectrum – those who exude mastery in many intelligences or profoundly in one and those who may be considered learning disabled.[6] No matter where a child lies on the spectrum of aptitude, research suggests that by implementing the MI theory into their learning process their strengths will become the focus, rather than their disabilities.[2]

Many educators find the MI theory appealing due to its comprehensiveness and ability to seemingly adapt to individual differences. Children with ADHD, for example, typically have a negative academic self-concept brought on by what seems to be a continual lack of success in the classroom. Overcoming what they perceive as academic failure involves strengthening areas which are struggles for children by using those areas in which they excel. In other words, if a child is skilled in music or physical activity, it is possible to incorporate those interests in the process of learning math or reading.[3] While some teachers may not have the resources or abilities to use the MI theory in their classrooms to its fullest, parents can help the learning process at home by understanding the concepts of the theory, focusing on their children's strengths, and using those strengths to gain understanding in more difficult subjects.

The MI theory also has some positive implications for children who have been identified as "gifted." Due to the curriculum incorporating sensory and environmental aspects, research suggests that it offers more diverse learning strategies, which can increase mental stimulation and maintain interest.[5]

Children who are participating in supervised visitation programs could very likely be experiencing a good deal of personal stress at home. Possible side effects of that stress could include decreased motivation in school, conflict in relationships with peers and teachers, and a negative view of self. **A visit monitor can intervene on behalf of the child and the parent (both the custodial parent and/or the visiting parent) by offering informative resources on the learning strategies of Multiple Intelligences Theory. Empowering the parents to empower their children can potentially improve and strengthen the familial relationship.**

Case Example and Discussion Questions

Read the case example below and then answer the questions about the case.

Catherine, who is 8 years old, has come in for a scheduled visitation with her mother. During the visit, Catherine makes a mistake while playing a game, and says "Oh, I'm so stupid." Her mother asks Catherine if anything is wrong and she responds by telling her mother that she is not doing well in school. In spite of her working hard to understand the material, she does not feel as smart as the other kids in her class and her grades "bad." She can't learn her multiplication tables. She claims the only classes she is doing well in are P.E. and Music. She looks down at the table and says, "I guess I'm just dumb." Her mother does not seem to know how to respond.

1. From the conversation that has taken place between Catherine and her mother, what seems to be Catherine's biggest concern? She feels stupid, her self-esteem is suffering, school is causing her anxiety, etc.
2. How might the child's anxiety and the parents' uncertainty on how to handle this situation affect the visitation and/or the parent/child relationship? She may feel

her parents cannot understand her which may result in some emotional distance between them, the parents may feel inadequate or frustrated, parents may respond by reprimanding her for not trying hard enough rather than offering positive alternatives, etc.

3. What information can the visitation monitor give the custodial and visitor parents that could help them encourage their child? Could help her focus on the areas in which she is capable, help them investigate other learning opportunities in which the MI theory is implemented into the curriculum, parents could talk to her teachers about implementing more creative ways of learning, etc. Is there a case worker? The case worker can be asked to speak to the teacher about Catherine's strengths and weaknesses. Is there a GAL? A GAL can be a good resource for finding out what is going on at school, and how Catherine can use her strengths to their fullest. In Catherine's case, her teacher tells her how to learn songs that have the multiplication tables in them. For example, she learns 'Pop goes the weasel' can be sung with multiples of six.

While there appears to be a surplus of resources that expound on the use of the MI theory in the classrooms and other educational settings, very little seems to target parents and the application of techniques at home. Supervised visitation staff may be helpful in the implementation of the theory at home by informing parents and offering understanding of the concept of MI theory. In doing so, there is the possibility of taking what resources are available and integrating them into the learning process at home. At the very least, the child can grow to understand that they are capable of learning and becoming valuable contributors in school.

Parents may feel frustrated by their child's lack of academic success in school and deal harshly with the child. The MI theory reframes the way parents and children think about their learning abilities.[3] This allows for a more positive and healthy exchange during visitations. The following table describes each intelligence and offers ideas for activities that can be used in promoting effective learning for each one. Some are appropriate for young children, while others may be adapted for older. Sometimes a visitation monitor

may notice that a child seems to have certain strengths. Pointing out those strengths to parents and to the child is a positive way to help build the child's understanding of self, and the parents' relationship with the child.

Table 1.1
Multiple Intelligences and Characteristics[2]

Intelligence	Characteristics	Common activities to promote intelligences	Occupations linked with intelligence
Bodily Kinesthetic	Good at sports and movement activities Demonstrate good fine and gross motor skills Enjoy things like swimming, dancing, competitive sports, or building things	Dancing, sports, ball games, climbing trees, finger plays, yoga, bean bag toss, dodge ball	Construction Worker, Fire Fighter, Athlete, Astronaut, Hairdresser, Doctor, Mechanic, Dancer, Choreographer, Artist
Interpersonal	Very social and good in social settings Settle conflicts Enjoy group games Have an awareness of other people's feelings	Group games, role playing, cooperative learning, card games, creating cartoons, thematic play	Teacher, Child Care, Waiter/Waitress, Hairdresser, Cashier, Nurse, Clergy
Intrapersonal	Strong sense of independence May play alone more than with others Strong sense of self-confidence Set goals to achieve	Body tracing, role playing, body part games, yoga, puppets	Clergy, Teacher, Psychologist, Counselor
Linguistic	Good with words Listening to and playing with words Like books, being read to Tell jokes or stories Good memories for words Spell words easily	Books, jokes, poetry, nursery rhymes, cooking, card or board games, story telling props	Editor, Lawyer, Judge, Teacher, Politician, Librarian, Mail Carrier, Pharmacist, TV and Newspaper Reporter, Actor
Logical-Mathematical	Good at logical thinking activities Enjoy puzzles or board games Enjoy math games or computers Learn how things work Good problem solving Critical thinking	Sorting, counting, blocks, board games, cooking, hide and seek, some computer games, puzzles	Banker, Accountant, Construction, Bookkeeper, Scientist, Chef, Mechanic, Architect, Computer Programmer, Carpenter, Engineer, Small Business Owner
Musical	Enjoy playing and listening to	Nursery rhymes,	Musician, Dancer,

	music May sing or play instrument Good at discriminating sounds in the environment May remember songs easily	musical instruments, listening to music, dancing, making simple rhythmic instruments, karaoke, some computer games	Singer, Entertainer, Music Teacher, Songwriter
Naturalist	Strong interest in nature or animals Prefer to play outdoors Enjoy playing with rocks, sticks, water, sand, animals, snow, or leaves	Sand, water, rocks, farm toys, toy shovels, play doh, wood, hammers nails, pets, planting seeds, hiking, gardening, nature scavenger hunt, cooking	Park Ranger, Zoo Keeper, Lumberjack, Fisherman, Florist, Famer/Rancher, Veterinarian, Chef, Landscaper
Spatial	Good at images and pictures Enjoy drawing or painting May be good at mazes, puzzles or building blocks Interest in machines Taking things apart and putting them together Design	Drawing, bowling, painting, sculpture, arranging furniture, puzzles, block play	Artist, Pilot, Photographer, Astronaut, Hairdresser, Florist, Architect, Engineer, Carpenter, Illustrator, Painter

TO LEARN MORE:

Multiple Intelligences: New Horizons in Theory and Practice, by Howard Gardner, Basic Books, www.basicbooks.com

Multiple Intelligences: Best Ideas From Research and Practice, by Mindy Kornhaber, Edward Fierros, and Shirley Veenema, Allyn & Bacon, www.pearsoned.co.uk

Quiz

1. What are the 8 intelligences that Gardner has identified?
2. Identify some characteristics of each.
3. What populations are able to benefit from the Multiple Intelligences Theory and in what ways?

4. How might a supervised visitation monitor help a parent identify a child's strengths?

[1] Jay Davidson, *Multiple Intelligences*, Child Dev. Inst. (2008) Retrieved April 27, 2009, from http://childdevelopmentinfo.com/learning/multiple_intelligences.htm

[2] Michael Rettig, *Using the Multiple Intelligences to Enhance Instruction for Young Children and Young Children with Disabilities*, 32 Early Child. Ed. Jour. 255, 256 (2005), http://www.citeulike.org/user/Shawnamay/article/151308

[3] Victoria Schirduan, Karen Case, & Judith Faryniarz, *How ADHD Students are Smart*, 66 The Educational Forum 326, 327, 328 (2002), http://findarticles.com/p/articles/mi_qa4013/is_200207/ai_n9138714/

[4] Victoria Schirduan & Karen Case, *Mindful Curriculum Leadership for Students with Attention Deficit Hyperactivity Disorder: Leading in Elementary Schools by Using Multiple Intelligences Theory (SUMIT)*, 106 Teachers College Rec. 92 (2006), http://www3.interscience.wiley.com/journal/118771389/abstract?CRETRY=1&SRETRY=0

[5] Daniel Fasko, Jr., *An Analysis of Multiple Intelligences Theory and Its Use with the Gifted and Talented*, 23 Roeper Rev. 129 (2001), http://www.thefreelibrary.com/An+Analysis+of+Multiple+Intelligences+Theory+and+Its+Use+with+the...-a074571884

[6]Joanna A. Christodoulou, *Applying Multiple Intelligence: How it Matters for Schools Today, 25 Years After its Introduction by Howard Gardner*, 66 School Administrator (2009), http://find.galegroup.com/itx/retrieve.do?contentSet=IAC-Documents&resultListType=RESULT_LIST&qrySerId=Locale%28en%2CUS%2C%29%3AHQE%3D%28__HR__%2CNone%2C42%29sn+0036-6439+and+iu+2+and+sp+22+and+vo+66+%24&sgHitCountType=None&inPS=true&sort=DateDescend&searchType=CCLSearchForm&tabID=T003&prodId=AONE&searchId=R1&currentPosition=1&userGroupName=tall85761&docId=A195675693&docType=IAC

JUNE 2009 EPRESS

Summer Phone Conferences

JUNE 25TH, THURSDAY

All calls are at 12:00PM EST

Dial 850-644-2255 to join us!

Summer is the time for conferences and summits!

Listed below are excellent conventions to consider:

★The Florida Network of Children's Advocacy Centers will host its 6th Annual Multidisciplinary Conference on Child Abuse in Orlando on August 12-14.

The FNCAC conference, a huge event anticipated all year, will once again be at the Caribe Royale Orlando Hotel & Convention Center. The Conference is a three-day event beginning on Wednesday, August 12, 2009 and ending on Friday, August 14, 2009. The goal of the Multidisciplinary Conference is to provide the multidisciplinary professionals who attend the Conference the instruction, information and strategies they need to protect and treat child abuse victims and their families and to hold offenders accountable.

This annual event has become a favorite for many professionals around the country - including medical professionals, attorneys, therapists, counselors, law enforcement personnel and social workers. Over 300 participants are expected at this year's conference. And, with more than 25 speakers and workshops, there will be something for everyone. Faculty includes presenters who are recognized for their passion and expertise.

The combination of high quality training and vast networking opportunities along with the excitement of Orlando brings an experience that is sure to challenge and inspire everyone who attends.

Speakers include: **Lt. Governor Jeff Kottkamp**; **Secretary of DCF, George Sheldon;**

Special Agent Al Danna, FDLE

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Log on to **www.fncac.org** for the entire schedule!

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Dependency Summit News

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Creating a forum for facilitating the exchange of information among individuals, groups and institutions, as well as, across professional disciplines through dialogue and break-out sessions.

Track 1: Child Protective Investigations
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Track 3: Legal Issues and Child and Family Advocacy
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Registration information

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Orlando, Florida 32819
http://www.universalorlando.com/hotels/loews-royal-pacific-resort.html

For more information:
http://www.dcf.state.fl.us/admin/dependency/

What Are Supervised Visitation Programs to You?

A Director Provides Her View

Sharon Rogers, executive director of the Judge Ben Gordon Jr. Family Visitation Centers in Shalimar, Crestview and DeFuniak Springs, wrote an opinion editorial that ran in a local paper in early May, articulating her view on the importance and uniqueness of supervised visitation. According to Rogers, supervised visitation centers provide more than services to children and families; they are places of refuge, where children can develop safe, healthy and loving relationships with their parents. Rogers cited effective security as an essential tool helping families heal and grow, and acknowledged the diversity of circumstance which causes families to require visitation services. Rogers relies on expertly trained staff and dedicated volunteers, not only to assist existing clients but to also help respond to the increasing demand for visitation services. Community financial support is also vital.

CONTACT YOUR LOCAL PAPER!

WRITE AN ARTICLE ABOUT SUPERVISED VISITATION

AND THE SERVICES YOUR PROGRAM PROVIDES!

What are some primary symptoms of obsessive-compulsive disorder? How are obsessive thinking and compulsive behavior connected? The following training addresses the disorder, and provides ways in which staff can develop effective strategies to work with clients with OCD.

Obsessive Compulsive Disorder (OCD) and Supervised Visitation

Introduction

Obsessive–compulsive disorder (OCD) is an anxiety disorder characterized by recurrent or persistent thoughts, impulses, or images that are experienced as intrusive or distressing (obsessions), and repetitive behaviors or mental acts (compulsions) often performed in response to an obsession (Storch, Merlo, Lehmkuhl, Geffken, Jacob, Ricketts, Murphy, & Goodman, 2007). This disorder occurs with 1-3% of adults in the US and has similar percentages in children (Storch et al., 2007; www.kidshealth.org, 2009). This training provides information about the disorder and how it may affect visitation programs.

Objectives

By the end of this training, monitors will be able to:

1. Define obsessive compulsive disorder.
2. Recognize symptoms of OCD, both primary and secondary and common themes of obsessions and compulsions.
3. Explain connection between obsessive thinking and compulsive behaviors.
4. Discuss how particularly problematic this illness can be and identify methods of treatment for OCD for both children and adults.
5. Evaluate supervised visitation program strategies for working with clients that suffer from OCD.

OCD at a glance

- In the United States estimates of 1 to 1.7 million children have OCD and nearly 6 million adults; as many as 1 in every 50 – 100 (Obsessive Compulsive Foundation, 2009; www.kidshealth.org, 2009).
- Obsessive compulsive disorder is the 4th most common psychiatric diagnosis among *all* Americans after phobias, substance abuse and major depression.
- Many people spend *up to nine years seeking treatment* before receiving the correct diagnosis (Obsessive Compulsive Foundation, 2009).
- Approximately 20% of kids with OCD have a family member with the disorder.

Obsessive compulsive disorder can be a debilitating illness for anyone, but it can be particularly challenging for a child. The primary symptoms are obsessions and compulsions. The obsessions or recurring, involuntary thoughts are irrational and cause extreme discomfort or anxiety. Frequent occurrences include worrying about germs/being infected with a disease, fear of being hurt or hurting others, and an overwhelming need for symmetry, perfection, and order. Other common obsessive behaviors such as counting may involve counting any item or event in certain patterns, such as grouping events in threes or believing that something will happen once a certain number has been reached. Examples of the need for symmetry—insisting that all the pencils have to be the same length or that your desk has to be organized a certain way before you can become comfortable.

In response to these fears, someone suffering from OCD would exhibit ritualized compulsive behaviors such as excessive hand washing, frequently checking to confirm that a task has been completed or asking the same question over and over again to alleviate the obsessive thoughts. Untreated it can be conducive to physical injury, behavioral outbursts and psychological trauma.

The average age of onset in studies analyzing children (generally 10 years old) can cause particular difficulties regarding the developmental processes of social skills and interfere with education. Often, if children are secretive about ritual behaviors their parents will

witness secondary symptoms. These secondary symptoms can include, but are not limited to:

- Temper tantrums
- Dermatitis
- Changes in school performance for the worse
- Changes regarding eating habits—food restrictions or refusals
- Avoidance of certain things
- Appearing distracted, inattentive or irritable
- Repeatedly needing reassurance
- Feeling the need to confess minor mistakes
- Inability to tolerate uncertainty

Risk Factors and Complications

- Having a family history of obsessive compulsive disorder increases your risk of developing OCD.
- Stressful life events such as divorce, moving, death of a loved one, birth of a sibling, or starting a new school year can increase the risk of developing these maladaptive coping skills.
- Having OCD can increase your risk of developing substance abuse problems, an eating disorder, depression and anxiety, increased suicidal ideation, inability to attend work or school, difficulty with relationships and a decrease in quality of life.

Symptoms of Obsessive Compulsive Disorder have been documented as far back in history as the 4th century BC, so this type of behavior pattern is not a new problem for people today. Since this time there have been many different explanations for the causes of OCD, but according to various studies it is believed to be caused by *a combination of neurochemistry and environmental triggers* (Obsessive Compulsive Foundation, 2009). As the understanding of what causes this disorder has increased so have the treatment options for working with individuals who suffer from OCD. Current treatment options that appear to be effective with adults include various forms of:

- Cognitive Behavioral Therapy,
- Medication including Selective Serotonin Reuptake Inhibitors (SSRIs),
- Group Therapy, and
- Exposure Response Prevention (ERP)

Each of these approaches works in a different way and some can be more affective treatments for different subtypes of OCD than others. There are several different

subtypes of OCD and these subtypes are categorized by the nature of the obsession and/or compulsion (Grados & Riddle, 2008). **OCD subtypes include:**

- Contamination/Cleaning;
- Aggressive/Sexual;
- Religious Obsession;
- Ordering/Symmetry;
- Hoarding.

Living with OCD

Living with OCD can be the largest challenge one faces, as it tends to build up and pile on to the ever mounting challenges that the daily routine of a "normal" life has. Regardless of the challenges that pile up, many of those who cope best have common themes in their life. (Bertman-Pate & Ferrer, n.d.).

Ways to live with OCD

1. Never give up hope
2. Try to get involved in some form of treatment
3. Consider modifying the obsessive or compulsive behaviors
    a. Get educated
    b. Understand that this is a process and will take time
    c. Choose 1 behavior to change
    d. Accountability – talk with someone who can be there for you
    e. Perseverance – and know that it may get tougher before it gets better
    f. Be a support for others
    g. Establish your routines and control your own life

Recognizing that as with other chronic illnesses, primary attention should be paid to the management of symptoms. A key focal point is the reduction of stress, which often triggers many other symptoms associated with OCD (Kelly, 2009). There are both healthy and unhealthy ways of dealing with stress. Some positive (healthy) ways of dealing with stress are proper sleep, frequent exercise, social support systems, meditation, and a consistent treatment plan (Kelly, 2009). Less healthy ways of coping with stress as it builds are isolation, ignoring the problem, shouldering unhealthy levels of blame, and the abuse of alcohol and drugs (Kelly, 2009).

Strategies for working with those who have OCD

When dealing with clients with Obsessive Compulsive Disorder, it is important to remember *that if they are not receiving treatment for their condition it can be extremely difficult for them to stop or refrain from performing a compulsion*. If a compulsion is suppressed it often becomes exceedingly difficult for the person with OCD to

concentrate on anything else but their obsessive thoughts. Try to keep this in mind while working with clients with OCD. It may be distracting to have clients performing compulsions, *but if they are not inappropriate it is probably best to allow them to do so that they can concentrate on the information* or interactions that are occurring at the time.

The following are some techniques that can be helpful to remember when working with OCD adults (Obsessive Compulsive Foundation, 2009):

- **Remain patient** if a client insists on acting on a compulsion;
- **Refrain from physical contact** as many subtypes of OCD do not like being touched unexpectedly;
- **Remember** that the obsession and compulsions are not in their control;
- Stress can lead to intensification of problem behaviors, so **remain calm** and try not to add to an already stressful situation.

Obsessive compulsive behaviors can make it almost impossible for a child to focus on their school work or to function appropriately in a school environment. Continue to focus attention and *use the strengths of the child to build upon steps toward acceptance and victory over a chronic illness.*

From a family-centered practice perspective, knowledge is power. Let the family know that OCD is treatable, and that it is no one's fault. It is an illness. Introduce the concept of creating a strategy to deal with the problem.

Case Studies

As a teenager, Joann found herself in a panic whenever she hit a bump while she was driving in the car. She would circle the block or double back on a street to see if there was an injured animal or person nearby, knowing that she had hit them. Now in her late 30s, Joann will stop and get out to see if she had accidentally hit something or someone whenever she feels the uneasiness of hitting a bump in the road.

Now using a supervised visitation to spend time with her child, Joann finds herself counting everyday as she gets ready. Her daughter recently asked why she [Joann] counted to herself all the time. Joann had no idea that this behavior was unusual, after all she had been counting to herself for years when performing any cosmetic task (washing her hands, putting on deodorant, brushing her teeth, putting on makeup, etc).

1. Is there a common connection between the 2 incidents? Yes OCD
2. What type of compulsions does Joann struggle with? Counting & fear of hurting someone else
3. What strategies would you suggest to Joann for addressing these behaviors? Open for response: if this becomes apparent at SV, and it's a dependency case,

talk with Joann about how a case worker might help. Joann needs to be offered links to services, but she does not need to be forced to use those services.

4. What if Joann's daughter is seen doing repetitive tasks at SV during the visit, like running back to the bathroom and washing her hands over and over? Suggestions include speaking to the parents about this behavior separately, explaining that intervention might be appropriate. Educate parents about the issues of OCD, explain that this is not the child's fault. The custodian may want additional information about referrals, treatment, and strategies.

Resources & Links

The Obsessive Compulsive Foundation - http://www.ocfoundation.org/

The National Institute of Mental Health - http://www.nimh.nih.gov/health/topics/getting-help-locate-services/index.shtml

OCDResource - http://www.ocdresource.com/

OCD Online - http://www.ocdonline.com/

Quiz

1. Approximately how many Americans suffer from Obsessive-compulsive disorder? Between 7 and 8 million
2. What are 2 ways in which OCD manifests? 2 of the following: worrying about germs/being infected with a disease, fear of being hurt or hurting someone else, need for symmetry perfection and order
3. True/False – When children are secretive about their OCD, it often reveals itself in secondary symptoms. True
4. Is OCD genetic? Explain. No, but environments where it exist can lead to the development of compulsions and obsessions.
5. Three healthy ways of dealing with the stress that often accompanies OCD are: proper sleep, frequent exercise, social support, meditation, consistency in treatment
6. What are 2 techniques to remember when working with someone who has OCD? Remain patient, refrain from physical contact, remember that the obsessions and compulsions are not under their control (yet), remain calm

References

Bertman-Pate, L. J., & Ferrer, L. (n.d.). Guidelines for families living with OCD. Retrieved May 11, 2009, from http://www.ocfoundation.org/UserFiles/File/Guidelines%20for%20Families.pdf

Grados, M. A., & Riddle, M. A. (2008). Two times four is four: OCD dimensions, classes, and categories. *Journal of the American Academy of Child & Adolescent Psychiatry, 47*(7), 731-733.

Kelly, O. (2009). Living with OCD: Coping with a chronic illness. Retrieved May 11, 2009 from http://ocd.about.com/od/livingwithoc1/a/livingwith_OCD.htm

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Storch, E. A., Merlo, L. J., Lehmkuhl, H., Geffken, G. R., Jacob, M., Ricketts, E., et al. (2008). Cognitive-behavioral therapy for obsessive-compulsive disorder: A non-randomized comparison of intensive and weekly approaches. *Journal of Anxiety Disorders, 22*(7), 1146-1158.

The Shift to Family-Centered Practice

As we mentioned in the last phone conference, the focus of the Clearinghouse will be on Family Centered Practice. To remain linked to the continuum of family services, programs must be part of new statewide initiatives and approaches to protecting families. **The Department of Children and Families has adopted the concepts of family-centered practice, and visitation programs will do the same.**

[If you are missing our phone conferences, you are missing a lot!]

When we discuss family-centered practice, it is distinguished from other types of service delivery, including professionally-centered models, family-allied models, and family-focused models. We are providing an overview of this concept for all stakeholders, in many different formats for the next few months, to get everyone thinking about how to incorporate family-centered practice into your programs. Fortunately, most

programs have already done much of this work, although we have not used the formal title of “family-centered.” Still, it is helpful to review the concepts and think about how they can be enacted at your program.

A professionally-centered model of services is distinguished by its reliance on the opinions of experts. This model, most akin to a medical help-giving model, suggests that the ‘expert’ informs the family what is best and appropriate.

In the family-allied model, the professional is still seen as an expert, but the family is the agent of the professional. Families are seen as being “in need of” the professional’s service.

In the family-focused model, families are seen as being capable of making decisions, but professionals provide the advice and assistance. The limitation of the model is that the professionals are capable of limiting the family’s options to what those professionals see as appropriate.

In the new family-centered model that the Department of Children and Families has chosen for its statewide approach to helping families, professionals are partners with and agents for those families. This means that the balance of power is shifted toward the family. It also recognizes that families are capable of making informed decisions that can help improve family functioning.

Strength-based

The family-centered model is ‘strength-based.’ This means that professionals who interact with family members seeks to empower them and will assume that family members will all have strengths that can be directed to helping the family. The families

will be active participants in developing and implementing their own plans for treatment, intervention, and moving forward.

It may be useful to remember that social workers generally describe two types of help-giving in a family-centered practice. First, there is 'relational' help giving, which involves empathy, warmth, and respect for the family on the part of all professionals who interact with them. This translates into a professional who listens to the family's concerns, who tries to understand what the family member is saying by putting himself into the position of the family, and who always seeks to focus on the family's strengths. Second, there is 'participatory' help giving, in which the professional actively seeks to help a family define their goals, helps strengthen a family's existing abilities, and seeks to help a family create new abilities, skills, and strengths. Thus, the family is equipped to be its own agent of change.

Main principles of family-centered practice include:

- Child safety and preservation of family connections;
- There is intrinsic value and worth in every family;
- Building on strengths to resolve issues is essential;
- Every child deserves safety, nurturing, and permanent caretaking; and
- Cultural and ethnic roots are a crucial part of the family's identity.

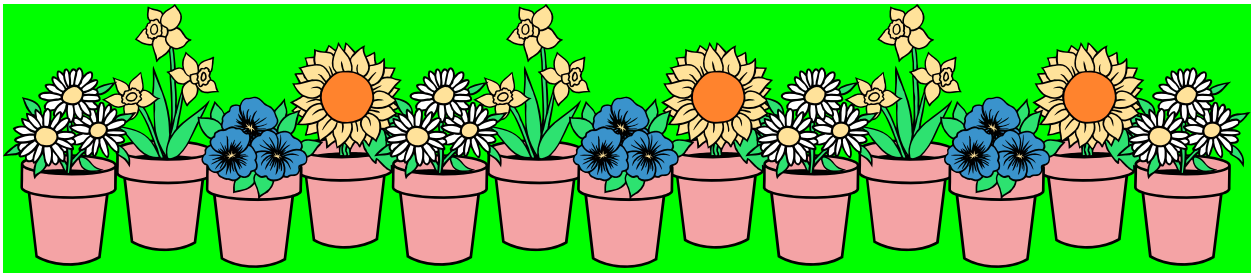
Other principles include:

- Appropriate and adequate resources must be provided in a timely and efficient way;
- Planned, appropriate placement should be based on sound information and the needs of the child;

- The most important investment of public resources is in the care and treatment of children;
- Intervention in the life of families should offer as much service as necessary to achieve desired goals, and no more; and
- Rights to privacy and confidentiality must be respected.

Please remember to Join us JUNE 25th by phone

JULY 2009 EPRESS



MARK YOUR CALENDARS!

SUMMER PHONE CONFERENCES:

THURSDAY, JULY 16
&
WEDNESDAY, AUGUST 5
NOON, EST

DIAL 850-644-2255 TO JOIN!
REMEMBER, PLEASE DO NOT PUT US ON HOLD!

➲SAVE THE DATE➲

WHAT: Training by the Clearinghouse

WHEN: Sept. 30, 2009, from 9:30am-3:30pm

COST: Only $25*. Includes lunch, beverages, and a folder of material

WHERE: The Children's Board
1002 East Palm Ave.
Tampa, FL 33605

*Make checks out to the CAC Board, NOT the Clearinghouse

Mail to:
Trish Waterman at
Supervised Visitation Program
700 East Twiggs Street
Tampa, FL 33602

HOPE TO SEE YOU THERE!

Low-Cost Training Registration Form

Directions

To register for the Sept. 30 training in Tampa, offered by the Clearinghouse on Supervised Visitation, please provide the following information. **Make sure to write checks to the CAC Board** and not the Clearinghouse. Please send both this form and money to:

Trish Waterman
Supervised Visitation Program
700 E. Twiggs Street
Tampa, FL 33602

NAME _____

SV PROGRAM _____

PROGRAM ADDRESS _____

PHONE NUMBER _____

EMAIL _____

PAID _____ yes _____ no

Thank you!

We look forward to seeing you there!

Other News:

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Registration information

The Loews Royal Pacific Hotel

August 26 - 28, 2009

Wednesday, Thursday, Friday

6300 Hollywood Way

Orlando, Florida 32819

http://www.universalorlando.com/hotels/loews-royal-pacific-resort.html

For more information:
http://www.dcf.state.fl.us/admin/dependency/

FUNDRAISING UPDATE

Last month, Children's Safety Services in St. Paul, Minnesota, hosted its 11th Annual Charity Golf Classic, to raise money for supervised visitation and safe exchanges—the two core services provided by the organization. Here, Director Teri McLaughlin provides a follow-up to the event:

Dear Friend,

I awoke yesterday morning to the most wonderful dream. Then I quickly realized that I wasn't dreaming. All the dreamlike wonder and splendor of the 11th Annual Children's Safety Centers Charity Golf Classic wasn't a dream at all. It really happened, like a dream come true. I'm sure you'll agree as you take this little walk back through this amazing day – June 24th, 2009.

Weather – Started out a little shaky with chance of storms and then a little rain. With the help of some singing to the Sun Gods by volunteers and many people's prayers, the rain ended just about the time we set out for the shot gun. I heard several players talking about the how the greens were holding a little better because of the brief refreshing rain. A little while later the sun, in all its glory, shone brightly. Truly a blessing.

Volunteers – Under the incredible coordination of Wells Fargo's amazing Meghan Abston, Jennifer Nygren and CSC's own Nate Sessions, we had over 70 volunteer ambassadors greeting and assisting golfers throughout the day. This army of volunteers came from Sam's Club, General Mills, Kohl's, Target, Wells Fargo, Stillwater HS students, Bemidji State University, Wal-Mart, along with the tried and true CSC Charity Golf Classic committee and returning volunteers. And many of these volunteer programs not only give volunteers but cash as well. Our Sam's and Kohl's volunteers that day brought with them almost $2,500. How did we ever get so lucky?

Sponsors – Including our extraordinary Presenting Sponsors, Sam's Club and General Mills we count among our friends, 20 sponsors of cash and in-kind services. This does not include the 80 plus auction donors.

144 Golfers, a SOLD_OUT event – All the event planners and tournament venues will tell you, participation in charity events in 2009 is down significantly. They

obviously don't know our supporters, 35 of which came from Sam's Clubs around the state. While the challenge of the course and the crowded field may have slowed the play down a bit, the course condition and incredible staff of StoneRidge made every moment that much better.

Golf and Sponsorship Fees - $46,400, not including in-kind golf donations of goody bag items from Sam's, General Mills, 3M, Thrivent, Dorsey Whitney, Outback Steakhouse and up until yesterday, how did we ever get along without the teeth shaped golf tees from Signature Orthodontics…hmmmm…do you suppose they'll help align our drives?

Games / Items purchased at Registration – Thanks to Jim Olson's much loved Safety Sticks, Bill Porter's Cigars, Fun Packs, Mulligans, Skins, Putting Contest, and Sponsor Games on the course, we blew previous records to pieces with receipts of $5220. Let's not forget the Party Cart provided by Stahl Construction and KQRS raising $340. With the smiles that followed them into the clubhouse, I can assure you that our winners Shawna and Lynnda hope this returns next year.

Golf Scores – Our First Place group from Comuniquest came in at 23 Under with a score of 49. Congratulations also goes out to the Second Place group from National Checking. As a testament to the skill and ability of those players OR their willingness to buy more Mulligans and Safety Sticks than an yone else, they really are WINNERS in our books!

Dinner by Outback Steakhouse of Maplewood - This year, Steve Parr and his team of Outback volunteers served nearly 175 delicious steak dinners prepared on location, in their mobile kitchen. Did you know that Outback has been serving our tournament since its inception? 'Gotta love those Blooming Onions.

Auction - This year's auction was a smashing success. We had well over 100 items in our live and silent auctions, netting proceeds of over $15,000 includi ng $1400 that came from our Wall of Wine (WOW) and $3500 in our Fund a Need – a 50% increase from 2008. Let's not forget the Can Raffle ticket sales of $902. This is a sure winner!

Net Event Proceeds – With some payables and receivables still outstanding, our projected total revenues are: $75,749 and our estimated direct expenses are $16,000 with estimated net proceeds of $59,749. Who says people aren't giving in these tough economic times?

So what does all this mean to the children and families we serve at CSC? Sixty some will reconnect with their parent and have many SAFE and loving visits together. This would not have happened with you. You helped preserve this critical parent / child relationship. And we know this relationship is such a strong predictor of the future health and success of these kids. God Bless you!

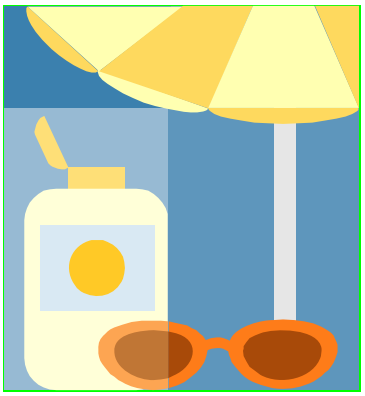
With humble gratitude,

Teri Walker McLaughlin

Executive Director

P.S. If you were not able to make it to the event, we understand and appreciate your support. There is still time to make a tax deductible donation to support the children and families that we serve. Thank you for all that you do.

AUGUST 2009 EPRESS



IT'S HOT, WITH A LOT GOING ON!

SUMMER PHONE CONFERENCES:

WEDNESDAY, AUGUST 5
NOON, EST
THURSDAY, SEPTEMBER 24
NOON, EST

DIAL 850-644-2255 TO JOIN!
REMEMBER, PLEASE DO NOT PUT US ON HOLD!

THREE Trainings This Month! The first…

★The Florida Network of Children's Advocacy Centers will host its 6th Annual Multidisciplinary Conference on Child Abuse in Orlando on August 12-14.

The FNCAC conference, a huge event anticipated all year, will once again be at the Caribe Royale Orlando Hotel & Convention Center. The Conference is a three-day event

beginning on Wednesday, August 12, 2009 and ending on Friday, August 14, 2009. The goal of the Multidisciplinary Conference is to provide the multidisciplinary professionals who attend the Conference the instruction, information and strategies they need to protect and treat child abuse victims and their families and to hold offenders accountable.

This annual event has become a favorite for many professionals around the country - including medical professionals, attorneys, therapists, counselors, law enforcement personnel and social workers. Over 300 participants are expected at this year's conference. And, with more than 25 speakers and workshops, there will be something for everyone. Faculty includes presenters who are recognized for their passion and expertise.

The combination of high quality training and vast networking opportunities along with the excitement of Orlando brings an experience that is sure to challenge and inspire everyone who attends.

Speakers include: **Lt. Governor Jeff Kottkamp**; **Secretary of DCF, George Sheldon;**

Special Agent Al Danna, FDLE.

On August 13th, a Supervised Visitation track of trainings will be provided. There will be sessions on documentation and ethical issues at SV, and sessions on child sexual abuse to meet the requirements of Florida Statutes 39.0139. In addition, there will be a meeting of the Florida Chapter of the Supervised Visitation Network, and Karen Oehme will be available all three days for scheduled individual program meetings. (Call Karen directly for an appointment!)

Log on to **www.fncac.org** for the entire schedule!

Registration Fees

Before July 13, 2009: $300 for individuals and $275 each for groups of 4 or more. Between July 13, 2009 and August 5, 2009: $325 for individuals and $300 each for groups of 4 or more. Registrations after August 5, 2009 must be made on-site at the conference.

Groups of 4 or more wishing to receive the discount must register by mail/fax using the registration form.

Registration payments are transferable, but will not be refunded.

Registration Deadlines

Registrations after July 31st must be faxed or submitted online.

Registrations after August 5th will only be accepted on-site at the conference.

They will also have on-site registration and early check-in at the Caribbean Registration Desk on August 11, 2009 from 1:00 - 4:00pm in the Convention Center.

Hotel Information

The Caribe Royale Orlando is an all-suite hotel. **Call 1-800-823-8300 to speak with a Reservations Specialist.**

★Registration will be CLOSED after Aug 5, 2009★

The second…

Dependency Summit News

The Department of Children and Families Office of Family Safety is pleased to announce the 2009 Dependency Summit, to be held August 26-28, 2009 in Orlando, Florida. The Dependency Summit is the largest child welfare event in Florida with over 1,700 child welfare professionals and related stakeholders expected to attend. The Dependency Summit is a working conference, balancing a variety of training workshops with professional and geographical breakout sessions intended to facilitate dialogue and discussion. The Dependency Summit reflects the Department's resolve to better serve Florida's children and families through ongoing support and professional development of Florida's child welfare and related stakeholder workforce. The goal of the Dependency Summit is to improve child welfare practice in Florida by both:

Disseminating state of the art information on child welfare research, evidenced based or promising programs and practices and training on policy, procedure or practice matters;

Creating a forum for facilitating the exchange of information among individuals, groups and institutions, as well as, across professional disciplines through dialogue and break-out sessions.

Track 1: Child Protective Investigations
Track 2: Legal Issues and Child and Family Advocacy
Track 3: Legal Issues and Child and Family Advocacy
Track 4: Multisystem Services Coordination

The audience of the Dependency Summit is diverse, and includes Advocates, Attorneys, Child Investigation Professionals, Child Protection Professionals and Stakeholders from the local judicial circuits, Community Based Care Providers, Guardians Ad Litem, Judges, Juvenile

Justice Professionals, Law Enforcement Professionals, Mental Health and Medical Child Welfare Providers, Supervised Visitation Programs, as well as any other affiliated parties.

Registration information
The Loews Royal Pacific Hotel
August 26 - 28, 2009
Wednesday, Thursday, Friday
6300 Hollywood Way
Orlando, Florida 32819
http://www.universalorlando.com/hotels/loews-royal-pacific-resort.html

For more information:
http://www.dcf.state.fl.us/admin/dependency/

The third…

➲SAVE THE DATE➲

REGISTRATION IS OPEN UNTIL WE REACH 50 PEOPLE

WHAT: SUPERVISED VISITATION TRAINING by the Clearinghouse. This is a full day of training on Florida's Best Practices for SV! We are keeping the costs as low as possible, and a working lunch of sandwiches is included in the registration fee. We will also be taking questions, solving problems, and unveiling the new Family Centered Practice Training required by DCF! Bring your staff! Bring volunteers! Bring interns! We have plenty of space for those who register early! Certificates of Training will be awarded. (Questions? Call Karen at 850-644-6303 or Trish, our host, at 813-272-7180.

WHEN: Sept. 30, 2009, from 9:30am-3:30pm

COST: Only $25*. Includes lunch, beverages, and a folder of material

WHERE: The Children's Board
1002 East Palm Ave.
Tampa, FL 33605

*Make checks out to the CAC Foundation, NOT the Clearinghouse. Mail to:

Trish Waterman at
Supervised Visitation Program
700 East Twiggs Street
Tampa, FL 33602

DO YOU KNOW WHO'S WATCHING YOU? IT MIGHT NOT BE SO EASY TO DETECT…

Updates for domestic violence cases: What you need to know about 21st Century Stalking

The harassing, unsolicited act of stalking has been around for centuries, however physical stalking has only been legally designated a crime since the 1990s. Since then, stalking has become more than a physical operation. Electronic stalking is fast become a serious, prevalent issue, where electronic mediums such as the Internet and other computer and communications technology are used to pursue, harass or contact another in an invasive fashion. Advances in science and technology have led to the development of new devices and techniques for the purpose of eavesdropping upon private communications. This "21st century" invasion of privacy resulting from the continual and increasing use of electronic mediums significantly threatens individuals' safety and privacy, and poses a unique hazard to free and civilized society.

To date, no study has specifically addressed the use of technology in intimate partner stalking. In 2006, the U.S. Justice Department's Bureau of Justice Statistics began measuring the prevalence of "cyberstalking" among stalking or harassment victims. A report published in that year found that 23 percent of stalking or harassment victims indicated that the stalker had used

some form of cyberstalking, such as cell-phone texting or email, to harass them. Additionally, the Stalking Resource Center (2003) and the Safety Net Project (Safety Net, 2004), have reported news stories and anecdotal experiences related to victims, indicating that technology is regularly and pervasively used in stalking.

The faceless avenue of technology emboldens stalkers and provides them with a sense of anonymity. The following is a list of some common, easy ways stalkers can electronically monitor victims:

- Caller ID—new caller ID devises offer not only the name and number of the caller, but also the exact address of the telephone.
- GPS and Location services—GPS devices are small devices that use satellite navigational technology to give precise worldwide positioning and pinpoint locations. They are affordable and widely available for consumer use. They come in a variety of sizes and appearances, including a small black box, a portable unit or even a small chip in a wristband. Stalkers have used these devises to track their victim's location.
- Computer monitoring software, aka spyware, was originally developed to monitor children's Internet use. However, stalkers use such personal surveillance programs to monitor the activities of their victims. Although the software programs vary, most record all computer activities. In addition to software programs, hardware devices called "keystroke loggers" that plug into the keyboard and back of the computer are readily available. These devices contain small hard drives that record every key typed, including all passwords, PIN numbers, Web sites and email.

- Hidden cameras have become more powerful, affordable, smaller and easier to disguise. Minicameras can be installed anywhere and activated remotely. Inexpensive wireless cameras are relatively easy to install and monitor by voyeurs nearby who intercept the wireless signal.

ANOTHER ABDUCTION DURING A SUPERVISED VISIT

This report comes from California. It is a reminder of the risks associated with all visits. -- Karen

Jul 21, 2009 3:52 am US/Pacific
Mom Allegedly Abducts Son During Supervised Visit
COMPTON, Calif. (CBS) —

Authorities are searching for a 10-month-old boy allegedly abducted by his mother during a supervised court ordered visitation Sunday afternoon in Compton.

Detectives from the Sheriff's Station in Compton said LaVerne Monique Monticue, 18, was spending time with her son, Jacob Smith Monticue at 823 West 136th Street.

During the course of the visitation, Monticue took clothing and food and fled from the location with her son said Deputy Jeff Gordon of the Sheriff's Headquarters Bureau in a news release.

Monticue's mother, Freddie McGill, was granted full custody of child after the court found the suspect guilty of child neglect according to Sheriff's Department.

The suspect was described as 5 feet 3 inches tall , weighing 150 pounds with a medium dark complexion. She was wearing brown pants and blouse and brown sandals.

Monticue was last seen boarding a Metro Blue line train at Willowbook Avenue and Imperial Highway.

Anyone with information on the whereabouts of the woman or her son call the sheriff's Compton Station at (310) 605-6500, or sheriff's Detective Arturo Flores at (310) 605-6582.

Remember to join the phone conferences, and call the Clearinghouse when you need assistance!

SEPTEMBER 2009 EPRESS

UPCOMING PHONE CONFERENCE:
THURSDAY, SEPTEMBER 24
NOON, EDT

DIAL 850-644-2255 TO JOIN IN.
REMEMBER, PLEASE DO NOT PUT US ON HOLD

LAST CHANCE FOR TAMPA TRAINING

REGISTRATION IS OPEN UNTIL WE REACH 50 PEOPLE

WHAT: SUPERVISED VISITATION TRAINING by the Clearinghouse. This is a full day of training on Florida's Best Practices and family-centered practice for SV! We are keeping the costs as low as possible, and a working lunch of sandwiches is included in the registration fee. We will also be taking questions, solving problems, and unveiling the new Family Centered Practice Training required by DCF! Bring your staff! Bring volunteers! Bring interns! We have plenty of space for those who register early! Certificates of Training will be awarded. (Questions? Call Karen at 850-644-6303 or Trish, our host, at 813-272-7180.

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1002 East Palm Ave.
Tampa, FL 33605

Mail to:

Supervised Visitation Program
700 East Twiggs Street
Tampa, FL 33602
Attn: Trish Waterman

Access and Visitation Update:

SPOTLIGHT ON "INCREASED PARENTING TIME"

As you know, next month we will be rolling up the statewide Access and Visitation Report. We have sent out numerous reminders that your individual programs should be printing out reports to ensure that:

A. All of your A and V cases are accurately reported, and

B. There is no missing data on any of those cases.

We set up a function in which all the missing data categories will be highlighted in RED. So when you print your test report this month, print it in COLOR, and you will see all missing data highlighted in RED!

Some of you have called to say that in your quarterly reports, the column which records whether there has been "increased parenting time" in the case has a N (reflecting the word NO), instead of a Y (meaning YES). This raises several essential points:

1. Every single A and V case reported on your sheet MUST indicate a Y – meaning that "YES, parenting time was increased in this case."
2. If the case says N ("NO, parenting time was not increased"), you must immediately look to the case to determine WHY!
3. Remember, only those cases in which a *non-custodial parent* (this can be adoptive, natural, etc.) receives access to his or her child is counted as an A and V case. This means that cases in which *only* a grandmother, or a sibling, or other relative receives access (but a non-custodial parent does not) CAN NOT BE an A and V case.
4. However, in many cases, there are services that are provided to a non-custodial parent in one month, and THEN to another relative in another month in the same case. These CAN BE "A and V" cases. Here's an example: In the Jones case, Mr. Jones is the non-custodial parent. In January the case is opened, and Mr. Jones has three visits with his son. In February, Mr. Jones' mother comes for a visit, without Mr. Jones. In the annual A and V report, the Jones case should have a Y in the "increased parenting time" column. (Remember, though, if you just ran a February report for the Jones case, the case would have an "N" – because the non-custodial

parent did not have a visit in that month. Still, for the YEAR, the case is solidly an A and V case, and the column should be marked "Y").

5. If you opened a case, but did not provide a service to that family, an N will show up on your report. This is because the Access and Visitation report only counts cases in which you actually provided a service. So if the family cancelled, no-showed, or withdrew from the program, *without having any service*, you cannot count this as an A and V case. If there was even ONE COMPLETED visit or exchange, though, the case will indicate a Y on the report. Our numbers last year indicated that each A and V family received an average of 13 visits. So if there is at least one service, a Y will show up on the report.

If you have questions, please call immediately. Remember, if there is missing data, the case can be deleted by the CBC or DCF, and funding for the case can be denied!!

Remember to join the phone conferences, and call the Clearinghouse when you need assistance!

Get Ready, Get Set, for SWINE FLU at SUPERVISED VISITATION

We have already had three confirmed cases of H1N1 Swine Flu at supervised visitation programs in Florida: two on the East Coast, and one on the West Coast. According to health authorities, Florida expects to see a large percentage of the population affected by H1N1 in the upcoming months. That means it is time to prepare your program NOW!

1.) What is H1N1 Swine Flu?

According to the Mayo Clinic, H1N1 (or swine flu) is a respiratory infection caused by influenza A viruses. The current strain is a genetic combination of swine, avian, and human influenza viruses. It is passed from human to human in the same manner as the regular flu virus–through direct contact with respiratory droplets–though it may be more severe.

2.) What are health professionals saying about it?

Most health organizations are in agreement that H1N1 is most serious in young children, pregnant women, and the ailing. Many middle-aged people were exposed to a weaker strain of this flu several decades ago and, as a result, have some immunity to the latest strain, though everyone should take precaution against the flu. The most recent outbreak has been labeled a *pandemic* by the World Health Organization, meaning that it is *widely spread and highly infectious*. Therefore, there are a number of safety precautions that everyone can follow to reduce the risk of catching H1N1:

- Avoid close contact with those showing H1N1-like symptoms.
- Wash hands with soap or use hand sanitizer on a regular basis.
- Minimize hand-to-mouth and hand-to-nose contact.
- Use a tissue to block sneezes and coughs, discarding the tissue immediately after usage.
- Avoid crowded areas if possible.
- Open doors and windows to improve airflow in enclosed settings.
- Maintain a healthy lifestyle by ensuring adequate sleep and exercise and eating a healthy diet.

- Stay home if you feel unwell.
- Wear a face mask when in direct contact with anyone suspected of infection.

3.) What are the symptoms?

A high fever and coughing are present in virtually all H1N1 cases. Other common symptoms include:

- shortness of breath
- fatigue
- weakness
- chills
- aches and pains
- sore throat
- headache
- vomiting
- wheezing
- diarrhea

At the sign of any combination of these symptoms, workers should stay home. If their severity escalates, a medical professional must be contacted.

3.) What do scientists predict for the future of the virus?

It is difficult to predict exactly how H1N1 will spread in the future. However, a newly developed vaccine, which will be made available to the public within the next few months, should greatly reduce the number of new cases. On the other hand, the reopening of schools around the country will likely increase the number of cases among

children and teens. Most health organizations recommend that whether the pandemic surges or declines, the same precautionary measures should be taken by everyone to minimize risk of exposure.

4.) What do supervised visitation programs need to know about protecting themselves and their programs?

All workplaces must be vigilant against the spread of H1N1; however, it is recommended that workers do not panic over the pandemic or enforce excessive precautionary measures. **The most effective method of avoiding an outbreak is education, and all workers should be informed about the nature of H1N1 and how it is spread.** As always, employees should wash their hands on a regular basis and encourage parents and children to do the same. Toys provided to children in visitation should be routinely disinfected, and hand sanitizer should be available to all parents and children before and after visitation. Likewise, employees should be encouraged to disinfect their computer, desks, phones, and any personal items at least once a day, and hand sanitizer should be made available for frequent usage. Any employees who are experiencing the common symptoms of H1N1 (detailed above) should stay home and contact a medical professional immediately. When possible, windows should be opened to improve interior air flow. It is not necessary that face masks be worn on a regular basis unless a known outbreak has affected the program.

5.) What should supervised visitation programs do today to prevent future outbreaks of H1N1 in the workplace?

- All employees should be provided with the list of tips for avoiding contamination, detailed in point 2; they should also be educated about the nature of H1N1 and how it spreads.
- Hand sanitizer should be provided for all workers, and habitual hand-washing with antibacterial soaps should be encouraged.
- Employees should also be reminded that if they or anyone in their family suspects they may be infected, they should stay home and contact a doctor.
- Supervisors are recommended to plan for absenteeism in case of an outbreak.
- Any workers showing flu-like symptoms should be sent home.
- Encourage employees to get a seasonal flu vaccine, which may reduce the personal risk of infection for any flu virus.

6.) What should supervised visitation programs do upon the first confirmation of an H1N1 infection in an employee?

If an employee has been diagnosed with H1N1, it is recommended that the workplace be disinfected immediately with antibacterial products. Office closure is not necessary. Face masks should also be provided on a request basis, though they may not be necessary. Management should plan for future absenteeism and develop flexible leave policies for the future. Any planning by management for an H1N1 outbreak should be shared with employees.

7.) What should program directors do NOW, before an outbreak?

Be sure that your referral sources give you discretion about cancelling visits/exchanges, and allow you to determine your own staffing needs. There is absolutely no way to

predict all of the possible scenarios that you might have to deal with this flu season, so remember that any of the following are possible, and should be considered:

- A child could become sick during a visit. This necessitates making decisions about calling the custodian to come pick up the child, and keeping the sick child away from other children.
- A child or parent could arrive at the program sick. How will you determine whether to let the visit or exchange occur? Think about that before it happens.
- If a child, parent, or staff member becomes ill, will you advise other staff, or family members in other cases, about that illness? Remember, not all sickness will be confirmed H1N1. Actually, most cases will not be confirmed by blood tests, so you might never know for sure.
- If a large portion of your staff is ill, how will you decide to cancel visits?
- What will you do if your security staff is ill? Will you still hold visits in high-risk cases?
- Parents may feign illness to manipulate the other parent's visitation with the child. You have no obligation to verify illness – err on the side of caution and cancel the visit even if you suspect that the parent may be fabricating the illness. Note: If the parties have frequently used illness or other problems as an excuse to circumvent the visitation order, the referral source should be notified.

7.) Where can I learn more?

Many businesses are using tips from public schools in planning for possible H1N1 contamination. The Leon County School Board has a slideshow available online

which reviews many of the suggestions detailed above. Also, the World Health Organization, the Center for Disease Control, the Mayo Clinic, and the Occupational Safety and Health Administration provide detailed information on H1N1 and provides many suggestions to reduce the hazard of contamination in the workplace.

Leon County School Board Slideshow:

http://www.leon.k12.fl.us/H1N1%20LCHD%20School%20Presentation%2008-10-09.pdf

CDC Information:

http://www.cdc.gov/h1n1flu/guidance/workplace.htm

http://www.cdc.gov/h1n1flu/

World Health Organization Information:

http://www.who.int/csr/disease/swineflu/guidance/communities/en/index.html

http://www.who.int/csr/disease/swineflu/en/

OSHA Information:

http://www.osha.gov/dsg/topics/pandemicflu/index.html

http://www.osha.gov/Publications/exposure-risk-classification-factsheet.html

http://www.osha.gov/Publications/protect-yourself-pandemic.html

The Mayo Clinic:

http://www.mayoclinic.com/health/swine-flu/ds01144

http://www.mayoclinic.com/health/swine-flu-pandemic/AN02013

Conference Announcement

The Florida Coalition for Children has scheduled its annual conference on October 12 -14, 2009 at the Rosen Shingle Creek in Orlando. The brochure is attached in pdf. The theme of the conference is "Protecting and Preserving Florida's Most Valuable Resources: Our Children and Families." 19 track sessions, with multiple CEUs are available at this training for professionals. For more information, log on to www.flchildren.org

Huffing at Visitation

Those of you who attended the Orlando FNCAC conference heard at the Statewide Meeting that a director recently caught a parent "huffing" Lysol in the bathroom during a visit. I recall a few years back we talked about not keeping Comet and Drano in the bathrooms, as these can be stolen and used to make methamphetamine (with other ingredients). But this parent simply wanted to get "high" the only way he could at the SV program. The Director said staff became suspicious when the father took an excessive amount of time in the bathroom. Of course, the visit was immediately halted and the referral source was notified.

For those of you new to the topic, inhalant abuse (commonly called "huffing") is the intentional inhalation of chemical vapors to attain a mental "high" or euphoric effect. A wide variety of substances, including many common household products, are abused by inhalers. For more info, read the link below.

Melissa Conrad Stoppler, MD, *Is Your Child or Teen "Huffing?"* MedicineNet.com (2005), http://www.medicinenet.com/script/main/art.asp?articlekey=47975

Question of the Month

I have a case that seems to be slipping through the cracks. The case had been a dependency case a year ago, but now it's just a paternity/custody case. We got it two months ago. The child is almost three, and I'm not sure she has ever been vaccinated. The parents and grandparents are not educated people, and the child stays with the grandmother most of the time while the mother works at an unskilled job. About a month ago, one of my volunteers told me that the grandmother bragged that the little girl is so healthy, she hasn't been to the doctor's since she left the hospital nearly three years ago. My staff do not think this child looks very healthy, and we started to wonder if we were exposing other children to someone who was never vaccinated. Or maybe this little girl is ill. She seems so pale and sickly. And she's small for her age. We're worried: should we be doing something about this case besides overseeing the visits between the father and the child?

Yes. The family is likely eligible for Medicaid, and can receive free immunizations and medical care. This is an opportunity for you to link the family to those services in your community. Do you know where your free/low cost medical clinic is in the community? If not, it's time to make that call and get all the information you can for the client, without identifying the client. Follow up, help the client identify transportation, if that's an issue. There are parents who oppose vaccinations on moral, religious, and other grounds, but it doesn't sound like those are issues with this family. Thus, take the initiative to help link the family to services, and be sure to document your concerns in your court reports. It may be that the grandmother does not have the correct medical history for this child, *but DCF and the court should be informed if there is question about whether the child is receiving medical care*. Below is a chart that describes the current recommendations for childhood immunizations. As you can see, this child should have had a full series of shots over the last two years.

If any child appears to be abused, neglected, or is failing to thrive, or needs medical attention, **you must call DCF**. **Call the hotline at 1-800-96-ABUSE.** They can decide whether an investigation is warranted. The investigator can also help link the caregivers to needed community resources. **I advise you to call the hotline today on this case!**

Vaccination Schedule from Birth-12 Years

Ages Birth – 24 Months

	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	24 mos
Hep B	birth/X		X		X			
Rotateq	X	X	X					
DtaP	X	X	X				X	

Hib	X	X	X			X		
Prevnar	X	X	X			X		
IPV	X	X	X					
MMR					X			
Varivax					X			
Hep A							X	X

Ages 4-11 Years

	4 yrs	12 Yrs
MMR	X	
Dtap	X	
IPV	X	
Varivax	X	
TdaP		X
Gardasil (HPV)		X
Meningococcal		X

(http://www.childrensmedicalclinics.net/for-parents/immunization-schedule.php)

(additional information available at aafp.org and cdc.gov)

Reminder to A and V Funded Programs

This is it! September marks the last month of the federal fiscal year. Go to the database at https://svpdb.org and print out your reports in COLOR to identify and fill in your missing data. Do not leave blank fields. If you need help, call the Clearinghouse immediately!

OCTOBER 2009 EPRESS

Upcoming Phone Conferences

FIRST FALL (OCTOBER) PHONE CONFERENCE:
WEDNESDAY, OCTOBER 28
NOON, EST

DIAL 850-644-2255 TO JOIN IN
REMEMBER, PLEASE DO NOT PUT US ON HOLD

NOVEMBER PHONE CONFERENCE:
****WEDNESDAY, NOVEMBER 18 NOON, EST**

DIAL 850-644-2255 TO JOIN IN
REMEMBER, PLEASE DO NOT PUT US ON HOLD

The Fall Family Visitation Times is attached to this email. Be sure to read it, as it contains important and helpful information!

Access & Visitation Reports

THIS IS IT! IT'S TIME FOR YOU TO FINALIZE YOUR A AND V REPORTS! You do not have to send them to us – but you do have to send them to your CBC representatives.

We will be running the annual statewide report on Monday, Oct. 5, so you have FIVE DAYS to fill in any missing data before we run the report.

If you have questions, please call immediately. Remember, if there is missing data, the case can be deleted by the CBC or DCF, and funding for the case can be denied!!

October is Domestic Violence Awareness Month

October is National Domestic Violence Awareness month and many of the Domestic Violence Centers & Shelters around the state are working to bring attention to many of these issues. Check out the Florida Coalition Against Domestic Violence website for a current listing of events in your area (http://www.fcadv.org/projects-dvam.php).

A short listing of events is listed below.

FavorHouse of NW Florida
October 21 - "Night of Stars", Silent Auction, Seville Quarter in Memory of Angela Faye Buchanan

October 29 - October Award Luncheon Honoring Law Enforcement, Heritage Hall Seville Quarter, FavorHouse and Escambia County Domestic Violence Coalition

Contact Sue Hand, Executive Director, FavorHouse - 850-434-1177

Harbor House

The 33rd Annual Domestic Violence Awareness Luncheon
Friday, October 9th, 2009
Sheraton Orlando Hotel Downtown
60 Lake Ivanhoe Blvd Orlando, FL 32801
Registration: 11:30 am
Luncheon: 12:00 pm to 1:00 pm
Training: 1:00pm to 2:00 pm
Luncheon & Training $50 per person
Training only $10 per person
CEUs $25 per person
Contact Min Sun Kim mskim@harborhousefl.com or 407 886-2244 x225

Walk a Mile in Her Shoes Awareness Event
UCF Campus, Student Union
October 21
11AM - 2PM
Contact - Kelly Bullard Domestic Violence Prevention Coordinator of Harbor House
407-886-2244 x231
kbullard@harborhousefl.com

Dick Batchelor Run for the Children
Downtown Orlando: Central Boulevard and Rosalind Avenue (just south of the bandshell at Lake Eola).
October 24
6:30 am - 7:00 am: Registration
8:00 am: 5k (3.1 miles)
9:15 am: Kids' Fun Run
Contact: Beth Ann Carr Director of Development of Harbor House 407-886-2244 x246
bcarr@harborhousefl.com
Event is presented by Universal Studios Foundation in support of the Howard Phillips Center for Children and Families. The Women's Resource Center hosts a "clothesline project" and DV awareness display at this annual event. Runners must register for this event

Haven of Lake &Sumter Counties

Annual "Balloons are Popping" Domestic Violence Awareness Luncheon
October 16th at the Savannah Center in The Villages
Contact: Rebecca L. Kessinger, Contract Manager 352-787-5889

Help Now of Osceola

Domestic Violence: From Support to Prevention - a 2 day conference on October 6th and 7th
Contact Tammy Douglass, Executive Director - Help Now of Osceola 407-847-3260

Lee Conlee House

LCH will host its survivor art show - "Visions: Looking Back, Moving Forward" at the Larimer Art Center in Palatka on October 12-23. A reception featuring entertainment and light refreshments is scheduled for 6:30p on Oct. 12.

The LCH golf tournament is Oct 24.
Contact Beth O'Grady, Executive Director - Lee Conlee House 386-325-4477

Peaceful Paths

October 22, 2009, 6:30 pm at the Northwest Park for the candlelight vigil where you can view this year's Clothesline Project, hear speakers and celebrate those who are making a difference in this work. Refreshments will be served and a playground for the little ones is available.
Contact Theresa Harrison, Executive Director - Peaceful Paths 352-377-5690

Refuge House

Domestic Violence Awareness Speak Out - Wednesday October 7, 2009 6:00 - 8:00 pm at Lake Ella. Speakers, musicians, poets and supporters come together for an evening of recognition and unity. The famous *Refuge House Hot Dog Buffet* will be served and there will be activities for children. FREE to all.
Contact Patricia Smith, 850-922-6062
Download the flyer

Safehouse of Seminole

SafeHouse of Seminole is participating in the Purple Light Nights™ domestic violence awareness campaign from October 1st through October 31st, following the national model.
Contact Jeanne Gold, Executive Director - SafeHouse of Seminole 407-302-5220 ext. 225

Safespace Foundation

Domestic Violence Walk and Expo "Standing Together Against Domestic Violence" Saturday October 10 from 8:00 am - 12:00 noon at the North Miami Beach Sen. Gwen Margolis Amphitheatre, 16501 NE 16th Avenue
Contact Roslyn Parker 305-948-2940

The Shelter for Abused Women and Children

Purple Light Nights™
Evenings throughout the month of October
Light up the night with purple bulbs this October to help raise awareness about domestic violence! It's simple - replace one of your outside lights with a purple bulb (or hang a string of purple lights in your window) and turn them on each night throughout October to let your neighbors know that you are part of the solution to ending family violence in your community. "Purple Light Nights™" is a national program designed by the Covington Domestic Violence Task Force, Washington.

Healing Arts
9:30 a.m. to 4:30 p.m.
Mondays - Saturdays throughout October (Begins October 2, 2009)
Options Thrift Shoppe

Visit the Healing Arts exhibit at Options Thrift Shoppe (968 Second Ave. N, Naples) and purchase art, jewelry, and collectibles donated to support our life-transforming programs and services.

Clothesline Project
9:30 a.m. to 4:30 p.m.
Mondays - Saturdays throughout October
Options Thrift Shoppe
Visit Options Thrift Shoppe to share in the stories of family violence victims and concerned community members who share their stories colorfully on t-shirts they have hand-crafted.

Teacher Appreciation
3 p.m.
Thursday, October 15
Collier County School Board Meeting
This event recognizes the vital role teachers play in stopping the violence before it begins again in a new generation, as well as addressing the immediate and long-term needs of children raised in violent homes.

Strut Your Mutt
Time - TBA
Saturday, October 24
Germain BMW, North Naples
Join The Shelter for this Halloween pet event hosted by The Humane Society Naples and featuring pet costume contests complete with prizes, local pet-related vendors and more. For more information, please contact The Humane Society Naples at 239.643.1880.

The Spring of Tampa Bay

October 6 Memorial Vigil Tampa - Franciscan Center
October 15 Memorial Vigil Plant City - McCall Park
Staff coordinator: Joanne Lighter
Theme: Healing and hope, memorial vigil to remember those who have died

October 11 - Love Shouldn't Hurt Motorcycle Ride
Chair: Plant City PD Chief Bill McDaniels
Staff coordinator: Kat Alley
Hillsborough route, ending at Hungry Harry's (Land O' Lakes)

October 22 Men in the Movement Rally
Chair: Charlie Hounchell
Staff coordinator: Lynanne Lawhead
Men in the Movement, partner with Crisis Center A Call To Men Program: elected officials, community leaders, athletes, youth

Child Sexual Abuse Curriculum Updates

One of the many services that the Clearinghouse on Supervised Visitation provides is that of online trainings for social services personnel. Of particular interest in recent months has been that of the Child Sexual Abuse Curriculum. Some interesting figures about this curriculum to note are as follows.

February 2009 – August 2009

- 90 total participants completed the training and the following identified themselves as
    - 41 as Child Welfare Worker/Child Protective Investigator
    - 8 as Guardian Ad Litem or GAL staff
    - 11 as Other (Trainee, Volunteers, Case Managers, Family Support Workers)
- geographic information from where people work
    - 34 Central Florida (Gainesville south to Sarasota)
    - 4 NE Florida (Tallahassee East, Gainesville North)
    - 2 NW Florida (Tallahassee West & Panhandle)
    - 6 South Florida (Sarasota South)
    - 1 out of state
- supervised visitation personnel
    - 37 total participants identified, 17 organizations represented
        - CASA
        - Child Protective Services (various locations)
        - Children's Home Society (various locations)
        - Family Nurturing Center
        - Family Treehouse Visitation Center
        - Family Visitation Center (various locations)
        - Guardian Ad Litem (various locations)
        - Gulf Coast Community Care
        - Kids Hope United
        - Tri County Community Council
        - The Meditation Center (out of state)

Vicarious Trauma

By Taylor Sisson

Tanya Johnson has worked at the Kid Visits Supervised Visitation Program for four years. She has been working with child abuse victims and domestic violence survivors during that time, and conducts most of the intake in the program. Recently Tanya has been assisting a family in which the mother was brutally raped and beaten by her ex-husband, who is the father of her child. Tanya has been having nightmares about the graphic details of the crime and gets nervous before she supervises each visit.

Tanya Johnson may be experiencing **vicarious trauma**. This article will explain what vicarious trauma is and how it differs from compassion fatigue. By the end of the article you will be able to identify risk factors of vicarious trauma and signs and symptoms indicating a person is experiencing vicarious trauma. You will also be able to identify coping mechanisms that aid in reducing the effects of vicarious trauma and locate other resources that further explain vicarious trauma.

● What is Vicarious Trauma?

Burnout and compassion fatigue are common terms used by social workers and clinicians in various fields. Most clinicians have personally experienced compassion fatigue or known someone who has. This term compassion fatigue gives you the sense that the clinician is simply running low on steam or feeling a little bit empty. Many clinicians complain of compassion fatigue, and rightly so. However, there are more serious problems in the field that are continuing to be lumped in under this category and clinicians continue to suffer problems that are far more serious than what is meant by the words compassion fatigue or burnout.

Social workers are suffering from problems like fear, helplessness, feelings of horror, and disruption of their individual sense of meaning and world view (Sabo, 2008). Currently a new term is getting more attention, a term that brings to light what is really happening and shows the true depth to which many social workers are suffering due to their heart to help those in need. The concept emerging is that of **vicarious trauma**.

Vicarious traumatization does not take the place of compassion fatigue but has a wholly different definition.

- **Compassion fatigue** is the "*natural consequent* behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other-the stress resulting from helping or wanting to help a traumatized or suffering person (Figley 1995)."
- Whereas **vicarious traumatization** is defined as the "*negative transformation* in the therapist's inner experience resulting from empathic engagement with clients' trauma material (Pearlman and Saakvitne 1995)."

● Who is at risk?

The risk factors of vicarious trauma are broken down into three categories:

• First, there are **characteristics of the client** that naturally put the clinician at higher risk.

Examples: Hostile and threatening clients, suicidal clients, and work with clients who may relate trauma stories of human cruelty and intense suffering (giving graphic details of trauma or reenacting aspects of the trauma).

• Second, there are **characteristics of the work environment and job** that may contribute to vicarious trauma.

Examples: These include large caseloads, back-to-back clients who are trauma survivors, absence of peer support and supervision, professional isolation, reimbursement issues, managed care, and barriers to the helper seeking help due to fear of stigmatization.

• Lastly, there are **characteristics of the worker** that may contribute to vicarious trauma.

Examples: These include lack of experience, personal victimization history that is unresolved (issues of shame, guilt, anxiety, and anger), lack of coping skills, and unrealistic expectations around recovery of patients.

● What are the symptoms?

The symptoms or indicators of vicarious trauma are broken into three categories:

• **Feelings**

Examples: The worker may begin to feel overwhelmed, drained, angry, a loss of pleasure, depressed, isolated, distant, or rejected.

• **Cognitions**

Examples: Thoughts of horror, loss of hope, pessimism, questioning of one's self-worth, over identifying with the client, and challenging one's own basic beliefs.

• **Behaviors**

Examples: Numbing, distancing, intrusive imagery, impacts on the ability to experience intimacy, and difficulty maintaining professional boundaries with the client.

● What can I do about it?

Assistance in coping with vicarious trauma can be found at three levels:

Individual resources, Peer resources, and Organizational resources

Individual Resources

• There are some natural resiliency factors that most workers already have or can tap into to prevent or cope with vicarious trauma. These include high self esteem, resourcefulness, desire and ability to help others, faith, and opportunities for meaningful action and activities.

• There also are many self-care measures that a worker can engage in to help themselves cope with vicarious trauma. These coping skills can be broken down into emotional, cognitive, and behavioral skills.

• **Emotional**: The emotional activities include engaging in relaxing activities like meditation, ensuring your own physical and mental well-being, having outside outlets, and expressing your feelings through writing or art.

• **Cognitive**: Cognitive skills include recognizing that you are not alone, setting realistic expectations, appreciating the rewards of your work, knowing that it is not your responsibility to "heal" your clients, and finding meaning and hope.

• **Behavioral**: The behavioral coping skills include balancing the composition of case loads, balancing work life with personal life, and when necessary, taking time off of work.

Peer Resources

• Help at this level focuses on maintaining and utilizing a strong peer/coworker support network. Here are some examples of using peer support:

• Obtain peer supervision.

• Engage in "debriefing" with peers. Use the opportunities to develop informal connection.

• Enhance your profession skills by participating in or leading training sessions.

Organizational Resources

• Providing help at this level is essential in combating and preventing vicarious trauma. Here are some examples of what an organization can do to help with this potential problem:

• Schedule team meetings that dedicate a portion of the time to "emotional checkups".

• Provide ongoing supervision, especially to new staff.

• Maintain professional connections and establish professional networks.

● Where can I go for help?

• For a handbook on vicarious trauma that has a great self assessment of self-care, recommended resources, a self-awareness exercise and much more: http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/pdfs/trauma_e.pdf

• For an article about vicarious trauma in the child welfare profession and what is being done about it: http://www.cwla.org/voice/0903stress.htm

References

Figley C. (1995). Compassion Fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. New York, NY: Brunner-Routledge.

Meichenbaum, D (n.d.). Self-Care for Trauma Psychotherapists. Retrieved from http://www.melissainstitute.org/documents/Meichenbaum_SelfCare_11thconf.pdf

Pearlman L, Saakvitne K. (1995a) Trauma and the therapist: Counter transference and vicarious traumatization in psychotherapy with incest survivors. London: WW Norton.

Sabo, B. M. (2008). Adverse psychosocial consequences: Compassion fatigue, burnout and vicarious traumatization: Are nurses who provide palliative and hematological cancer care vulnerable? *Indian Journal of Palliative Care*, 14(1).

Remember to join the phone conferences, and call the Clearinghouse when you need assistance!

Resolving Ethical Dilemmas

We used the following training "think piece" at the September training in Tampa. We've included it here for those of you who could not make the training.

Clearinghouse on Supervised Visitation
Framework for Ethical Decision Making

By Annelise Martin

An ethical dilemma is a difficult situation in which a person must make a decision based on an ethical principle. Sometimes the person must choose between competing ethical principles to make a decision.

People are faced with ethical dilemmas everyday. The intensity of the dilemma can vary greatly depending on potential consequences. For example, one can face an ethical dilemma when deciding whether or not to roll through a stop sign in a rural area. A more difficult ethical dilemma is deciding whether or not to be honest about prior recreational drug use on a job application. There is much potential for ethical dilemmas that arise when working with clients at a supervised visitation program.

If the resolution to a dilemma is not clear, staff and volunteers should have other people with whom to consult, like a supervisor or the director. Because of the complicated nature of

ethical dilemmas, SV staff should not have to make decisions on their own. Still, it is helpful to have an understanding of the framework for making such decisions. The following framework lays the foundation for what principles are important. However, there may be times when providers have to make a choice that is not necessarily a good choice, but simply a "less bad" choice.

Ethical Principles

There are six main ethical principles that can be used as a guide to resolve ethical dilemmas:

1) The Principle of the Protection of Life
2) The Principle of Justice
3) The Principle of Self-Determination
4) The Principle of Least Harm
5) The Principle of Privacy and Confidentiality
6) The Principle of Truthfulness and Full Disclosure

Each principle is described further below, followed by several ethical dilemmas that relate to that principle. Some will be more difficult to solve than others. This happens when a decision poses a violation of a different ethical principle, which often occurs in real life.

Please read over these examples and consider how you would address or resolve the dilemma.

I) Principle of the Protection of Life

This principle highlights the belief that people have a right not to be harmed. Part of this principle also implies that people have the responsibility to consider how their actions may harm others, whether intentional or not. A person also has the right to engage in an activity that is not harmful to others.

Dilemma 1: Shantelle is a survivor of domestic violence. Her husband, Bobby, is currently allowed supervised visits. One day after a visit, Shantelle finds a threatening note on her car in Bobby's handwriting. Should Bobby be allowed to continue to use the program?

Things to Consider

- Bobby's actions are threatening to violate Shantelle's principle of the protection of life.
- Bobby generally has a right to talk and act as he pleases. Dismissing him from the program would violate his right to self-determination.

Solution: Bobby should not be allowed to continue the program. Although this is a minor violation to Bobby's rights, there is a much greater violation of Shantelle's rights if Bobby is allowed to continue. The Protection of Life principle must prevail in this situation. It's not clear if the car was in the SV parking lot when Shantelle saw the note

on it…if so, should SV staff report this to the police, since it was on the Center's property?

Dilemma 2: Mysti drops off her children Beau and Sara for a visit with their father. She is 15 minutes late to pick up the children. When she finally arrives, staff notice that she is staggering a bit and smells strongly of alcohol. After further discussion with her, staff determine that she is drunk and she should not be operating a vehicle. Mysti swears she only had one drink and she is fine to drive. Should staff let Mysti take the children home in her car?

Things to Consider

● If Mysti drove the children home and got in a car accident, she would be violating her children's right of the protection of life.
● If a visit monitor tells Mysti she is not allowed to drive, he would be violating her right to self-determination.

Solution: Even though Mysti does have a right to make decisions about her own life, her decision to drink and drive violates her children's right be protected. Because of this, the visit monitor should not let Mysti drive home with the children.

Dilemma 3: Jim is a father who is accused of domestic violence against his ex-wife, Rachel, who has an order for protection against Jim. During one visit, Jim is spending time of the floor coloring with his son George. After George is done drawing his picture, Jim compliments him on the drawing and hangs it on the wall. At the end of the visit when Jim is exiting the room, staff notice that he turns toward the picture and pretends to shoot at it with his hand formed as a gun. He says, "Pow." Staff examine the picture and realize it is a picture of George's mother, Rachel. Staff perceive this as a threat against Rachel's life. Should Jim be allowed to continue visiting, although he acts lovingly toward George during the visit and did not make this gesture in front of George?

Things to Consider

● The Principle of Least Harm states that people have the right to choose options that will inflict the least amount of harm. Dismissing Jim from the program would be traumatic for both George and Jim.
● Jim's actions are a threat to Rachel's right to Protection of Life. The program has a responsibility to protect Rachel's safety.

Possible Solution: Jim should be warned that this type of behavior is not appropriate and will not be tolerated. He says he "was only kidding." The staff alert the court and Rachel about Jim's actions. This allows Rachel information to help her protect herself. The court allows Jim to continue visits with his son, but also sets a hearing to determine whether there have been any violations of the order for protection and discuss Jim's behavior.

II) **Principle of Justice**

This is also known as the principle of Equality and Inequality. This principle does not imply that all individuals must be treated equally; instead it means that all people of equal

status must be treated equally, and those who are unequal must be treated *proportionally unequally*.

Dilemma 1: Mr. Jones is a very respectful and compliant visiting father. He frequently requests five extra minutes at the end of each visit to say goodbye to his children. Staff abide by program rules and do not grant him this extra time. Instead, staff advise him to begin the goodbye process earlier. Later, while Mrs. Nunez is visiting her children, staff notice that her children are having a very difficult time saying goodbye. They are crying uncontrollably and clinging to their mother's leg. Instead of being firm with the end time, staff allow Mrs. Nunez to calm her children down before leaving.

Things to Consider

● The principle of least harm advises us to make decisions that will inflict the least amount of harm possible. Mr. Jones and his children may desire extra time, but they seem to be dealing well with the end time. Still, Mr. Jones will perceive the granting of extra time to Mrs. Nunez as unfair and unequal. On the other hand, Mrs. Nunez and her children are having a very difficult time coping with the goodbye process, and making them leave at a strict time would only make it worse.

● The principle of justice guides us to treat people fairly. Because the goodbye process may be difficult for the Nunez family, granting Mrs. Nunez extra time is fair for her, although in future visits, the goodbye process should be started earlier. Even though this solution may not be fair to the Joneses, who also desire extra time, it is a fair solution.

Possible Solution: Mrs. Nunez should receive extra time to calm her children, but the staff in the next visit should anticipate this problem and begin the wind-down process earlier. Mr. Jones should be required to end his visit on time. Both families should be dealt with respectfully and sensitively. There is no need to be abrupt with either of them.

Dilemma 2: Mr. Green was divorced from Mrs. Green several years ago, after he was diagnosed with Huntington's Disease, a neuromuscular condition that has progressed rapidly. He now uses a wheelchair and has little control over his arms and neck. His two children, Amy and Ida, are upset with Mr. Green's deterioration, and are alternately angry and afraid of him at visits. They sometimes refuse to help him pick up toys or turn the pages in a book. They walk away from him and ignore him. The visitation staff have witnessed Mr. Green's deterioration and they are saddened by it. Mr. Green is still very upset with Mrs. Green, and he speaks very angrily about her and the divorce at visits, especially when he is frustrated by the girls' actions. Staff feel so sorry for him that they allow him to "vent" and rarely redirect him.

Things to Consider

● Mr. Green is in a terrible situation. His divorce, rapidly progressing disease, and relationship with his daughters make staff feel sympathy for him. They do not want to contribute to his misfortune.
● The principle of justice guides staff to treat individuals fairly. Mr. Green's behavior is in direct violation of program policies. Other clients who act like this are quickly and firmly redirected.

Possible Solution: Despite Mr. Green's terrible situation, staff have a responsibility to treat all clients fairly. Allowing Mr. Green to bend the rules because of his situation is not fair to the other clients who are held to program policies. It is also not fair to Mrs. Green or the children. Staff need to remember that they do not have all the information in the case. Thus, Mr. Green must be directed like all other parents.

III) **Principle of Self-Determination**

This is also known as the Principle of Autonomy and Freedom. This principle respects an individual's independence. This means a person has the right to make decisions about his or her own life.

Dilemma 1: Fred is the father of two children, ages six and eight. He has a long history of depression, and six months ago attempted suicide by shooting himself in the head. The attempt left him disabled and in a wheelchair. He drools and is incontinent but is requesting that the court grant supervised visitation. Fred and the children's mother are divorced. The children have not seen their father for many months, and have not been told the details of their father's condition. Should Fred be allowed visits, despite his condition? Would the SV program make the decision about whether Fred should be allowed to visit?

Things to Consider

- Allowing the children to visit Fred might be very traumatic. Using the principle of least harm, we are guided to make decisions that will inflict the least amount of harm possible. While the children may miss their father, they could experience deep pain from learning of his attempted suicide and seeing his physical condition.
- Fred is the father of these children. Although his body may be in bad condition, he is still able to make sound decisions. Under the principle of self-determination, he has the right to make a decision about seeing his children.

Possible Solution: Although the children might experience immediate pain and trauma from learning about their father's condition, it is possible that they may suffer longer term consequences by never seeing him again. Fred does have the right to make decisions about his life, and therefore he should be welcomed at supervised visits.

Dilemma 2: Mrs. Sing is new to your supervised visitation program, which utilizes a group setting (in which many families visit at once). She seems very confused by the process, but is very excited to visit her daughter, Lucy. Mrs. Sing is the only person mentioned in the court order who can visit Lucy, but she shows up with her mother and sister for the first visit. You feel terrible that Mrs. Sing did not understand this part of the visitation program policy. Mrs. Sing is very insistent that all three women must visit Lucy. It does not seem like this situation could cause any harm, and staff will be right there if anything happens. Should staff respect Mrs. Sing's right to freely choose who visits her child?

Things to Consider

● The court has specifically ordered that Mrs. Sing is the only person that can visit Lucy. Allowing other adults to arrive unannounced for visits could cause confusion and stretch staff resources. Other families who see the extra visitors will also demand their right to bring other people to the visits.
● Mrs. Sing has a right to make decisions concerning her daughter's life as part of the principle of self-determination. Lucy may benefit from seeing the other adults.
● Even though it is a violation of Mrs. Sing's autonomy, it might be a violation of the order from the court to let her bring other people. However, if the court allows the program discretion to allow other visitors, the provider may be able to accommodate Mrs. Sing if it plans ahead.

Possible Solution: Depending on the facts of the case, the visitors may pose no harm to Lucy. (If the other visitors do pose a threat to Lucy, the principle of the protection of life will exclude the visitors.) Thus, programs should decide in advance how flexible they can be about additional visitors. Some programs may not be able to accommodate other adults because of space limitations, but other programs may have plenty of staff and space to supervise the extra people. In this case, though, if the program has not developed a policy --approved by the court--about additional visitors and how they are screened and supervised, the program may have to turn away the extra people because they have not had time to plan for the relatives.

Dilemma 3: Janel is a young mother of three boys. Janel's children were removed from the home because of her substance abuse problem. She works two minimum wage jobs and takes care of her mentally ill sister. During the visitation, Janel seems very disengaged. She greets her children at the beginning of the visit, but then just sits on the couch and watches her sons play. The monitor thinks this behavior is an indication that Janel is a bad mother and does not care for her children. The monitor frequently suggests activities to try and engage Janel, but Janel refuses. Should the monitor continue to try to engage Janel, or respect Janel's right to self-determination?

Things to Consider

● The visit monitor is concerned about the well-being of the children. The monitor wonders whether these visits are not benefitting the children, who may feel like their mother does not care about them. In addition, the monitor is worried that Janel is not fulfilling the terms of her case plan and will not be able to get the children back if she shows no interest in them.
●As part of Janel's right to self-determination she has the right to choose how involved she is during these visits. In addition, different cultures and different people may not consider Janel's behavior harmful.

Possible Solution: Instead of pressuring Janel into become more involved, the monitor should explain that the program is trying to help her. A family-centered approach would be asking what Janel wants to happen at visits, and letting her choose activities for the children. This allows her to exercise self determination while helping her fulfill the case plan. Staff should consult the case worker about Janel's case plan. It may be that Janel only has to undergo treatment for her substance abuse to get the children back.

IV) **Principle of Least Harm**
This principle means that people should be given the most appropriate and least harmful option.

Dilemma 1: Wanda brings her three children to a scheduled visit with their father. There is a history of domestic violence in the family. The children appear unwashed and wear dirty clothing. Wanda is very tearful and upset, confiding to staff that she has been unable to sleep, is anxious, can't concentrate, and is unable to tend to her children's needs. What is an appropriate reaction to this situation that would cause the least amount of harm to everyone involved?

Things to Consider

● The children have a right to protection of life. It appears their mother may not be caring for them properly.
● Wanda has the right to self determination and the ability to choose how she raises her children. Programs should be able to connect client to resources so that they do the least harm, and they will them increase the health and safety of the children and Wanda.

Possible Solution: Staff should talk to Wanda about the condition of the children, and about her own health. They should try to connect Wanda with community resources that can address her problems; after all, she may need counseling, treatment, and services for herself, as well as help in caring for the children. If staff become truly concerned that Wanda is neglecting the care of her children, staff should call the Child Abuse Hotline at 1-800-96ABUSE. If the children are simply not as well cared for as they could be, staff should work to link Wanda with services to improve the situation.

Dilemma 2: Gena is a mother with a developmental disability who has been ordered supervised visits because of a pending neglect case. Her five year old daughter, Lisa, is very aware of her mother's limitations. Lisa began to adopt a parenting role in order to accommodate the mother's deficits. For example, the child would tell the mother what to do or "interpret" the visit monitor's comments to her. Last week, the foster parents could not bring Lisa for a particular visit, and the staff called Gena by telephone. Nevertheless Gena appeared for the visit and cried hysterically when told the visit would not occur. What is another way visitation staff could inform Gena of the situation that would take her challenges into consideration and make the experience less traumatic?

Things to Consider

● The principle of justice guides us to treat all clients fairly. The procedure used to inform Gena that the visit is canceled is the same procedure used for all other clients. Giving Gena special treatment might not be fair to others.
● This is clearly a very difficult situation for Gena, partially because of her developmental challenges. The principle of least harm guides us to find a different way to inform Gena of the cancelled visit so that the experience is less traumatic for her.

Possible Solution: The principle of justice guides us to treat everyone fairly. Gena needs special consideration and different treatment because of her development disabilities. The supervised visitation staff consulted with the case worker to figure out a way to keep

Gena informed. The residential staff of the group home now hang a sign up on Gena's door so she knows when a visit will occur. They found a less traumatic way to deliver the both good and bad news to Gena and to help her keep track of visits. Make sure that involving the group home staff does not violate Gena's right to privacy and confidentiality. Hanging a note on her door not only lets group home staff, but other residents as well know all about Gena's private business, and this may not be the best way to deal with the situation.

Dilemma 3: Staff realize that one of the visiting fathers who was charged with domestic violence is asserting control over his ex-wife by wearing an excessive amount of cologne and intentionally rubbing his neck on his child so the child will smell like the father. The mother is terrified by this smell and refuses to return to the supervised visitation program. As a result of this situation, staff decide to post signs and send letters to visiting parents stating they are no longer allowed to wear cologne during their visits. Is there another course of action that would respect everyone's principle of least harm?

Things to Consider

● The principle of justice guides us to treat everyone fairly. This means that rules generally apply to everyone, and those rules must be applied fairly.
● The principle of least harm guides us to mark the least harmful decision. Banning everyone from wearing cologne may be excessive.

Possible Solution: Despite the principle of justice, creating a sweeping ban is excessive. Supervised visitation providers need to consider how rules may affect every person involved. This provider should address the problem with the individual father and not create a rule program-wide. Remember that the father's right of self determination is involved here, too, as he wants to wear a specific cologne. The mother's right to protection of life is also involved. But the overarching principle here may be the principle of justice. It is unfair to apply a new rule to everyone when the intent is to alter one parent's behavior. Staff must tell the father that he cannot wear the cologne to visits. Also, staff must be vigilant in case he simply tries to substitute some other behavior to try to control his ex-wife by using the child and/or the visits.

5) **Principle of Privacy and Confidentiality**
This principle means that people have a right to have their personal information protected.

Dilemma 1: During the last visit, Lance overhears the visit monitor tell his daughter, Nadia, that the monitor's daughter is on the same soccer team as Nadia. Lance calls the program the next day because Nadia's birthday is coming up soon, and he wants to buy her new soccer cleats. But he doesn't know the size, so he wants to call the coach. He asks the monitor for the coach's name. Should you tell Lance what his daughter's coach's name is?

Things to Consider

● This request seems harmless. Lance seems like he wants to be a good father, and his daughter would be very upset if she did not get her birthday present.
● Programs have a responsibility to protect client information. Lance could have an ulterior motive for wanting this information.

Possible Solution: Even though this request seems harmless, there could be unforeseen consequences caused by sharing this information. For example, if there is domestic violence in this case, Lance might be using the monitor to get information that will give enable him to stalk his child or ex-wife outside of the visit. Lance might get the game details from the coach, who may not realize that there is an injunction for protection against Lance. The program should not disclose this information. Also, the monitor should not have shared the information about his/her own daughter being on the same team as Nadia; that would have avoided the entire issue.

Dilemma 2: Juanita, a mother of 3-year old Jazzlyn, is upset because Jazzlyn came home from a visit talking about her new favorite game, Princess Magic. Juanita is very upset about this because she believes fairytales are evil. She thinks that her husband, Neil, is corrupting Jazzlyn and she insists on hearing exactly what happened at the visit, down to the smallest detail, and whether Neil and Jazzlyn did in fact play Princess Magic. Should you tell Juanita what happened during the visit?

Things to Consider

● Juanita is the custodial parent and has a right to protect Jazzlyn's safety.
● Neil also has parental rights and has the right to decide what games he will play with his daughter.
● Juanita may simply be nervous about the visitation process and may need to be reassured that Jazzlyn is safe and happy at visits.

Possible Solution: Staff should reassure Juanita that the visit went well. Staff can generally describe what activities the father and daughter engaged in at each visit. Because of parental concerns, many programs allow parents to see the visit notes taken during each visit. It seems excessive and time-consuming to give Juanita minute details; however, programs should consider being able to record visits for times when the *referral source* wants such detailed information. This case may be resolved by staff taking time to reassure Juanita that Jazzlyn is fine during visits. If specific activities – and disagreements between the parents-- become an issue, the referral source should be consulted if the program does not have the discretion to settle any disagreements.

VI) **Principle of Truthfulness and Full Disclosure**
This is also known as the Principle of Fidelity. This principle means that people have the right to know the truth.

Dilemma 1: David is a father of two boys. During his regularly scheduled visits he has made indirect threats to visitation staff and has intimidated staff. He even stalked two staff members,

following them to their homes after the program closed. Although staff have tried to deal with David and make him feel like a partner in the service, the director of the program decides for the safety and well-being of everyone involved that David should be terminated from the program. The director also decides that it is too risky to tell David the real reason he is being asked to leave, and instead blames it on understaffing. Does David have a right to know the real reason?

Things to Consider

● The principle of least harm would guide us to not tell David the truth. He has shown volatility and the program manager has a responsibility to protect staff members.
● Under the principle of truthfulness David has a right to know the reason he is being terminated from the program.

Possible Solution: The program director should not deceive David. She should tell him the reasons he is being terminated from the program. In addition, the referral source and the child's mother should be aware of the real reason for the termination, so that David can be held accountable for his actions, and parties can make safety decisions for themselves. However, this solution "punishes" the child, in effect, which increases the dilemma.

Dilemma 2: Mrs. Eastman is a custodial parent who brings her son to scheduled visits with his father, Mr. Martell. She calls one day to cancel a visit, explaining that her new husband is being rushed to the hospital because he is having a heart attack. When staff call Mr. Martell to cancel the visit, Mr. Martell says, "Why do they need to cancel? I'll bet they are just making up a lie." Should staff tell Mr. Martell the real reason for the cancellation?

Things to Consider

● Mr. Eastman and Mrs. Eastman want to exercise their privacy and right to confidentiality during the crisis.
● The principle of full disclosure guides us to tell Mr. Martell the truth.

Possible Solution: In this case, Mr. Martell's right to full disclosure does not outweigh Mrs. Eastman's right to privacy. There may be many pieces of information that staff keep from parents after weighing these considerations. Mr. Martell can be patiently and respectfully reminded that staff will note that he was ready for the visit, but that it was cancelled by Mrs. Eastman, and that staff will contact him as soon as possible to reschedule.

Dilemma 3: A visit monitor is meeting with Mary prior to her first visit with her two children. During this process the monitor is reading the rules for the visit and explaining the rationale behind the rules. Mary becomes agitated and states, "Just because I'm a minority doesn't mean I can't read. I'm sick of you people assuming I am stupid." The visit monitor is shocked by this response. Should he allow Mary to finish reading the rules on her own, or should he explain that this is the procedure used for all new families?

Things to Consider

● The principle of self-determination may guide us to decide that Mary has a right to decide to read the rules by herself.
● The principle of full disclosure would guide us to decide that Mary should know that this is the same introduction that every new parent receives. In addition, it may be detrimental to Mary for staff not to give her the full introduction to the rules, as the supplemental information helps explain nuances and grey areas that clients and staff need to discuss.

Possible Solution: The monitor should tell Mary that this is part of the intake process. The monitor reads and explains the rules to every new parent because they can be very confusing. This treatment has nothing to do with her race. However, it might also be helpful for staff to examine their own tone and attitude to ensure that they have been respectful to Mary and have not insulted her by "talking down" to her. Staff should also be aware that Mary may have been a victim of discrimination in the past, which could account for her sensitivity at intake.

Solving Ethical Dilemmas in the Workplace

These examples demonstrate how dilemmas arise when a decision could potentially violate an important ethical principle. These situations are not easy to resolve, and there usually is not one best answer. Did you propose any solutions that were different than the ones provided? In a real life situation, what would you do if the solution you thought was best was not the same as a solution a coworker thought was best? Different individuals can place a varying amount of importance on certain ethical principles. It is important to consult your supervisor when facing an ethical dilemma.

Another factor that can affect the resolution of a dilemma is an individual's culture. As we come across ethical dilemmas within our workplace, we need to keep in mind the different values each principle may have for someone of a different race, background, religion, or ethnicity. We cannot assume that our value system is identical to that of everyone we work with, and we should take the time to explore the value systems of others. For example, the principle of self-determination has high importance within the White American culture. Other cultures may place more value on the principle of full-disclosure. This does not mean that we necessarily have to agree with and act according to a different culture's value system, but taking these differences into consideration can help make this difficult process easier for everyone.

Help us Update our Program List

Please take the time to look through your district in this list and let us know if you recognize any program that is no longer operating/providing Supervised Visitation services or if you know of a new program starting up that we have not listed. Thanks so much!

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NOVEMBER 2009 EPRESS

Upcoming Phone Conferences

NOVEMBER PHONE CONFERENCE:
****WEDNESDAY, NOVEMBER 18**
NOON, EST

DIAL 850-644-2255 TO JOIN IN
REMEMBER, PLEASE DO NOT PUT US ON HOLD

DECEMBER PHONE CONFERENCE:
THURSDAY, DECEMBER 10
NOON, EST

DIAL 850-644-2255 TO JOIN IN
REMEMBER, PLEASE DO NOT PUT US ON HOLD

Website for NEW Online Trainings

A new webpage has been launched that includes new trainings and links to the New Fall Newsletter.

It includes PowerPoint Presentations from the new statewide focus on Family Centered Practice (available now), Multiple Intelligences (available now), and Diversity (coming in 2010). The Fall Newsletter is also attached.

Check it out at http://familyvio.csw.fsu.edu/SV/nc_prac_mat.php

Supervised Visitation with Blended Families

By Haley VanErem

The United States has a high divorce rate compared to other countries. In 1997 there were 4.3 divorces per 1,000 people, and in 1999 the Census Bureau statistics reported that the divorce rate was about 50% (Granvold, 2005). The United States also has a high remarriage rate, with the majority of people who have been divorced eventually remarrying.

The high rates of remarriage along with high rates of cohabitation (Teachman and Tedrow, 2008) in the United States create large numbers of blended families, which have unique challenges (Granvold, 2005). According to the U.S. Census Bureau, "blended families are formed when remarriages occur or when children living in a household share only one or no biological parent. The presence of a step-parent, stepsibling, or half-sibling designates a family as blended," (Kreider and Fields, 2005, p. 1). Though the terms "stepfamily" and "blended family" are often used interchangeably, a blended family can also include children of the newly formed couple (Teachman and Tedrow).

Blended families are very prevalent in today's society. In 2001, 10.6 million children lived in blended families, making up about 15% of the country's children (Kreider and Fields, 2005). Of these, 5.1 million live with *at least* one step-parent. According to Ganong and Coleman (2004), some studies estimate that around 33% of children in the United States will live in a blended family before they are adults. Clearly, issues involving blended families affect many children.

Risks and Resilience with Blended Families

Though most children from blended families thrive, many studies have found that in general, stepchildren are more likely to fare worse in many areas (including school achievement, emotional, behavioral, and social problems) than children living with both of their parents (Ganong and Coleman, 2004). Remarriage can be a very stressful event, and children can have a hard time adjusting to the change (Nicholson, Sanders, Halford, Phillips, and Whitton, 2008). These effects can be long-lasting; for example, blended families are associated with higher rates of children's criminal behavior and drug and alcohol use.

Though the differences between children from blended families and children living with both parents are small, they affect a significant number of children from blended families. In other words, there are many children in blended families who fare slightly worse than their counterparts who are living with more traditional families. About 25% of children in blended families experience problems, close to twice that of children living with both parents (Nicholson et al., 2008). However, some of these differences may be due to other factors not specific to living in a stepfamily, like socioeconomic status.

Child abuse is also more prevalent in blended families. Many studies show that children who live with an adult who is not a biological parent are more at risk for abuse (Ganong and Coleman, 2004). Physical abuse is seven times more common with children in blended families than with children who live with both parents (Nicholson et al., 2008). Children in stepfamilies have a higher rate of both physical and sexual abuse, and they are more likely to witness family violence (Turner, Finkelhor, and Ormrod, 2007). In fact, this exposure to abuse and violence

may be one reason why children in blended families are more at risk for other problems as mentioned above.

There are several factors that are associated with resilience within blended families. For example, school attachment and neighbor support can both be considered protective factors (Rodgers and Rose, 2002). Also, according to Nicholson et al. (2008), new family traditions can help children overcome their sense of loss of their previous life. It is also suggested that step-parents may be more effective if they do not take an early, active role in discipline. Rules and the role of the step-parent should be clear to the children. It is important that agencies determine ways to build on these resiliency factors and suggestions.

Visitation with Blended Families

Blended families may be more likely to be referred to supervised visitation, and sometimes they are already in a supervised visitation program due to previous marriages with allegations of parental misconduct. Remember that children can establish important bonds to step-parents, grandparents, and siblings that should be taken into account in the visitation process, if there is court, parental, and program agreement that other family members can be involved in visits.

Sometimes, partners in an already blended family experience the pains of divorce. When this happens, there may be occasions when a step-parent gets awarded supervised visitation. In general, custody of children goes to the biological parent, even if a step-parent's relationship is very significant to the children. The circumstances must be unusual for a step-parent to receive custody of children. However, visitation is sometimes awarded to step-parents following a divorce or death (Malia, 2008). This can have implications on supervised visitation programs.

Tips for Your Program

Because blended families are so common in the United States, it is important for visitation facilities to be able to accommodate these families and the different issues that accompany them. Here are some suggestions for your program:

- Supervisors should be aware of characteristics and risks with blended families. They should be knowledgeable of how living in a blended family affects children.
- The agency should keep careful track of which step-parents have visitation rights and whether or not a visiting parent's spouse has the right to accompany the parent on a visit per the court order.
- The agency should consider the circumstances under which step-parents or other family members might be able to be involved in visitation. The policy should include ways to build on strengths and resilience factors of blended families. Some programs can accommodate extra visitors when the court order allows it; other programs simply do not have the capacity to accommodate more visitors.

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NEW EXCHANGE CENTERS ANNOUNCED

The Family Nurturing Center is pleased to announce the opening of two new exchange centers! We will now be providing exchange services in Arlington and on the Northside on Wednesdays, Fridays, and Sundays! Best of all, there is no service fee for these centers!

These centers are operating in partnership with the YMCA, which is a positive community based setting where families can feel safe and comfortable. If you know someone who is exchanging their children in a parking lot or a police substation or some other unmonitored setting, please let them know there is a better option available through the Family Nurturing Center.

Referrals to our program can be made by visiting our website at www.fncflorida.org or calling us at 904.389.4244.

From Historic City News. St Augustine

Benefit for Kids' Bridge Visitation Center

October 17, 2009

Nancy Sikes-Kline reported to Historic City News that in partnership with the Junior Service League's Annual Black and White Ball, Mane de Leon Salon will present "Royal Cuts" a charity event to benefit Kids' Bridge Supervised Visitation Center.

Historic City News readers are invited to support a great local cause on Thursday, October 22nd, between 5:00 and 9:00 p.m. at Mane de Leon Salon, located at 2303 Ponce de Leon Boulevard.

"100% of the proceeds go to Kids' Bridge", Sikes-Kline said.

Kids' Bridge was founded in 2002 with funding from the Junior Service League. Last year they experienced a 60% increase in demand for service; providing a safe, healing haven for families in crisis.

Throughout its seventy-five year history the Junior Service League of St. Augustine has focused its efforts on improving life in St. Johns County.

A group of strong, dedicated women have committed millions of dollars and thousands of volunteer hours to these efforts.

The impact of over seven decades of volunteerism can be seen and felt throughout the community.

Proceeds raised at the annual fall gala are critical to funding their year-long efforts.

Each year the President-Elect asks for volunteers to chair the event.

Because of the enormity of this task, three women act as team leaders.

Over the years, the title, "Gala Girls" has lovingly been bestowed on the trio.

This year's Junior Service League president, Amy Vo, will oversee some of the best and brightest to organize the upcoming gala.

Karen Strandhagen, Erin Warrell, and Kelly Carrothers will be pulling out all of the stops.

Because of the popularity of the black and white theme, the Junior Service League decided to host it once again, dubbing the event—Black And White Ball, "Simply the Best."

The gala is a black-tie event where guests are treated to a delicious dinner, an extensive silent auction, dancing and mock gambling, and desserts.

Because the event is one of the first to kick-off the social season, it is here that the traditional Society King and Queen are coroneted.

Each year a slate of prominent men and women from the community are nominated for the title, and the competition is fierce.
The candidates commit to raising monetary donations through creative fundraising. 2008's candidates collectively raised nearly $100,000 to support the projects of the Junior Service League.

From The Christian Science Monitor
http://www.csmonitor.com/2009/1014/p09s02-coop.html

Child abuse: when family courts get it wrong

States must reform a system that too often awards custody to the abusive parent.

By Kathleen Russell

from the October 14, 2009 edition

SAN RAFAEL, CALIF - When a parent harms his or her own child, family courts are supposed to step in and safeguard the victim.

Can you imagine what a tragedy it would be if courts awarded custody to the wrong parent – the abuser?

Actually, according to one conservative estimate, more than 58,000 children per year are ordered by family courts into unsupervised contact with physically or sexually abusive parents following divorce in the United States.

The fact that this type of scandal is taking place in the American justice system defies the imagination. Not since the Roman Catholic Church pedophile scandal has the US seen this level of institutional harm inflicted on innocent children.

Consider the case of Jonea Rogers, a hairstylist from Marin County, Calif. During her costly divorce, she sought help from numerous law enforcement, child protection, and family court authorities to protect her daughter from what medical evidence and reports by the child and her baby sitter suggested could be ongoing neglect or sexual abuse or both by the girl's father or grandfather.

None of the authorities she approached would effectively intervene to protect her daughter. So in 2000, Ms. Rogers eventually felt that she had no choice but to flee with her child to protect her.

More than three years later, this protective mother was caught and jailed for five months, while her daughter was immediately handed over to her alleged abusers. Rogers faced criminal charges for

violating a court order by fleeing with her child. After considering the evidence in her case, a jury of her peers completely exonerated her of all wrongdoing.

The very same evidence that exonerated her in the criminal court had been called "frivolous" by the family court judge and disregarded. Despite her acquittal, Rogers was never granted custody of her daughter, who lives with her alleged abusers to this day. She is now forced to pay a fee to visit with her daughter a few times a month in a supervised visitation facility.

As we see in many cases across the country, even when physical or sexual abuse of children is alleged during a divorce, American family courts routinely award custody to the parent with an established record of domestic violence restraining orders, child abuse, neglect, alcoholism, addiction, dangerous mental illness, or a combination.

Meanwhile, the child's other parent, commonly referred to as the "protective parent," is typically demonized by court professionals as an "alienator" for bringing evidence of child abuse to the court's attention.

This happens because the reigning paradigm in family courts across the country is an unscientific, discredited theory known as "Parental Alienation Syndrome," or PAS.

PAS and its many derivatives suggest that the parent who asks the court to protect his or her child by limiting the alleged abuser's access to that child is "alienating" the child from the other parent.

The theory suggests that a parent "coaches" a son or daughter to fabricate false abuse allegations, and the court's attention immediately shifts away from investigating an alleged crime and instead focuses on the "uncooperative parent" who refuses to share custody of the child with the alleged abuser or molester.

PAS is tricky for the courts because parents in heated custody battles often badmouth each other and sometimes exaggerate claims of neglect, and children overhear their parents complaints about each other. Though rare, false allegations of abuse do occur. Research on child sexual abuse indicates that close to 98 percent of children who claim sexual abuse in the context of a high conflict divorce are telling the truth, yet family courts routinely proceed as if the opposite were true.

Protective parents not only lose custody of the children they are trying to protect, but they lose their life savings, too. Many cannot even afford a lawyer to represent their interests, but are saddled with hefty supervised visitation fees and often threatened with a loss of custody if they object to paying the bevy of court-appointed experts that the judge assigns to their case.

Fees quickly add up to tens or even hundreds of thousands of dollars. Many such parents go bankrupt, making court appeals impossible. The family law "machine" operates as Big Business, and a sophisticated cottage industry has sprung up that appears to be preying on desperate parents and children who are trying to escape family violence.

Four factors conspire against protective parents:

1. Family law judges are granted broad discretion in their decisionmaking;

2. Juries are nonexistent in most family law courtrooms;

3. Costly appeals are out of reach for most litigants; and

4. Children are not afforded a voice in these important proceedings that determine their future. As a result, nothing short of a major overhaul of the family court system will suffice.

Here in California, home to some of the most egregious cases, the Center for Judicial Excellence and its partner organizations in the Safe Child Coalition recently worked with State Sen. Mark Leno (D) of San Francisco to unanimously pass an audit request through the California legislature to address this growing problem.

The request asks the state auditor to investigate the procedures used by family courts to appoint, train, evaluate, and discipline the plethora of professionals they use in cases in Marin and Sacramento counties.

The legislature should also pass two sensible bills in 2010. Assemblyman Jim Beall (D) of San Jose has proposed a bill that would outlaw PAS in state family courts, and a bill by Assemblywoman Fiona Ma (D) of San Francisco would allow children to have a voice in family court proceedings.

Other states must open their eyes to this problem. Family courts are being manipulated in ways that tragically undermine their mission.

We must ensure access to justice for all who find themselves in our nation's family courts. There are at least 58,000 reasons to get serious about reform today.

Kathleen Russell is a cofounder and staff consultant to the Center for Judicial Excellence in Marin County, Calif.

HIV Today: What you need to know

By Taylor Sisson

Introduction

Most people know that the human immunodeficiency virus, or HIV, is a virus that attacks the immune system of infected persons, which can lead to acquired immunodeficiency syndrome (AIDS) and even death. At the onset of the AIDS epidemic in the early 1980's, HIV/AIDS was mostly confined to men who have sex with men (MSM) and injection drug users (IDU). This is not the case today. There is a large and growing number of heterosexuals, specifically African Americans and Hispanic/Latinos, who are contracting HIV.

Objectives

This article will explain:

1. Some current statistics and trends about the populations infected with HIV/AIDS
2. Who is at risk
3. How you get HIV
4. How to protect yourself from HIV
5. How people with HIV can prosper and live healthy
6. What is being done to stop the spread of HIV
7. What resources are available for people living with HIV/AIDS

Statistics

- Today the HIV demographic is changing and heterosexual African Americans and Hispanic/Latino populations are becoming more vulnerable.

- In the past four years the rate of new infections among women has remained stable, but the rate among African American women is increasing.

- HIV/AIDS is the leading cause of death for black women ages 25 to 34

- 51% of the newly diagnosed HIV/AIDS cases in the United States between 2000 and 2003 were among African-Americans, but African Americans make up only 13% of the population.

- Diagnoses are up five percent among men (11 percent among MSM).

- If an expecting mother has HIV/AIDS, modern drugs are highly effective at preventing HIV transmission during pregnancy, labor and delivery. When combined with other interventions, including formula feeding (no breast feeding), a complete course of treatment can cut the risk of transmission to below 2%.

- If a woman takes no preventive drugs and breastfeeds, the chance of the baby becoming infected increases to 20-45%

Protecting Against HIV

Anyone can get HIV and all are at risk, although certain populations are at a higher risk. So, it is important that everyone take precautions to protect themselves against infections. Over recent years, not much has changed in the way of these precautions:

- Abstain from sex (oral, anal, or vaginal sex) until you are in a relationship with only one person.

- Use condoms, even if both partners have HIV (as to not get a new strand of the virus).

- If you are a man who has had sex with other men, get tested at least once a year.

- Do not inject illicit drugs

- If injecting, use only clean needles, syringes, and other works.

- Never share needles, syringes, or other works.

- More information can be found at http://www.cdc.gov/hiv/topics/basic/index.htm#prevention

Living With HIV/AIDS

Fifteen years ago, when the average life expectancy after diagnosis was seven years, an HIV diagnosis was often seen as a death sentence. However, this is not the case today. Many professionals see HIV as a chronic disease. A recent study found that a diagnosed person, on average, is living for twenty-four years after that diagnosis. The obvious reason for the change in life expectancy is the higher quality of healthcare, including the development of new antiretroviral drugs and treatment.

Treatment

- HIV is treatable, but currently there is no cure for HIV.
- Treatment works by lowering the amount of HIV in the body.
- There are more than 20 approved drugs for treating HIV/AIDS, with most people Taking a combination of two or more drugs.
- Infected people should consult with a doctor about when to start treatment. When to start treatment varies among persons.
- T-helper cell count and other factors, such as viral load and opportunistic infections, are taken into account before starting treatment.
- Drug resistance tests taken prior to treatment can be helpful in determining what combination of drugs to take.
- There are often public funds to help those who cannot afford treatment on their own (see resources section).

Health

HIV positive people should think about the following:

- First and foremost, contact a healthcare provider that has experienced with HIV/AIDS. This is important to do even if you cannot afford or do not want to use antiretroviral drugs.
- Have good nutrition. Infected persons should increase the amount of food they eat and maintain their lean body weight.
- Eat a balanced diet. This includes plenty of protein and whole grain foods, with some sugar and fat.
- Exercise. This can help build and maintain muscle.
- Drink plenty of liquids to help your body deal with any medications you are taking.
- Practice food safety. Keep the kitchen clean, wash foods, and be careful about food preparation and storage.
- If you want to use nutritional supplements, be sure to get expert advice from a health care provider.

Protecting others

- Abstain from sex.
- If having sex, use condoms correctly and consistently.
- Use protection during oral sex.

- Tell others that you have HIV; it is illegal to knowingly infect others.
- Do not share drug needles or razors.
- Do not breast feed if your child is not infected and you are infected.
- Guidelines for caring for an infected person can be found at: http://www.cdc.gov/hiv/resources/brochures/careathome/index.htm

What is being done?

Below are some major national HIV/AIDS initiatives:

1. **The Diffusion of Effective Behavioral Interventions project (DEBI)** is a national-level strategy to provide high quality training and on-going technical assistance on selected evidence-based HIV/STD/ Viral Hepatitis prevention interventions to state and community HIV/STD program staff. You can learn more at: http://www.effectiveinterventions.org

2. **Replicating Effective Programs (REP)** project helps make HIV prevention interventions that have been shown to work more accessible. They use everyday language and are packaged in a user-friendly way. http://www.cdc.gov/hiv/projects/rep/default.htm.

3. **REACH 2010** – ***Racial and Ethnic Approaches to Community Health*** is a national program funded through the Centers for Disease Control and Prevention (CDC). REACH2010 is designed to eliminate disparities in the following six priority areas: cardiovascular disease, immunizations, breast and cervical cancer screening and management, diabetes, **HIV/AIDS,** and infant mortality. The racial and ethnic groups targeted by REACH 2010 are African Americans, American Indians, Alaska Natives, Asian Americans, Hispanics, and Pacific Islanders.

    - **REACH 2010 - Coalition to Reduce HIV in Broward's Minority Communities** works in Broward County to prevent and educate about HIV/AIDS in minority communities. http://chua2.fiu.edu/faculty/darroww/reach2010/

Helpful Resources

- "The Body"
  This site has lots of practical information and links to more resources and support networks for those living with HIV and AIDS:
  http://www.thebody.com/

- AIDS Treatment Data Network has links to federal and state resources for people living with HIV/AIDS. This aid includes housing, drug assistance programs, and disability SSI. Visit: http://www.atdn.org/

- Florida Department of Health

http://www.doh.state.fl.us/Disease_ctrl/aids/index.html

- Center For Disease Control (CDC)
  http://www.cdc.gov/hiv/
  1-800-CDC-INFO (24 Hours/Day)

http://www.cdc.gov/hiv/topics/surveillance/basic.htm

http://www.thebody.com/content/art6083.html#anchor51759

http://www.aidshelp.cc/education_articles/state_of_hiv.htm

http://www.msnbc.msn.com/id/15655257/

http://www.aids.gov/podcast/black/2009_national_awareness_transcript.html

http://www.avert.org/aids-statistics.htm

http://chua2.fiu.edu/faculty/darroww/reach2010/

Beyond Christmas

By Taylor Sisson

America is made up of many different cultural and religious groups, but around this time of the year, Christmas is the prominent holiday. Consistent with a family-centered practice, supervised visitation providers (and all social service providers) need to be culturally aware and respectful of those with different backgrounds.

With the Christmas "holiday season" coming up, it is important for us to be mindful of these different religious holidays and how clients view these holidays. Remember, we can only respect the views of those around us when we take the time to learn what those other views are! To that end, this article reminds us of the following:

- The dates of some of the non-Christian major religious holidays.
- The associated practices and rituals one might expect to see.
- How practitioners can be mindful of and validating toward their clients religious beliefs and rituals.

Judaism

When Jewish holidays occur is determined by the Hebrew calendar, which corresponds not only to the moon but also to the season. This is different than the Gregorian calendar that is internationally accepted and we commonly use. Explaining the way different calendars work and

correspond with each other is difficult. The point is that Jewish holidays will always occur around the same time every year but not always on the same Gregorian calendar day every year. For example, Rosh Hashanah occurred on September 19, 2009, but next year it will fall on September 9, 2010. It is also important to know that Jewish holidays start at sunset the night before and end at sunset the next day. Practitioners working with people of Jewish heritage should be aware of the dates that the major holy days will occur and also the practices one might expect to encounter during these days:

- **Hanukkah**

  Known as the "Celebration of Lights," it has come to commemorate two related events in Jewish history--the liberation of the land from Seleucid domination, and the miracle of the oil during the rededication. Seleucid Empire had taken over the Jewish land, removed their priests and defiled their holy places. After freeing themselves from the empire's rule, the Israelites went about purifying and rededicating the temple for eight days. During these days, oil for their ceremonial candle should have lasted only one day but lasted for the whole eight days. This was seen as a miracle and is recreated in the eight-day celebration and lighting of the eight Hanukkah candles.

  Hanukkah will occur next from sunset, December 11 to sunset, December 19, 2009. Common practices associated with this celebration include:

  - Lighting a nine branched candle stick holder called a Chanukkiyah or Menorah. (One candle for each night, and one candle to light the other candles)
  - Playing games.
  - Playing with a dreidel.
  - Giving gifts.
  - Giving of money (Hanukkah Gelt) to children.

- **Purim**

  Purim is a holiday that commemorates the deliverance of the Jews in the Persian Empire from their enemies. It was not instituted as a commandment, but as a memorial. The story of Purim is described in the book of Esther.

  Purim will occur next on sunset, 27 February – nightfall, 28 February, 2010. Common practices in relation to this holiday include:

  - The entire book of Esther is read in the Synagogue every year at Purim.
  - It is customary to dress up as one of the characters in the story of Esther when attending the service.
  - Sending food gifts to friends.
  - Giving charity to the poor.

- Eating a festive meal.

- **The Passover**

  Passover commemorates two things. First, it commemorates the exodus of the Israelites from the oppressive land of Egypt. A springtime festival it also celebrates the rebirth of the earth after the winter.

  Passover will occur next from sunset of March 29 to nightfall of April 5, 2010. Common practices in relation to this holiday include:

  - Abstinence from and removing from one's home all grain products that are already fermented (e.g. yeast breads and most alcoholic beverages), and substances that can cause fermentation.
  - The consumption of matzo, or unleavened bread.
  - The eating of bitter herbs.
  - A special meal, called a Seder, is celebrated on the first night of Passover.

- **Rosh-Hashanah**

  Rosh-Hashanah literally means "head of the year" and is often called the "Jewish New Year." It represents either analogically or literally the creation of the World, or Universe and is celebrated for two days. Rosh-Hashanah is also called the Day of Judgment. Jews believe that on this day God reviews an individual's actions of the past year and judges his or her fate for the coming year.

  Rosh-Hashanah will occur next from sunset, September 8 – sunset, September 10, 2010. Common practices in relation to this holiday include:

  - Rosh Hashanah is observed as a day of rest.
  - A trumpet made from a ram's horn is blown, intended to symbolically awaken the listeners from their "slumbers" and alert them to the coming judgment.
  - Many people dress in white as a symbol of purification.
  - A custom called Tashlikh is often observed in which individuals throw bread crumbs into a stream of water as a symbol of casting one's sins away.
  - Rosh-Hashanah begins "ten days of repentance," which end on Yom Kippur. These are days of self-examination.

- **Yom Kippur**

  Also known as the "The Day of Atonement," is the holiest day on the Jewish Calendar. God accepts one's repentance and seals him or her up for a good and

bountiful year. The two principle themes of this day are repentance and confession.

Yom Kippur will occur next on sunset, September 17 – nightfall until September 18. Common practices in relation to this holiday include:

- A 25-hour period of fasting and intensive prayer.
- Spending most of the day in synagogue services.
- No wearing of leather shoes.
- No bathing or washing.
- No anointing oneself with perfumes or lotions.
- No marital relations.
- No dealing with money.

- **Sukkot**

Sometimes known as the Feast of Tabernacles, Sukkot recognizes the fact that the Israelites dwelt in huts during their 40 years of wandering in the desert after the Exodus from Egypt. The holiday lasts for seven days.

Sukkot will occur next on sunset, September 22 through sunset, September 29, 2010. Common practices in relation to this holiday depend on the day and include:

- Gatherings of music and dance.
- Living in a "booth" or "hut."
- Activities that will interfere with relaxation and enjoyment of the holiday—such as laundering, mending clothes, engaging in labor-intensive activities—are not permitted.

Islam

Muslim holidays are also determined by a lunar calendar. Again, this means that the dates on which they occur will change from year to year. Also, Sunni and Shia Muslims use different calendars and the major holidays may occur on different days depending on which calendar one is using. The two major Muslim holidays are:

- **Eid ul-Fitr**

Eid ul-Fitr is often abbreviated as Eid or called the "Smaller Eid." This holiday marks the end of Ramadan, which is a month of fasting. Eid ul-Fitr occurs next on September 10, 2010. Celebratory activities include:

- Visiting relatives, friends and acquaintances.
- Paying visits to the graveyards.

- Praying with family.
- Eating festive family meals.
- Giving gifts.
- Wearing nice or, if possible, new clothes.
- Eating sweet foods.

- **Eid al-Adha**

  Eid al-Adha is called the "Festival of Sacrifice" or "Greater Eid." This holiday commemorate the willingness of Ibrahim, a figure from the Quran, to sacrifice his son Ismael as an act of obedience to God. The festivities last for three days or more depending on the country. It is a very happy time. This holiday will occur next November 27 to November 30, 2009. Some of the rituals involved are:

  - Prayer.
  - Sacrificing a goat, sheep, cow or a camel, sending some of the meat to the poor and some to friends.
  - Distributing meat among people is considered an essential part of the festival during this period, making sure no one goes without food.
  - Visiting family and friends.
  - Giving gifts to children.

Bahá'í

The Bahá'í Faith believes that there is one God and that all religions are really worshipping that one God, they are all paths to God. There are nine annual Bahá'í holy days plus an annual fast. With the exception of New Year, Bahá'í holidays commemorate major events in the lives of the founders of the Bahá'í Faith.

On holy days, Bahá'ís do not work and this is considered a sacrifice. These holy days are often observed by the reading or chanting of prayers, sometimes from scriptures of other Faiths, and passages recounting episodes in Bahá'í history relevant to the occasion, accompanied by music suitable for the occasion. There is no clergy or ritual, or set practices to commemorate the various holy days. Different communities may organize different programs of devotional character appropriate to the day in question. Holy Days of celebrative nature often include artistic contributions of music, dance, mime, and crafts, as well as refreshments, according to local custom. Here are the three most important holy days for Bahá'ís are:

- **Ascension of Baha'u'llah** (May 29)
  This date marks the passing of Bahá'u'lláh in 1892, in Acre (Akka), in the Holy Land. At the time of His death, He had been a prisoner of the Shah of Persia and the Ottoman Empire for 40 years.
  - The event is usually observed at the actual time of His passing, 3:00 a.m.
  - Work should be suspended on this holiday.

- **Declaration of the Bab** (May 23)

  The Bahá'í Faith began in Persia (now Iran) on this day in 1844. It commemorates the announcement by the Prophet known as the Bab of his mission as founder of a new faith and forerunner of a Prophet greater than Himself, Bahá'u'lláh. The Bahá'í calendar dates from this year.

  - Commemorations should be held at about two hours after sunset.
  - Work should be suspended on this holiday.

- **Naw-Ruz** (New Year) (March 21)
  The Baha'i New Year's Day coincides with the spring equinox. Naw-Ruz is an ancient Persian festival celebrating the "new day" and for Baha'is it marks the end of the annual 19-Day Fast. This date has been celebrated as the New Year in Persia for thousands of years.
  - This is one of the nine holy days of the year when work is suspended.

Hinduism

It has been said that Hindus have a holiday for every day of the year, but even that may be an understatement! Exactly how many Hindu festivals are celebrated is not known, but one scholar of Hinduism has listed more than a thousand different Hindu festivals.

As in most ancient religions, many of the Hindu holidays are based on the cycle of nature. They mark the change of seasons, celebrate the harvest, and encourage fertility of the land. Others are dedicated to a particular deity, such as Shiva or Ganesh. Still other popular holidays commemorate events in the lives of Rama or Krishna. In addition to the major Hindu festivals that are celebrated throughout India, many regional festivals are also held in honor of various deities. They include a wide variety of rituals, including worship, prayer, processions, magical acts, music, dancing, lovemaking, eating, drinking, and feeding the poor.

Below are some major festivals likely to be observed by most Hindus:

- **Holi** - festival of colors and spring (February-March)

  It celebrates spring, commemorates various events in Hindu mythology and is a time of disregarding social norms and indulging in general merrymaking.

  - Hindus attend a public bonfire.
  - Spray friends and family with colored powders and water, which gives the holiday its common name "Festival of Colors."

- **Mahashivaratri (Shiva Ratri)** - night sacred to Shiva (February-March)

Mahashivaratri is especially important to Saivites (devotees of Shiva), but it is celebrated by most Hindus.

- The day of Mahashivaratri is spent in meditation on Shiva
- fasting (some may take water or fruit).
- Temples dedicated to Shiva are filled with devotees offering prayers.
- ffferings are made to Shiva in the form of Bilva leaves, fruits, and other specially prepared foods.
- After fasting and meditating throughout the day, a vigil is held all night with continued prayers and meditation.

- **Rama Navami** - birthday of Lord Rama (April)

  - Many Hindus mark this day by fasting through the day followed by feasting in the evening
  - Lord Rama is believed to have born at noon, so temples and family shrines are elaborately decorated and traditional prayers are chanted together by the family in the morning.
  - Images of baby Rama are placed on cradles and rocked by devotees.

- **Krishna Jayanti** - birthday of Lord Krishna (July-August)

  - At midnight, the ritual of waving lit lamps is performed.
  - One should fast the whole day before the celebration at midnight.

- **Raksha Bandhan**- renewing bonds between brothers and sisters (July-August).

  - The festival is marked by the tying of a rakhi, or holy thread by the sister on the wrist of her brother.
  - The brother, in return, offers a gift to his sister and vows to look after her as she presents sweets to her brother.
  - The brother and sister traditionally feed one another sweets.

- **Kumbh Mela** - pilgrimage every 12 years to four cities in India. It occurs four times every twelve years and rotates among four locations.

- **Ganesha-Chaturthi (Ganesha Utsava)** - festival of Ganesh (August-September).

  It is the birthday of Lord Ganesha. The festival lasts for 10 days.

- Life-like clay models of Lord Ganesha are made for sale by specially skilled artisans.
- For 10 days, Ganesha is worshipped.

- **Dassera** - victory of Rama over demon king Ravana (September-October)

This is celebrated for 10 days in some parts of the subcontinent.

- Rasa and Garba dances by men and women of all sects are done to please the Goddess.
- The Dashera in Gujarat are followed by 9 nights of singing and dancing.

- **Navaratri** - festival of Shakti (in Bengal) or Rama's victory over Ravana

Navaratri is celebrated four times a year.

- Worship and ritual vary greatly among sects and regions.

- **Diwali** - festival of lights and Laksmi (September-October).

This is a Hindu festival of lights lasting five days. For many Hindus, Diwali is also New Year's Eve. Diwali is celebrated with a variety of rituals, which depend in large part on one's location, but they center on the lighting of candles, electric lights and fireworks.

- Gambling is encouraged during the Diwali season as a way of ensuring good luck for the coming year and in remembrance of the games of dice played by the Lord Shiva and Parvati.
- In honour of Lakshmi, the female player always wins during Diwali.
- On this day, merchants perform religious ceremonies and open new account books.
- It is generally a time for visiting, exchanging gifts, cleaning and decorating houses, feasting, setting off fireworks displays, and wearing new clothes.

Buddhism

There are many holidays and festivals celebrated by Buddhists around the world each year, most of which commemorate important events in the life of the Buddha or various Bodhisattvas. The dates of the holidays are based on the lunar calendar and often differ by country and tradition.

Buddhist holidays are joyful occasions. A festival day normally begins with a visit to the local temple, where one offers food or other items to the monks and listens to a Dharma talk. The afternoon might consist of distributing food to the poor to earn merit, circumambulating (walking around) the temple three times in honor of the Three Jewels, chanting and meditation.

Some of the more important Buddhist holidays are:

- **Buddhist New Year**(April)

  The Buddhist New Year is celebrated on different days throughout the world.

  - New Year celebrations begin with cleaning of house.
  - People perform various traditions and rituals to welcome the New Year.
  - A most important tradition is to throw water on each other. This is done to purify the souls.
  - Some people illuminate their houses with colorful lights.

- **Vesak** (Buddha Day)(first full moon day in May)

  Vesak is the birthday of the Buddha and the most important festival in Buddhism. On the first full moon day in May, Buddhists all over the world celebrate the birth, enlightenment and death of the Buddha in a single day.

  - Devotees are enjoined to make a special effort to refrain from killing of any kind. They are encouraged to partake of vegetarian food for the day.
  - Most make special efforts to bring happiness to the unfortunate like the aged, the handicapped and the sick.

- **Sangha Day** (Magha Puja Day or Fourfold Assembly Day)(approximately July)

  Sangha Day commemorates the Buddha's visit to Veruvana Monastery in the city of Rajagaha, when 1,250 arhats are said to have spontaneously returned from their wanderings to pay their respects to the Buddha.

  - It is a time when monastics will make an effort to gather together to share their knowledge and experiences.

- **Dhamma Day** (Asalha Puja Day)(July)

  Dhamma Day is observed on the full moon day of the eighth lunar month (July). It commemorates the "turning of the wheel of the Dharma" - the Buddha's first sermon.

- Dhamma day is usually celebrated with readings from the Buddhist scriptures, and is an opportunity to reflect deeply on their content.

- **Observance Day** (Uposatha)

  Observance Day refers to each of the four traditional monthly holy days that continue to be observed in Theravada countries - the new moon, full moon, and quarter moon days.

  - In Buddhist countries, lay Buddhists generally go to the Temple to pass the day and night, often observing the three refuges and eight precepts.
  - They spend their time reading Dhamma books, listening to Dhamma sermons, meditating and discussing the Dhamma.
  - The Buddha taught that the Uposatha day is for "the cleansing of the defiled mind," resulting in inner calm and joy.

- **Kathina Ceremony** (Robe Offering Ceremony)(usually October)

  The Kathina Ceremony is held on any convenient date within one month of the conclusion of the three month rains retreat season.

  - On this day, the laity offer new robes and other necessities to the monks and nuns.

- **Festival of Floating Bowls** (Loy Krathong)(November)

  At the end of the Kathin Festival season, when the rivers and canals are full of water, the Loy Krathong Festival takes place in all parts of Thailand on the full moon night of the twelfth lunar month.
  - People bring bowls made of leaves (which contain flowers), candles and incense sticks, and float them in the water. As they go, all bad luck is supposed to disappear.

- **Elephant Festival (**third Saturday in November)

  The Buddha used the example of a wild elephant that is harnessed to a tame one to train to teach that a person new to Buddhism should be helped by an older Buddhist. To mark this saying, Thai Buddhists hold an Elephant Festival on the third Saturday in November.

- **The Festival of the Tooth (**August)

  On a small hill in Sri Lanka is a great temple that was built to house a relic of the Buddha - his tooth. The tooth can never be seen, as it is kept deep inside many

caskets. But once a year in August, on the night of the full moon, there is a special procession for it.

- **Ancestor Day** (Ulambana)(July)

  In Mahayana countries, it is believed that the gates of hell are opened on the first day of the eighth lunar month and ghosts may visit the world for 15 days.
    - Food offerings are made during this time to relieve the sufferings of the ghosts.
    - On the fifteenth day, Ulambana or Ancestor Day, people visit cemeteries to make offerings to their departed ancestors.

DECEMBER 2009 EPRESS

Upcoming Phone Conferences

DECEMBER PHONE CONFERENCE:
****THURSDAY, DECEMBER 10**
NOON, EST

DIAL 850-644-2255 TO JOIN IN
REMEMBER, PLEASE DO NOT PUT US ON HOLD

JANUARY PHONE CONFERENCE:
WEDNESDAY, JANUARY 27
NOON, EST

DIAL 850-644-2255 TO JOIN IN
REMEMBER, PLEASE DO NOT PUT US ON HOLD

HAPPY

HOLIDAYS

Free Tools From the CDC

The Centers for Disease Control website have countless resources available that deal with violence prevention that are free to everyone. All you have to do is order them! These resources cover abuse and violence prevention topics ranging from home and recreational safety to triage plans to child maltreatment and youth violence.

Among the free materials offered:

Coping with Stress After a Traumatic Event (Tip Sheet)

- Normal reactions to stress
- Time to heal from traumatic event
- Steps to help you feel better
- Knowing when to ask for help
- National Suicide Prevention Hotline

Promoting Respectful, Nonviolent Intimate Partner Relationships: A Strategic Direction for Intimate Partner Violence Prevention (Glossy Sheet)

- Intimate Partner Violence as a Public Health Problem
- The Center for Disease Control and Prevention's Role in Intimate Partner Violence
- The CDC's Strategic Direction for Intimate Partner Violence Prevention
- Characteristics of Respectful Relationships
- Key Aspects for promoting respectful relationships
- Four priorities of the CDC's strategy to prevent intimate partner violence

Promoting Healthy Parenting Practices Across Cultural Groups: A CDC Research Brief (Booklet)

- Family Protective Factors
- Strategies for strengthening protective factors
- Cultural Norms and Cultural Competence in parenting
- CDC's Healthy Parenting Cultural Norms Study
- Finding of the study: Good v. Bad behaviors
- Parental reactions to misbehaving: Similarities and differences across cultures

Parent Training Programs: Insight for Practitioners (Booklet)

- The need for research on parenting programs
- About parenting training programs
- Components of the parenting training programs
- Outcomes of the parenting training programs and its importance
- Less effective programs
- Implication for practice

CDC Websites for Additional Resources

Here's how to order:
Violence Prevention webpage - http://www.cdc.gov/ViolencePrevention/index.html
Violence Prevention Publication webpage - http://www.cdc.gov/injury/publications/index.html
Order Form website - http://wwwn.cdc.gov/pubs/ncipc.aspx

Cultural Competency Intake Script

As a follow-up to the November phone call, we are offering you the next step in increasing your cultural sensitivity and competency.

In order for us to best serve your family, we want to be as sensitive as possible to your specific cultural needs. We have a few questions we want to ask you in order to help us to better understand and assist your family.

1. Does your family have any religious or cultural beliefs that we should be aware of during visitations?
   **Can you share with us what religion, if any, you belong to?*

2. Are there any religious holidays that your family typically celebrates together?

3. What customs or traditions are involved in celebrating those holidays/events? (Fasting, gift-giving, special clothing worn, prayer, etc.)
   **How do you celebrate? What sort of things do you do or not do?*

4. (If the program offers food or beverages:) Are there any foods you and your family refrain from eating? During specific times or in general? So that we can be prepared, are there any special foods or food treats that you will want to bring to a visit to share with your child around the holidays?
   **Is there anything you are not allowed to eat? Ever or only during certain times?*

5. Does your family have any prayer or other religious rituals that need to be acknowledged during visitations?
   **Will you ever need to pray during visitations? What is needed in order for you to do that?*

6. What is the generally accepted expression of emotion or affection by your culture/family?
   **When you are happy, how do you show it to your family? When you are sad, angry, excited, proud, etc.?*

7. Spanking and physical discipline is prohibited during visitations, however it would help us to know what your family's typical approach is to discipline? (Of course, SV staff recognize that parents whose children were removed as a result of physical abuse may not answer this question truthfully or at all.)
   **When your child misbehaves, how do you correct him/her?*

8. Is there anything else regarding your cultural beliefs, values, or traditions that you would like us to know as we seek to serve your family?
   **What other beliefs and customs does your family have that might come up during visitation?*

**Alternate, plain language questions to help in understanding.*

The Research: **Helping Children Cope with Stress**

By Lisa Langenderfer

For school-age children, daily stress is common. Sources can include anxiety about school, problems with teachers, parents, and/or peers, poor grades and other school difficulties, unfair punishment, and boredom (Fallin, Wallinga, & Coleman, 2001, 18).

Coping strategies are "purposeful, cognitive, and behavioral efforts to manage stress" that are affected by personal circumstances and personalities of each child (Fallin, et al., 2001, 18). There are two types of coping strategies: those which aim to change the stressor and those which aim to manage emotions associated with the stressor (Fallin et al., 2001, 18). Children's coping strategies often include activities such as religious involvement, discussing emotions, exercise, engaging in aggressive behavior, cognitive restructuring, problem solving, emotional regulation, wishful thinking, and submission (Fallin et al., 2001, 18).

It is essential that children be able to tap into their physiological and environmental resources when they are faced with stress, whether they are readily available or merely possibly accessible. Examples of children's healthy resources include self-esteem, problem-solving skills, money, health, and social support of family, friends, and teachers (Fallin, et al., 2001, 18).

Because stress is so common in school settings, social workers, teachers, and others who deal with children, need to know how to address the needs of their students in stressful situations. After assessing a child's stressors, efforts should be made to help the child respond to the daily stressors and increase resources (Fallin et al., 2001, 19-20).

When possible stressors should be changed (e.g., separate two arguing children); if it is not possible, physical and emotional responses to stress should be changed (Fallin et al., 2001, 20). Aside from counseling, role playing is a way to accomplish this. The teacher can present a student with a common stressful situation and have the student state how they see and feel about the problem; then, other students in the discussion can contribute ideas of how to perceive and deal with the stressors differently (Fallin et al., 2001, 20). Fallin et al. (2001), also suggests having children focus on positive experiences by drawing pictures of people, places, things, or times that made them feel positive (20).

It is also important to increase positive resources of the child. Good health and energy, self-esteem, and social support are three resources that, if lacking, can lead a child to choose ineffective coping strategies (Fallin et al., 2001, 21). Again, the school setting is a prime location to carry out this task. First, health needs to be a team effort between school and home. Parents need to be educated on their child's physical and emotional health while teachers can promote healthy living in their classrooms (e.g., lessons on hygiene and nutrition) (Fallin et al., 2001, 21). Second, self-esteem can be increased by having students choose a "person of the day" and having each student write what they like best about the "person of the day" (Fallin et al., 2001, 21). Be sure though, that each child is chosen at least once, so that the child does not feel left out. Lastly, social support can be increased by employing social skills workshops (aimed at peer interaction) as well as having teachers promote friendships among students (e.g., a friendship bulletin board in the classroom) (Fallin et al., 2001, 21). Another activity to increase social support is to have students complete a "web of support" in which important members of their different social groups are identified (Fallin et al., 2001, 22).

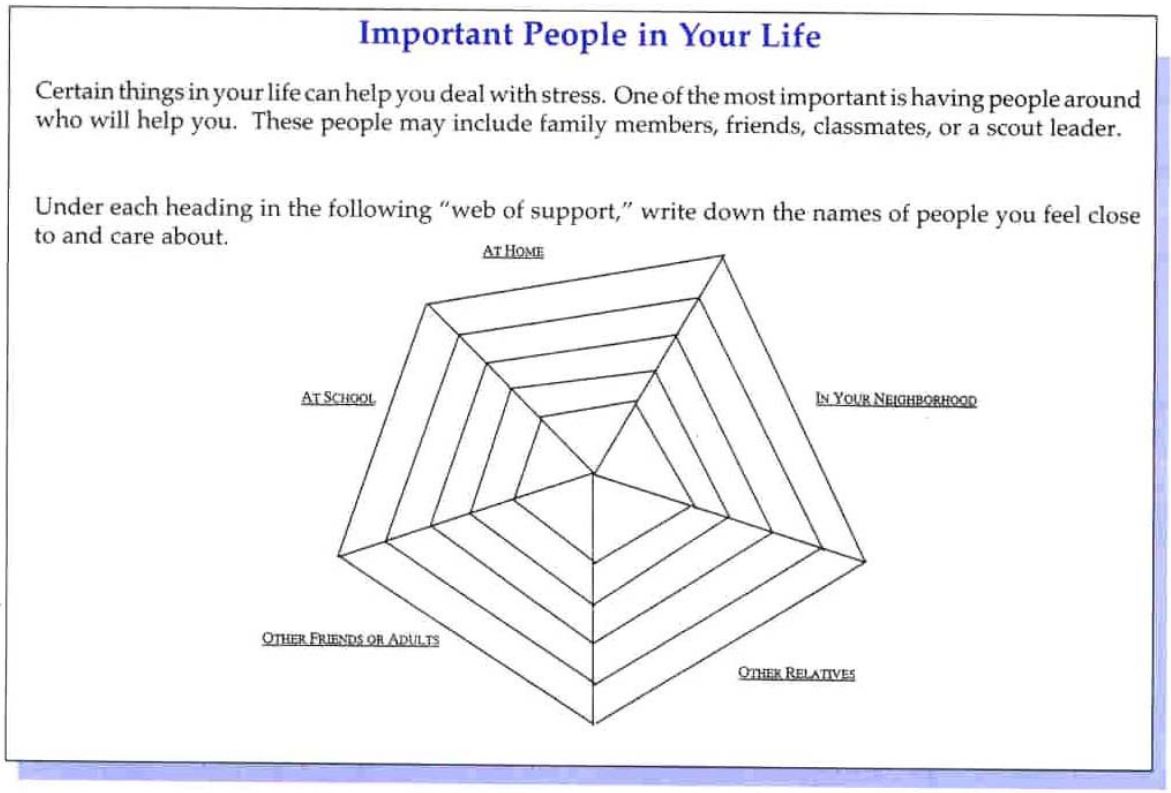

Figure 1
Web of Social Support

(Fallin et al., 2001, 22)

The Girl Scouts of America also provide tips for helping children cope with stress. First, use age-appropriate, creative ways to get kids to discuss their feelings; for preschoolers, puppets are a good tool while for teenagers, journal writing can be helpful (Girl Scouts of America, 2005). In addition, looking at healthy coping mechanisms of media characters can help children cope with stress (Girl Scouts of America, 2005). Other ideas include exercising to reduce tension and volunteering with family or friends to bond (Girl Scouts of America, 2005).

Nemours is another proponent of bonding with family to help kids cope with stress (2009). Physical health is also emphasized, with a focus on proper sleep and nutrition (Nemours, 2009). Finally, it is recommended that foreseeable stress be acknowledged in advance (e.g., a doctor's appointment) so the child has time to discuss any anxieties with a parent before the stressful situation arises (Nemours, 2009). If a child is hesitant to discuss his or her fears, the parent can choose to expresses some of his or her own anxieties to open communication (Nemours, 2009). If a child continues to refuse to discuss his or her stress and it is clearly and significantly affecting his or her home or academic life, professional counseling should be sought (Nemours, 2009).

The American Academy of Pediatrics promotes the 7 C's of resilience to promote effective coping. The 7 C's are competence, confidence, connection, character, contribution, coping, and control (AAP, 2006). For teens, the American Academy of Pediatrics' website (2006) offers a personal stress management guide to help address their stressors.

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DCF's Article on "Child on Child Sexual Abuse" is attached. It is a pdf file.

Director Stella Johnson sent this story in below, sharing it with the state "so we keep vigilant in remembering that the families who come to us are in crisis." She says "we can let ourselves become too comfortable with anyone because you never know what is going on in their mind."

Double-murder, suicide in Clay County stuns community

Father kills children, self while wife was in shower; Fleming Island couple was undergoing divorce

JOHN PEMBERTON/The Times-Union
ORANGE PARK — Clay County residents still stunned by the slaying of Somer Thompson endured another night of mourning Tuesday, this time for two sleeping children slain by their father who then killed himself.

Jerry Waite Whitelaw Jr., 49, fatally shot his son, Kevin, 16, and daughter, Katie, 11, in their home at 2921 Grande Oaks Way in the gated Fleming Island neighborhood of Margaret's Walk, said Sgt. Dan Mahla of the Sheriff's Office.

Whitelaw then shot himself. His wife, Dana, didn't hear anything and found the bodies after getting out of the shower, Mahla said. Deputies received a call from her at 6:15 a.m.

County court records show Dana Whitelaw, 47, filed for divorce in August after 16 years of marriage. The records don't indicate why the couple was divorcing. Dana Whitelaw was seeking alimony and other support. The couple was still living together.

The family attended Grace Episcopal Church in Orange Park, where Dana Whitelaw worked as a day school secretary and her daughter was a sixth-grader. More than 500 people packed the church Tuesday night for a 45-minute prayer service, during which candles were lit and hymns were sung.

"God will protect Kevin because he knows God's name. God will protect Katie because he knows she knows God's name," Rector Kurt Dunkle told the congregants. "Terrible things did happen this morning. God is there to pick up the pieces."

The prayer service came two weeks after Clay residents began mourning the death of 7-year-old Somer, whose slaying remains unsolved. She lived about 2 miles from the Whitelaw's church.

Sheriff Rick Beseler said the slayings have left him shaken and angry.

"I don't know how much more tragedy Clay County can take," Beseler said. "It's bad enough when it's adults, but when it's children, it's lives unfulfilled and opportunities lost. It's just so sad."

Mike Cannady, an Orange Park native who attended the church service, said people have sought comfort in each other and prayer as a result of the tragedies.

“It’s brought people closer together. It’s brought people closer to God,” said Cannady, 43.

William “Mac” McGauley, Dana Whitelaw’s father, issued a statement on behalf of his daughter thanking members of the church and day school and St. Johns Country Day School for their “outpouring of love, support and prayers.” Kevin Whitelaw was a junior at St. Johns Country Day School.

“I cannot tell you how much it means to my daughter and the rest of my family to know how much we are loved,” the e-mailed statement said. “The grief we feel is overwhelming and so we ask for and appreciate your patience as we make the necessary arrangements to lay our family members to rest.”

Beseler said he was told the couple separated in June. Deputies had never been called to the home for any problems.

A neighbor of the Whitelaws said he was unaware of any problems the couple was having.

“You would never have known they were getting a divorce,” Christi Achors said.

Regarding the couple’s children, Achors said: “They were great kids. They played outside. It was a normal family.”

Jerry Whitelaw had been working at Idea Integration, a technology consulting company in the Modis building in downtown Jacksonville. He was no longer employed by the company, said Jason Mudd, a company spokesman. Company officials declined to discuss his employment. His former co-workers were provided counseling.

“We are shocked and saddened by this tragic news,” Mudd said.

About 350 students in grades 8-12 at St. Johns Country Day School were told about the killings at a mid-morning auditorium assembly, said Carol Gay, the school’s public relations and publications director.

“They were somber and tearful,” Gay said. “It’s the reaction you could expect to have when someone close to you or you just saw yesterday is no longer here.”

She said Kevin attended the school for several years and was on the football team.
“Students and teachers often talk about our school as a family,” said Greg Foster, headmaster at the school. “The terrible news this morning has left our school with a profound sense of loss.

Grief counselors were sent to both St. Johns Country Day and Grace Episcopal Day School. Katie was one of about 200 students at Grace Episcopal.

“We’re extraordinarily sad at what has happened and our prayers are with the entire family,” Dunkle said earlier in the day.

Jerry Whitelaw’s only other local trouble with the law occurred in 1992 when he pleaded no contest to charges of criminal mischief with property damage and resisting an officer without violence, according to the Florida Department of Law Enforcement.

Below is a recent article about a child abduction.

Child Abducted from Visitation:

At St. Petersburg marina, boaters worry about father, son

By Emily Nipps and Andy Boyle, Times Staff Writers. Nov. 30, 2009

ST. PETERSBURG — A Palm Bay father who authorities say kidnapped his 3-year-old son and set out to sea in a camouflaged sailboat had no boating experience, according to boaters who say they know him.

Those who got to know 35-year-old Paul Martikainen were worried Monday morning as they tended their boats at Salt Creek Marina in St. Petersburg. Witnesses at the marina said they saw Martikainen and the boy, Luke Finch, get into the 32-foot Bristol sailboat, according to Cocoa Beach police.

Gabriel Guzman, 28, and Sam Mageramov, 37, were at the marina and saw Martikainen leave about 4 p.m. Saturday.

As he was leaving, they said a dinghy attached to Martikainen's boat came loose. The two helped him tie it back to his boat, they said.

Guzman said at one point the boy emerged from inside the boat, but Martikainen told him to go back. The boy didn't seem scared, Guzman said.

"We should have saved the boy," Guzman said. "We could have saved him had we known."

In recent weeks, Guzman said, Martikainen started asking various boating questions, such as how to tie certain types of knots.

Debra Van Skiver, who works for a towing company near the marina, said she sold the boat, a 1977 32-foot Bristol, to Martikainen for $6,109 during the third week of October. He told friends he was purchasing it for someone in Arkansas and would be transporting it after working on it, but Martikainen himself had no sailing experience.

He appeared to be living aboard the boat as he worked on it, said Ted Scaratt, whose boat was docked next to Martikainen's.

He mentioned he would try sailing it after visiting his son over Thanksgiving, Van Skiver said, and she advised him to take some boating classes first.

"This is a man with not a lot of sailing experience," Van Skiver said, noting that she has a child, too. "It is impossible to take care of a child and sail a boat without multiple people."

The boat was recently painted battleship gray, covering the identifying numbers and making the vessel difficult to find in the water. This led authorities to believe the abduction was planned, according to Cocoa Beach police spokeswoman Barbara Matthews.

Luke was reported missing Saturday afternoon after he disappeared from a Cocoa park during a visit with his father monitored by a court-appointed supervisor. Martikainen slipped away sometime after noon.

An Amber Alert sent out Saturday evening said Martikainen was thought to be traveling in a green 1995 Ford Explorer with tag number 142KEA. Shortly after news of the alert ran on local news broadcasts, a caller told authorities that the vehicle was at the marina, Matthews said.

People who got to know Martikainen at the marina described him as a nice, friendly guy who often bought doughnuts to share with other boaters.

Scaratt, Martikainen's neighbor at the marina, said Martikainen has dual citizenship and said he once served in the military in Finland. "He never gave an indication that he was capable of this," Scaratt said.

Van Skiver said the boat was seaworthy. It has a sleeping cabin, a kitchenette and standard safety equipment such as a compass and VHF radio. Martikainen purchased a GPS system before Thanksgiving, she said, but it has no EPIRB, a device that helps rescuers locate boats in distress.

The boat also had adult life vests but no child vests, and Van Skiver didn't know if Martikainen bought one.

The U.S. Coast Guard is assisting Cocoa Beach police in the search for the father and son. The Coast Guard is broadcasting an alert about Martikainen on a marine emergency channel, the *Orlando Sentinel* reported.

Martikainen was ordered to have supervised visitation because of previous allegations of abusing the boy, Matthews said.

Matthews said the child's mother is "afraid … but very hopeful." The mother or other relatives of the boy could not be reached.

Records show that Martikainen and Christa Lee Finch got a marriage license in 2004 in Palm Beach County. The ceremony was held at Great Outdoors in Titusville in Brevard County on Dec. 3, 2004.

Martikainen has an arrest record that includes driving without a license and failing to go to court multiple times in the 1990s. In 1999 he was arrested in Palm Beach on a felony charge of trafficking Ecstasy.

In February he was charged with child abuse and domestic battery.

Emily Nipps can be reached at nipps@sptimes.com or (727) 893-8452.

Follow-Up Story

COCOA, Fla. -- A 3-year-old boy, taken by his father during a supervised visit was found on the father's sailboat in the Gulf of Mexico Tuesday morning.

The boy, Luke Finch, was taken by his biological father, Paul Martikainen, an immigrant from Finland during a supervised visit at Riverfront Park in Cocoa Village Saturday. Police say Martikainen eluded the person supervising the visit and fled.

The Coast Guard says they spotted the boat Monday night and kept it under surveillance all night. At sun-up Tuesday, two Coast Guard Cutters and helicopter intercepted the boat and took boy.

According to Cocoa police, Luke was taken aboard the Coast Guard Cutter Crocodile, which is expected at the Coast Guard Station in Ft. Myers Beach at approximately 7:00pm. Cocoa Detective Nellie Woodruff is also aboard the Cutter with Luke. Police said Luke seems to be in good health and will be reunited with his mother in Ft. Myers Beach.

Paul Martikainen, police said, is still aboard his sailboat, which is being towed to shore by the Coast Guard Cutter Kodiak Island. They will make landfall much later in the evening, at which time Martikainen will be taken in custody by the FBI on a Federal arrest warrant.

"We are extremely happy about the outcome of this. It could have gone so much worse and we are so thankful that Luke is safe. This was a group effort and would not have been possible without the help of many, many law enforcement agencies" Cocoa Police Chief Mark Klayman said through a statement released Tuesday morning by police.

The Coast Guard said the boat was in the Gulf and appeared to be heading toward Mexico when they caught up with it.

Glad you asked! Parenting Tips and Conversation Starters

Several of you have asked for more parenting tips to offer your clients. Some programs print these out (like Fortune Cookie messages on colored paper), and hand them out to parents at intake, during drop off and pick up, and at other contact. These pointers are consistent with Family-Centered Practice.

Parenting Tips and Ideas:

- Establish "together time" Establish a regular weekly routine for doing something special with your child -- even if it's just going out for ice cream
- Don't be afraid to ask where your kids are going and who they'll be with. Get to know your kid's friends -- and their parents -- so you're familiar with their activities.
- Try to be there after school when your child gets home.
- Eat together often. Meals are a great time to talk about the day and bond.
- Be a better listener. Ask and encourage questions. Ask your kid's input about family decisions. Showing your willingness to listen will make your child feel more comfortable about opening up to you.
- Don't react in a way that will cut off further discussion. If your child says things that challenge or shock you, turn them into a calm discussion.
- Be a living, day to day, example of your value system. Show the compassion, honesty, generosity and openness you want your child to have.
- Know that there is no such thing as "do as I say, not as I do" when it comes to your kids.
- Examine your own behavior.
- Reward good behavior consistently and immediately. Expressions of love, appreciation, and thanks go a long way – even for kids who think of themselves too old for hugs.
- Accentuate the positive. Emphasize what your kid does right. Restrain the urge to be critical. Affection and respect will reinforce good (and change bad) behavior. Embarrassment or uneasiness won't.
- Create rules. Discuss in advance the consequences of breaking them. Don't make empty threats or let the rule-breaker off easy. Don't impose harsh or unexpected new punishments.
- Set a curfew. Enforce it strictly, but be ready to negotiate on special occasions.
- Have kids check in at regular times. Give them a phone card, change or even a pager, with clear rules for using it.
- Call parents whose home is to be used for a party. On a party night, don't be afraid to stop in to say hello (and make sure that adult supervision is in place).
- Let your children know to never be afraid to call you, and that no matter what, you will come and pick them up from wherever they are if they need to get out of an uncomfortable or potentially dangerous situation… be their lifeline!
- Listen to your instincts. Don't be afraid to intervene if your gut reaction tells you something's wrong.
- Let your children know how much you care in every situation you can, and especially when they are having problems.
- Keep a positive attitude about your ability to be a parent. Trust your instincts.

- Take care of yourself. Meet your needs for support with other adults so you can establish healthy parent-child boundaries.
- Take time to teach your children values while they are young. Live your own values every day.
- Make your home a safe, secure, and positive environment. Provide appropriate privacy for each family member.
- Get involved in your child's school, your neighborhood, and your community. You, not the teachers and other authority figures in your child's life, are responsible for parenting your child.
- Set clear rules and limits for your children. Be flexible and adjust the rules and limits as they grow and are able to set them for themselves.
- Follow through with consequences for your children's misbehavior. Be certain the consequences are immediate and relate to the misbehavior, not your anger.
- Let your children take responsibility for their own actions. They will learn quickly if misbehavior results in unpleasant natural consequences.
- Be a guide for your children. Offer to help with homework, in social situations, and with concerns about the future. Be there to help them direct and redirect their energy and to understand and express their feelings.
- You are separate from your child. Let go of the responsibility for all of your children's feelings or outcome of their decisions. Your children' successes or failures are theirs, not yours.
- Provide an environment for your children where a foundation of mutual appreciation, support, and respect is the basis of your relationship into their adult years.
- Teach your kids how to help themselves. Many parents often do for their kids. This only robs their children of the opportunity to learn self-reliance—a vital key to their self-esteem. One of the best things you can do is to help your kids learn how to do for themselves.
- Don't do anything to your child that you wouldn't want your child to do to you. The list of things you don't want to be doing includes yelling, hitting, spitting, making fun of people and putting others down. There are far better ways for you to handle conflict, stress and common misbehaviors. Commit to learning these "Ultimate Parenting" tools that are based on mutual respect.
- Laughing, tickling, and playing together is the foundation of a happy home. Having fun can go a long way in providing your family with much needed quality time and in preventing much of the needless conflict and behaviors that drive you crazy.
- Children who experience a regular dose of quality time with their parents do not need to act out to get their attention.
- Kids need to feel in control of certain areas of their life. They also need boundaries. Create family rules but ensure that there is flexibility too. For instance, a family rule might be that the common areas of the home need to be clean before bed, but the tidiness of the children's room is left up to them.
- Most parents unknowingly teach their kids to not listen to them. If you consistently repeat yourself and then don't follow through on what you've said, you are teaching your kids to ignore you.
- Give positive verbal attention through affirmations such as "Great job!" "Fantastic!" and similar responses.
- Small to moderate amounts of computer game play has shown to be beneficial for social interaction. Computer game players scored more favorably on both family closeness and

friendship networks, as well as on activity involvement, compared to those who never played computer games.

- Show your love. Every day, tell your children: "I love you. You're special to me." Give lots of hugs and kisses.
- Listen when your children talk. Listening to your children tells them that you think they're important and that you're interested in what they have to say.
- Make your children feel safe. Comfort them when they're scared. Show them you've taken steps to protect them.
- Provide order in their lives. Keep a regular schedule of meals, naps and bedtimes. If you have to change the schedule, tell them about the changes ahead of time.
- Praise your children. When your children learn something new or behave well, tell them you're proud of them.
- Criticize the behavior, not the child. When your child makes a mistake, don't say, "You were bad." Instead, explain what the child did wrong. For example, say: "Running into the street without looking isn't safe." Then tell the child what to do instead: "First, look both ways for cars."
- Be consistent. Your rules don't have to be the same ones other parents have, but they do need to be clear and consistent. (Consistent means the rules are the same all the time.) If two parents are raising a child, both need to use the same rules. Also, make sure baby-sitters and relatives know (and follow) your family rules.
- Spend time with your children. Do things together, such as reading, walking, playing and cleaning house. What children want most is your attention. Bad behavior is usually an attempt to get your attention.

Sources:

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Wallenius, M., Rimpelä, A., Punamäki, R., Lintonen, T. (2009). Digital game playing motives among adolescents: Relations to parent–child communication, school performance, sleeping habits, and perceived health. *Journal of Applied Developmental Psychology*. 30, 463-474.

Healthy Foster Care America Website Now Available

In 2007, the American Academy of Pediatrics (AAP) created the Task Force on Foster Care (TFOFC) with the charge to increase the awareness, knowledge, and skills of pediatricians regarding the needs of children and teens in foster care. The ultimate goal is to improve the health and well-being of children and teens in foster care. Recently, the TFOFC launched the Healthy Foster Care America website to engage communities and their leaders in supporting children, teens, and their families with an effective, multidisciplinary, integrated, and comprehensive continuum of care. The site was developed as a place where professionals and partner organizations can find the latest tools, resources, facts, and figures on the health and well-being of children and teens in foster care.

www.aap.org/fostercare/

Inside the Research: Fathers and Family Reunification

Chapin Hall's implementation study of the Integrated Assessment (IA) program in Illinois showed that when both parents participated in the IA interviews, more children are eventually able to return home to their parents. More specifically, when both parents were interviewed, the likelihood of family reunification was 3.2 times greater than when neither parent was interviewed. Furthermore, when only one parent was interviewed, the likelihood of reunification was 2.4 times greater than when neither parent was interviewed.

http://www.chapinhall.org/research/inside/when-both-their-parents

First-Ever National Data on Adopted Children and Their Families

Adoption USA: A Chartbook Based on the 2007 National Survey of Adoptive Parents presents findings from the first nationally representative survey of adoptive parents in the United States. About 2% of U.S. children joined their families through adoption. The Chartbook describes the characteristics, adoption experiences, and well-being of these children and their families, making comparisons between adopted children and the general population of children in the United States and among children adopted through different adoption types. The Chartbook contains information on types of adoption, adoption by relatives, contact with birth families, physical health and social and emotional well-being of adopted children, and parenting. It is based on the National Survey of Adoptive Parents, a collaborative effort of several agencies within the U.S. Department of Health and Human Services (HHS). Researchers from Child Trends conducted the analyses under contract to HHS.

http://aspe.hhs.gov/hsp/09/NSAP/chartbook/