JANUARY 2010 EPRESS

Happy New Year!

Upcoming Phone Conferences

JANUARY PHONE CONFERENCE
****WEDNESDAY, JANUARY 27**
NOON, EST

DIAL 850-644-2255 TO PARTICIPATE

REMEMBER NOT TO PUT US ON HOLD

PLEASE REPLY TO THE REMINDER EMAIL AS YOUR WAY OF CONFIRMING YOUR PLANS TO ATTEND

Monthly Phone Call Survey

At December's phone call, the group decided to ask directors if they wanted to change the time of the monthly phone call. 23 people so far have logged on to a one-minute online survey to indicate their preferences.

Please take a moment and give your input. Two questions: what day, and what time, is preferable.

http://www.surveymonkey.com/s/P7QK3CF

Just so you know, from the current information in the survey online, the group appears to want to change the time to 9 am on Wednesdays.

Give your feedback, because we can't read your mind!!

Lots of Free Training Available!

National Stalking Awareness Month 2010

A resolution (H.R. 960) has been introduced to the United States House of Representatives, designating January 2010 as National Stalking Awareness Month.

Begin planning for National Stalking Awareness Month 2010 by visiting www.stalkingawarenessmonth.org, where you can find resources to promote the month including:

- Artwork for posters, buttons, magnets, banners, and other media,
- Social networking site status updates (New!)
- Stalking knowledge quiz
- Outreach materials

The Stalking Resource Center (SRC) has a limited number of National Stalking Awareness Month theme posters printed and available for agencies interested in promoting the month. To request theme posters, please e-mail src@ncvc.org.

Guide for Stalking Support Groups

The SRC released a new publication, *How to Start and Facilitate a Support Group for Victims of Stalking*, a guide for victim service providers, volunteers, and other concerned community members on how to initiate and run a stalking support group in their agency or community.

To request printed copies of the guide, please e-mail src@ncvc.org.

Webinar:

The Stalking Resource Center, in partnership with the Department of Justice Office on Violence Against Women, will host the Webinar, *"Supervising Offenders Who Stalk, Part II,"* on January 20, 2010, at 2:00 p.m. Eastern Standard Time (1:00 p.m. CST, 12:00 p.m. MST, 11:00 a.m. PST). This is the second session of a two-part Webinar series on the topic. Subjects addressed in this Webinar will include:

- **Overview of Responding to Stalking: A Guide for Community Corrections Officers,**
- **How stalkers use technology to stalk and challenges that presents for supervision, and**

- **Practices used by participants who are supervising offenders engaged in stalking behaviors.**

For more information or to request training from the Stalking Resource Center, please visit

www.ncvc.org/src.

DCF Child Welfare
Professional Development Series

This valuable training series is open to anyone in the child welfare system.

January 11, 2010, FIU Kovens Center
3000 NE 151 St., Miami, FL. 33181

January 13, 2010, The Double Tree Hotel
10100 International Dr., Orlando, FL. 32821

January 15, 2010, Florida State University
Conference Center, 555 W. Pensacola St.
Tallahassee, FL. 32306-1640

Please register by January 7. Use the following link to register

https://fstraining.dcf.state.fl.us/checkbox/survey.aspx?s=ec811dacd57649f3bca5ad79e391f0d7

For more information, please contact

Annette Kariko at (850) 922-6656 or annette_kariko@dcf.state.fl.us

If you choose to attend this free training, the Clearinghouse will provide you with a training certificate.

Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Legal Professionals (Online Training)

Let your judges and family law attorneys know about this!

Developed by the National Center on Substance Abuse and Child Welfare and the American Bar Association Center on Children and the Law, this customized tutorial will help judges and attorneys gain an understanding of the work that child welfare and substance abuse treatment professionals perform, and will provide tips on how to engage and retain families in substance abuse treatment. It also highlights judicial and attorney roles and responsibilities and underscores the importance of partnership and collaboration among the three systems. This training is available on the National Center on Substance Abuse and Child Welfare website. The following trainings are also available online:

Understanding Child Welfare and Dependency Court: A Guide for Substance Abuse Treatment Professionals

Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Child Welfare Professionals.

There is no cost to enroll in these online tutorials. Continuing Education Units are available upon successful completion of a tutorial.
http://www.ncsacw.samhsa.gov/training/default.aspx

Free Material

Free Special Issue of Child Abuse and Neglect: The International Journal, 1989-2009

Elsevier, the leading publisher of scientific, technical and medical information products and services, recently announced the publication of a freely available Special Issue of Child Abuse and Neglect: The International Journal, 1989-2009 on the 20th Anniversary of the U.N. Convention on the Rights of the Child CRC). The Special Issue aims to celebrate the 20th anniversary of the adoption of the UN Convention on the Rights of the Child. It provides an overview of two decades of development in the areas of child maltreatment research, data collection, and reporting practice, as required by the Convention on the Rights of the Child and will facilitate information and practice exchange to support governments and professionals in their important efforts globally. The Special Issue will be freely available online, to all, for a year, along with Part 2 of the Special Issue which will be published in January 2010. Part 1 can

currently be accessed at:

http://www.sciencedirect.com/science/issue/5847-2009-999669988-1554191

DCF Firearms Memo

In December, the Department of Children and Families released a memo to clarify its policies relating to firearms. The memo stated that according to Florida law, the Department cannot keep any lists or records of gun ownership. Any employee who does so commits a felony. Thus, workers cannot maintain any record of clients who own firearms.

The memo also clarified the Department's policy on safe firearm storage. Florida law requires that all adults store firearms safely for the protection of minors (in this case, people under the age of 16). To comply with this law, any adult who knows or should know that a minor could get access to a firearm must keep it in a locked container or secured with a trigger lock unless the firearm is able to be accessed as quickly by the adult as if it were on the adult's body. The Department also attached a form entitled Acknowledgment of Firearms Safety Requirements for parents to sign so providers with the Department can ensure that parents and other adults in placements are aware of the requirements.

Finally, the Department of Children and Families previously required parents to store firearms and ammunitions separately. However, because this regulation was not supported by a Florida law, it is no longer required by the Department.

Legislative Jumpstart:

Sharon Rogers, Legislative Chair for the Florida Chapter of the Supervised Visitation Network, is preparing to submit a bill draft to the Florida Legislature tracking the recommendations of the 2008 Report to the Florida Legislature. Sharon will keep us all posted of her progress.

Important News:

Child-abuse deaths soar in Florida

(from the Tallahassee Democrat, Dec. 30, 2009)

About 200 children were fatally abused in Florida in 2008, a roughly 20 percent increase over 2007. Unemployment rates and drug use also increased in the state — a factor in many of the deaths, according to a preliminary report.

The number of kids fatally abused who had involvement with the state child welfare agency also increased 20 percent, the State Child Abuse Death Review Committee determined in a report obtained by The Associated Press. In 2008, 79 children were killed who had some type of involvement with the Department of Children and Families in the past five years, compared with 66 children who died in 2007.

"The numbers should be a call for careful scrutiny and accountability, especially when so many of the children were already known to the department or the hotline," said Andrea Moore, child advocate and Broward County attorney who represents foster children.

The investigation verified 198 child-abuse deaths in 2008 and six deaths from previous years that weren't verified until 2008. That's an increase from 163 child deaths in 2007.

At least one of the child-abuse deaths in 2008 occurred in the Big Bend. One-month-old Tameha Bines of Tallahassee was an apparent victim of shaken baby syndrome. Her father, Darren Bines, faces first-degree murder charges.

Florida has one of the highest per-capita rates of child deaths reported to the state abuse hotline in the country, partly because its figures count such events as car accidents, drownings and suicides, which aren't included in most other states.

Twelve of the children died while in foster care, the Department of Children and Families said. Eighty-six percent of the deaths could have been prevented by a state agency like DCF or a caretaker. Seven percent were not preventable, according to the report.

But DCF officials said most of the children came into state custody as a result of abuse or with a pre-existing illness that led to their death, not because they were abused while in state care.

"The more I know about child abuse and domestic violence the more convinced I am that the roots are in substance abuse and mental health," DCF Secretary George

Sheldon told The Associated Press. The agency has begun focusing more resources on treating those problems in adults and educating caseworkers on recognizing the symptoms.

Experts say the sour economy also contributed to the problem. Florida's unemployment rate jumped from 4.1 percent to 6.2 percent in 2008, accounting for the loss of about 339,600 jobs.

Unemployed men between 18-30 who watch the children while the mother is at work are the most common abusers, according to the report. Crying, toilet training and feeding are the most common triggers of physical abuse in young children.

"The fact that many of these males are unattached, non-biological fathers contributes to their inability to cope with crying and they very often lack appropriate knowledge of child development and parenting skills," the report says.

Many of the men also have criminal records and histories of substance abuse and domestic violence.

Among the deaths was a 3-month old boy who was thrown out a car window by his mother's irate boyfriend in Tampa in May. Jasmine Bedwell told caseworkers Richard McTear Jr. beat her on two occasions and threatened to harm her son. DCF determined caseworkers didn't take the threats seriously because she promised to get an injunction against him.

Sheldon said he's troubled by an increase in the number of violent child deaths, especially shaken baby deaths. He gets an e-mail alert on his Blackberry every time there's a report of a child dying from abuse.

The number of traumatic injuries increased from 45 physical abuse deaths in 2007 to 59 deaths in 2008.

About 465 deaths were reported to the Florida Abuse Hotline in 2008. Of those, 201 were verified as child abuse or neglect, according to the report.

The report comes after a newspaper investigation showed thousands of calls to the hotline each month aren't forwarded for investigation. Agency records show that the DCF Hotline screened out allegations of physical or sexual abuse, medical neglect and inadequate supervision of very young children. Calls from judges, social workers, school counselors

and hospital workers are among those that have gone without investigation, according to *The Miami Herald.*

DCF has said they would review referrals from the hotline to prevention workers within 24 hours among other changes.

This article highlights the fact that despite shrinking budgets, services that provide safe contact between adults and children are more necessary than ever!

Below is the article about the kidnapping in December from a supervised visit. When you read this, think of how much money the city, county, and state spent on finding this child. Be sure to reference this case when the court considers using a relative or friend to supervise a visit, instead of using the local SV program.

911 tape sheds light on kidnapping

Published: December 4, 2009

A 911 tape released by Cocoa police sheds light on the kidnapping of 3-year-old Luke Finch. Finch and his father, Paul Martikainen, 35, disappeared during a supervised visit Saturday in Cocoa. It triggered a land, sea and air search for them. Martikainen is charged with international parental kidnapping.

The pair ended up in St. Petersburg on Saturday, where witnesses reported them taking off in a sailboat for Mexico. Tuesday morning, the U.S. Coast Guard located them south of Fort Myers. In the 911 call released Thursday, Bob Rumble, court-appointed supervisor of Martikainen's visits with his son, told a dispatcher he had searched unsuccessfully for the pair for an hour.

"I'm freaking out. I don't know what to do. I'm at Cocoa Village Park, and I can't find them anywhere," Rumble said. Rumble, a family friend, was appointed by the family court to keep tabs on Martikainen during parental visits with Finch.

Carrie Hoeppner, of the Department of Children & Families, said child welfare investigators confirmed Martikainen had abused the boy in 2009. Rumble told the dispatcher he was supervising a nine-hour visit between Finch and his father when he lost them.

"I went in there to pick up a pizza and use the bathroom, and I have looked everywhere, and I don't know what to do," said Rumble, who will not face charges or sanctions.

The call led authorities to put out a statewide Missing Child Alert for Finch.

A Coast Guard C-130 aircraft detected the sailboat by radar. The Coast Guard rescued the toddler early Tuesday.

Director News from December

On Friday December 11, local firefighters were at the Lillian Saunders Community Center to give a helping hand as we began a massive renovation of the Lillian Saunders Community Center.

The Lillian Saunders Community Center has sat vacant for over ten years. Through the Jacksonville Journey initiative, the Family Nurturing Center stepped forward through a bid process to take over the management of the center and re-open the facility.

Once Builders Care has completed renovations, Family Nurturing Center will offer their core services including supervised visitation, monitored exchange, and parent education at the center. Family Nurturing Center has already reached out to a host of other agencies including Youth Crisis Center, Jacksonville Hospitality Institute, and Hubbard House to bring a variety of resources to the community center.

Builders Care is the charitable arm of the Northeast Florida Builders Association. Through the generosity of the Northeast Florida Builders Association, Builders Care provides construction services for nonprofit agencies and needy families with children or senior citizens. To learn more about Builders Care, contact Chris Simons at 904.219.4674 or visit www.builderscare.org. Submitted by Stella Johnson

New Year's Resolutions

Start 2010 with the following:

1. **Participate in the monthly conference calls with the Clearinghouse.**
2. **Keep the Chief Judge and/or Trial Court Administrator apprised of your program's resources and policies.**
3. **Plan at least one Spring-time in-service learning opportunity for staff. (Call the Clearinghouse if you need ideas.)**

4. **Take the new training on Family-Centered practice on the Clearinghouse website if you have not already done so. Be sure your staff is trained as well.**
5. **Help make it a happy and safe New Year for your staff and the children and families you serve!**

FEBRUARY 2010 EPRESS

****Please note the changes to the upcoming phone conferences, identified in the boxes below.****

FEBRUARY PHONE CONFERENCE
WEDNESDAY, FEBRUARY 24

9:00AM, EST
NEW PHONE NUMBER!!
DIAL 866-244-8528 TO PARTICIPATE, YOU WILL NEED TO ENTER A PASS CODE TO PARTICIPATE.
THE PASS CODE IS 635786

REMEMBER NOT TO PUT US ON HOLD
NOTE: THIS IS A NEW TIME AND NUMBER!!

MARCH PHONE CONFERENCE
WEDNESDAY, MARCH 17

9:00AM, EST
NEW PHONE NUMBER!!
DIAL 866-244-8528 TO PARTICIPATE, YOU WILL NEED TO ENTER A PASS CODE TO PARTICIPATE.
THE PASS CODE IS 635786

REMEMBER NOT TO PUT US ON HOLD

NOTE: THIS IS A NEW TIME AND NUMBER!

IMPORTANT ANNOUCEMENT!

The Clearinghouse on Supervised Visitation is going to mail out 2 NEW posters that cover great material on Family-Centered Practice and Multiple Intelligences. If you want to receive these you must *email your current mailing address* to Karen Oehme at fsuvisit@aol.com. Be sure to put **SV POSTERS** in the subject line.

(If you have already done this in the last week, you do not need to do it again.)

Monthly Phone Call Survey Results

At December's phone call, the group decided to ask directors if they wanted to change the time of the monthly phone call. The results show that the group would like to try 9:00am on Wednesdays.

See directions for using the new conference line at the beginning of this E press.

Happenings in the Legislative Session:

Sharon Rogers, Legislative Chair for the Florida Chapter of the Supervised Visitation Network, has submitted a bill draft to the Florida Legislature tracking the recommendations of the 2008 Report to the Florida Legislature. Representative Mia Jones (D), of District 14, has sponsored this bill in the House and Senator Stephen Wise (R) from District 5 has sponsored the Senate bill. It should be an exciting process to see it develop during this legislative session. Attached is a copy of the House Bill.

Free Material

Free Special Issue of Child Abuse and Neglect: The International Journal, 1989-2009

Elsevier, the leading publisher of scientific, technical and medical information products and services, recently announced the publication of a freely available Special Issue of Child Abuse and Neglect: The International Journal, 1989-2009 on the 20th Anniversary of the U.N. Convention on the Rights of the Child CRC). The Special Issue aims to celebrate the 20th anniversary of the adoption of the UN Convention on the Rights of the Child. It provides an overview of two decades of development in the areas of child maltreatment research, data collection, and reporting practice, as required by the Convention on the Rights of the Child and will facilitate information and practice exchange to support governments and professionals in their important efforts globally. The Special Issue will be freely available online, to all, for a year, along with Part 2 of the Special Issue, which will be published in January 2010. Part 1 can currently be accessed at: http://www.sciencedirect.com/science/issue/5847-2009-999669988-1554191

New Year's Resolutions

How are you doing with those New Year's Resolutions? Last month we outlined a few ideas for 2010, so take a few minutes to recap.

- ☐ **Participate in the monthly conference calls with the Clearinghouse.**
- ☐ **Keep the Chief Judge and/or Trial Court Administrator updated on your program, resources, and policies.**
- ☐ **Plan at least one seasonal in-service learning opportunity for staff (spring, summer, fall, winter). Call the Clearinghouse if you are looking for ideas.**
- ☐ **Check out the new trainings on the Clearinghouse website that are available for you and your staff. We have new trainings that address Family-Centered Practice and Multiple Intelligences.**

☐ **Make 2010 a happy and safe year for your staff and the children and families you serve!**

How are we at the Clearinghouse doing? Are there new things you would like to see us work on?

NEW DIRECTOR TRAINING ONLINE:

WHAT: "Organizational Diversity: How Florida's Supervised Visitation Programs Can Build Diversity into Every Service"

WHEN: On the Clearinghouse website THIS MONTH! (Check it out after Feb 15)

WHERE: Look under Clearinghouse, then under New Family-Centered- Practice Material. http://familyvio.csw.fsu.edu/SV/nc_prac_mat.php

HOW: It is a PowerPoint presentation, complete with presenter's notes, in case you want to use it to train lead staff.

WHO: For all program directors and lead staff.

WHY: This is an easy way to learn how to expand your program's cultural competency. Plus, there are certificates of completion at the end of the training.

Program News

- Restoration 1, Inc. has moved. Restoration has relocated from Panama City to Tallahassee and is now taking family court cases.

  Restoration 1, Inc
  Stephanie Giles
  603 Franklin Ct
  Tallahassee, FL 32301
  850.765.8040
  restorationsvp@gmail.com
  http://restoration1inc.com/

Thanks to Stephanie Giles for the update!

- Congratulations to Jodi Bixler. Jodi is the director at a new Supervised Visitation Center in east Pasco County.

  East Pasco Visitation Center
  12724 Smith Rd
  Dade City, FL 33525
  352.521.3358
  jbixler@sunrisepasco.org

- Recent news from the January phone conference confirmed that Effective Resolutions of the 6th judicial circuit has closed.

If you have any news regarding SV programs in your area please let us know by emailing fsuvisit@aol.com or calling the Clearinghouse at 850-644-1715.

Save the Date: Orlando Conference

Start looking for funding now!

The Florida Network of Children's Advocacy Centers (FNCAC) is willing to provide us a one-day conference registration of $175 for their annual conference in Orlando on Aug. 4-6, with an SV track on August 5.

Executive Director John Knight will also allow us to have our annual FL chapter meeting there again after the training.

Please plan to attend. Certificates of Training will be provided for all those who attend. If you participate in any of the other sessions, those too will count toward training.

See details at www.fncac.org

High Quality Training Available at

http://www.hunter.cuny.edu/socwork/nrcfcpp/teleconferences/teleconference_schedule.html

2010 NRCPFC Teleconference Series
A Service of the Children's Bureau

We are pleased to announce the 2010 NRCPFC teleconference series.
All calls are held from 3:00 to 4:30 PM EST.

DATE	CALL TOPIC
Wednesday, March 10, 2010	Father Engagement
Wednesday, April 21, 2010	Secondary Trauma
Wednesday, May 12, 2010	Children who Run Away from Care
Wednesday, June 2, 2010	Concurrent Planning
Wednesday, June 16, 2010	Working with Undocumented Families

Each teleconference is designed to provide a forum for participants to share their experiences in implementing improved child welfare practices and to learn about national trends and research findings.

Registration details will be posted online at this site.
http://www.hunter.cuny.edu/socwork/nrcfcpp/teleconferences/teleconference_schedule.html

Please note that there are a limited number of phone lines available for each call. If you would like to include others in the call, we encourage you to invite them to a central location, where they can participate with you using a speaker phone.

Questions? Contact Millicent Williams at 301-649-3572 williamsmgm@gmail.com.

Training Unit

Understanding Caregiver's Experiences in the Context of HIV/AIDS

By: Thola Msani, Laura Cassels, & Mark Stern

Editor's Note: *In the past several years, supervised visitation staff have served clients who are caring for various relatives infected with HIV/AIDS, as well as raising children. It is important to remember the heavy burden that this care has on the caregiver.*

Over the last three decades, HIV/AIDS has proven to be a devastating pandemic. Since it was first identified in 1980, 20 million people worldwide have died of AIDS, while 38 million are currently living with HIV (UNAIDS, 2004). HIV is blind to age, ethnicity, and gender; it affects adults, children, men, women, and every cultural/ethnic group. Across the globe, 1,200 people are infected with HIV everyday. At least 95% of those infected reside in developing countries, and more than 50% are women and young children (Lamptey, et al, 2002).

Approximately every 9.5 minutes, someone in the United States is infected with HIV. In 2006, an estimated 56, 300 people became infected with HIV, and currently more than 1 million people in the United States are living with the virus. One out of five people who are living with HIV are not aware that they are even infected (http://www.nineandahalfminutes.org/get-the-facts.php). In Florida, the greatest numbers of AIDS cases were reported from three counties located in the southeastern part of the state: Broward, Miami-Dade, and Orange. These three counties reported a combined total of 1,758 cases in 2007, which is 46% of the statewide total (http://www.doh.state.fl.us/disease_ctrl/aids/trends/epiprof/mini_aids07c.pdf). In 2005, roughly 49% of the people diagnosed with HIV/AIDS were African American, followed by Caucasian (31%), Hispanic (18%), Asian (1%), and American Indian (less than 1%). Of all the racial ethnic groups represented in the United States, African Americans have been hit the hardest by HIV/AIDS (http://www.cdc.gov/hiv/topics/aa/index.htm). The rate of people living with HIV/AIDS (or PLWHA) among African Americans is estimated to be 17 times greater than that of Caucasians, and 7 times greater than the rate of Hispanic women. (http://www.doh.state.fl.us/Disease_ctrl/aids/Docs/HIV_AIDS_Womens_Report_4_2008.pdf).

The effects of HIV/AIDS are not felt only by those carrying the virus. Communities and families of sufferers are also subject to pain and struggle, often creating an excessive amount of stress and hopelessness for caregivers. Van Dyk (2008) confirms that "AIDS has changed the medical landscape

completely and placed a tremendous burden on the shoulders of caregivers, moreover, this burden is especially heavy in South Africa where the prevalence of HIV and AIDS is very high. Public hospitals across the countries are swamped by patients diagnosed with AIDS related illness…it is estimated that one in every three to four patients admitted to many public hospitals (in South Africa) is HIV positive" (Smith, 2004 quoted in Van Dyk (2008:406).

Who are caregivers?

A caregiver, in the context of HIV/AIDS, is anyone (professional, lay, or family) involved in taking care of the physical, psychological, emotional, and/or spiritual needs of the person coping with HIV/AIDS (Van Dyk, 2008). In the formal health sector, caregivers are usually nurses, counselors, and social workers. However, due to the epidemic rate of HIV infection throughout other countries, formal care is not always an option. According to Van Dyk (2008), caregivers who battle with HIV/AIDS in the formal, as well as informal health sector, consist of the following groups or individuals:

- Heath care professionals (mainly nurses and doctors) caring for AIDS patients in hospitals, clinics, hospices, and home-based care settings;
- Social workers based in hospitals or in government organizations offering support services or counseling to people with HIV/AIDS;
- Volunteers working in a formal capacity for AIDS care organizations that offer various services such as home-based care, spiritual care, and legal advice. Also included are informal volunteers such as friends, neighbors, and church members;
- Educators (e.g. school teachers) supporting orphans and other children with HIV/AIDS;
- Family members who care for sick loved ones in the home. This burden of care is predominantly borne by women, particularly female children who may have to look after a sick parent. Men are also increasingly called upon to care for a sick partner.

The information provided in this article will focus mainly on the informal caregiver's (family member's) experiences. However, some of the issues that caregivers experience in general will be addressed, including coping strategies that caregivers use in HIV/AIDS caring relationships.

African Americans in Florida, the majority of whom are financially disadvantaged, remain particularly affected by the virus; as a result, the burden of care and expense falls almost exclusively on the family caregiver.

Issues that Caregivers Encounter in HIV/AIDS Caring Relationship

There are numerous issues that caregivers encounter while caring for a person with HIV/AIDS. First, caring for people with HIV infection or AIDS puts stress on caregivers that goes beyond that which is experienced when caring for people with other diseases (Van Dyk, 2008:408). This specific type of stress is associated with the stigma attached to having HIV/AIDS, the financial cost involved in HIV/AIDS care-giving, and the psychological and physical implications of caring for a person with HIV/AIDS.

Unfortunately, most people infected and affected with HIV and AIDS are those who have a history of being marginalized, such as blacks, gay men, and the poor. Despite the fact that the epidemic is different in every city and every state, some groups of people are hit harder by HIV than others. In the

United States, gay and bisexual men of all races bear the greatest burden. Hispanic men and black men and women also have a high rate of HIV compared with other racial or ethnic groups. It is important for people to understand that race, by itself, is not a risk factor for HIV infection. Poverty, homelessness, lack of access to health care, incarceration rates, drug use, and higher rates of sexually transmitted diseases (STDs) can all increase rates of HIV (http://www.nineandahalfminutes.org/get-the-facts.php).

Family members with HIV/AIDS who also have the misfortune of being poor often experience an extra burden because "poverty involves a great deal more than inadequate income or consumption, it is not simply about being deprived of necessities such as food, medicine and clothes, but is often also about living in a situation of: hopelessness, uncertainty about the future and alienation from 'mainstream' society" (Aliber, 2001).

Physical Impact of Caring for Person with HIV/AIDS

Abraham (1997) indicates that individuals who deal with chronic and debilitating illnesses often "prefer to be cared for in their own home, and by the people, they know. In most cases, family members take the position of caring for their loved one in the context of HIV/AIDS. Family members feel obligated to care for, love, and support their loved ones when sick." Women in particular have historically played an active role in caring for their sick loved ones. Studies have shown that married men who are ill and being cared for at home are most likely to have their wife as caregiver. Men are less likely to be open about their HIV status and seek external support; therefore, they often rely on the commitment and discretion of their wives to care for them.)

Many caregivers are simultaneously raising children, and trying to earn a living. This places an inordinate amount of stress on the caregiver.

There are many tasks involved in caring for sick individuals. These include cooking, feeding, bathing, dressing, laundering, and helping the patient to use the bathroom. Health needs must also be met, such as administering medication at home, accompanying the patient to health facilities, and providing psychological and moral support. It is more demanding for caregivers when the sick family member is unable to bathe or dress him/herself as the caregivers spend most of their time taking caring of their loved one and neglecting their own needs. This can result in negative effects on their own health and well-being. Moreover, when the family member has moved from HIV to AIDS, there is a likelihood they she/he will loose contact with reality or experience mental disturbances. This may result in 24-hour care, which is both physically and emotionally demanding for caregivers.

Caregivers in the formal sector (nurses, counselors, and social workers) experience similar issues of demands and stress when working with patients who have AIDS. Caregivers working in the AIDS context are prone to occupational stress, which often leads to burnout. This can be described as the end stage of a chronic process of deterioration and frustration in the individual worker, due to chronic emotional and interpersonal stressors in the work situation (Miller, 2000:28).

Psychosocial Implication of Caring in the Context of HIV/AIDS

Bartlett and Finkbeiner (2006:5) confirm that "people affected by HIV infection face greater emotional strain than most people ever do… those affected by the disease are shocked or angry or depressed or afraid or guilty or confused or have any number of these emotions at once." Family members who are caregivers are placed in an extremely difficult situation when caring for their loved one; it is even more difficult when the stricken family member was the household's main source of income. Furthermore, even after the individual has passed, HIV/AIDS continues to place a tremendous burden on caregivers as they experience the process of grief and bereavement.

In the process of caring for persons with HIV/AIDS, caregivers spend most of their time and energy looking after the patient; this may result in a lack of human interaction, which can create a sense

of isolation. When there are children at home, they may feel lonely or neglected because the focus is continuously on the sick family member. In addition, stigma and discrimination in the context of HIV/AIDS is experienced not only by the infected individual but also by the caregivers. Stigma is described as a quality that discredits an individual or group in the eyes of others, while discrimination is described as any type of treatment based on difference or inequality that puts a person at a disadvantage (Link, 2000; Crawford, 2002).

Financial Implication of Caring for Person with HIV/AIDS

Family caregivers are often unseen and undervalued, and as a result the stress that is associated with care-giving is over looked. Naidu (2004: 20) indicates that "family members are experiencing direct and indirect cost when caring for HIV/AIDS-infected individuals. The direct cost is the out-of-pocket cost to the household, which is actual expenditure on goods and services purchased." In addition, Booysen et al (2002:109) state that "indirect costs are mostly associated with loss of earning for the person and the caregiver."

There is no cure for HIV/AIDS; consequently medication is the only option for people who are infected by the virus. HIV/AIDS medications are very expensive and are only available to those who are meeting the established criteria. In most cases, medications have other adverse effects on individuals which can cause other types of sickness. Caregivers are then responsible for further supporting their loved one physically, emotionally, and financially. In some instances, it becomes an even bigger burden for those who are already under financial constraint. Caregiving expenses related to nutrition, transportation, and daily living are a constant consideration (Kasiram et al, 2006: 83). The financial implication is not only an individual issue for the caregiver; it becomes a global concern when considering the huge numbers of people infected with HIV/AIDS.

Coping Strategies in a Caring Relationship

Coping strategies refer to the specific efforts, both behavioral and psychological, that people employ to master, tolerate, reduce, or minimize stressful events. Two general coping strategies have been distinguished: problem-solving strategies and emotion-focused strategies. Problem-solving strategies are efforts to actively alleviate stressful circumstances, whereas emotion-focused coping strategies involve efforts to regulate the emotional consequences of stressful or potentially stressful events (http://www.macses.ucsf.edu/Research/Psychosocial/notebook/coping.html).

Several researchers have observed that the masking and controlling of emotions is one of the coping strategies used by caregivers, including family members. Moreover, Lazarus and Folkman (1984) state that "one of the factors that influences an individual's coping strategy is self-control, putting a brave face and concealing their hurt, anger and disappointment, or anxiety," which helps them to function best. Being in control helps them to have hope about the future and encourage perseverance under difficult circumstances.

Bartlett and Finkbeiner (2006) mention that "people affected by HIV infection face greater emotional strain than most people ever do […] [but] with time, people come to deal with these worries and emotions, using the same strategies that have worked for them in all their previous periods of difficulty." Faith and prayer have been identified by many researchers as two of the coping mechanisms that caregivers typically apply in their life situations. Furthermore, researchers, such as MelNick, 2002& Catalan et al, 1996 confirm that "faith and religion is the coping mechanism employed in the arena of HIV/AIDS."

AIDS kills ten times more people than war each year (Barnett, T., White, A., 2002). In Florida, African Americans, the majority of whom are financially disadvantaged, remain particularly affected by the virus; as a result, the burden of care and expense falls almost exclusively on the family caregiver. Stress and fear about the future has been identified by researchers as a major issue among caregivers,

especially since there is still no cure for HIV/AIDS. There is more that can be done in assisting care-givers in their relationships with infected family members, such as support groups, financial assistance, and respite care. Van Dyk (2008) confirms that "caring for HIV/AIDS individuals is very demanding and they need physical, emotional, psychological and spiritual care."

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Refugee Families at Supervised Visitation

By Kelly Mayor

Introduction

Over 60,000 people were admitted to the United States as refugees in 2008. Visit monitors may face unique challenges in serving refugee clients. This short training will help identify some of those challenges.

Overview

This training will assist monitors in understanding common problems faced by refugees when assimilating to American culture. It also offers visit monitors some perspective of a culturally competent visit service.

Objectives

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

1. Explain why a refugee may come to the United States;
2. Identify common characteristics of today's refugees;
3. Discuss challenges that refugee parents face in adjusting to American culture;
4. Discuss challenges that refugee children face; and
5. Identify ways that monitors can be culturally competent when working with refugees.

Snapshots

- According to the US Department of State data from 2008, 30% of refugees were from Burma, 23% were from Iraq, 9% were from Bhutan, 9% were from Iran, 7% were from Cuba, 5% were from Burundi, 2% were from Vietnam, 2% were from Ukraine, and 2% were from Liberia. The remaining refugees are from other countries across the globe.
- In 2008, 57% of refugees were single, and 38% of refugees were married (a small percentage is unknown).
- The two states where the most refugees settled were California (16%) and Texas (9%). Other states where refugees decided to live included Florida (6%), New York (6%), Michigan (6%), and Arizona (5%).

Who is considered a refugee?

According to the Immigration and Nationality Act, a refugee is someone who is "unable or unwilling to return to his or her country of nationality because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion." Refugees must submit an application while they are living in their native country in order to be allowed to come to the United States.

What is an asylee?

An asylee is someone who seeks asylum in the United States. This is similar to a refugee except that the person applies while they are in the United States, whereas a refugee applies while in their country of origin. Of those granted asylum in 2008, 24% were from China, 7% were from Colombia, 5% were from Haiti, and 5% were from Venezuela. About 20% of the asylees in 2008 took up residence in Florida.

Most Common Countries that Refugees Come From

In order to become more culturally competent when working with refugees, it is helpful to know some information about their background. The following information will help monitors to become more familiar with the countries that refugees are most likely to come from.

Burma (Myanmar)- In 2008, 30% of refugees coming into the United States came from Burma, also known as Myanmar. Burma is located in Southern Asia, between Thailand and Bangladesh. The Burmese government has been exploiting its citizens through physical abuse, sexual abuse, forced labor, excessive taxation, and restriction of freedom. Currently the military junta in Burma is using the country's natural resources to pay for excessive military and corruption, while decreasing support to food production. Most refugees from Burma will never be able to return back home. The primary language spoken by these refugees is Burmese.

Iraq- About 23% of refugees were from Iraq in 2008. Millions of Iraqis have fled their homes during the past seven years. According to Refugees International, the government in Iraq lacks the capacity to address the humanitarian needs of its residents. Iraq has a major lack of security and ongoing violence, especially in the central providences. There is also a lack of jobs and basic social services. The primary language spoken by these refugees is Arabic.

Bhutan- 9% of refugees were from Bhutan in 2008, and this percentage is expected to increase in the next few years. Bhutan is a very small Buddhist country that is located between India and China. Beginning in the early 1990s, Bhutan began to exile the Nepalis, who are the ethnic minority, in an attempt to create a homogenous culture. The primary language spoken by these refugees is Dzongkha.

Iran- 9% of refugees were from Iran in 2008. Many of the Iran refugees originally fled from Afghanistan and are now being deported by Iran. Iran is located in the Middle East. The primary language spoken by these refugees is Farsi, although Kurdish is also spoken.

Cuba- 7% of refugees were from Cuba in 2008. Since 1959, Cubans refugees have tried to escape Cuba's communist regime. Since Cuba is only 90 miles south of Florida, many Cubans fled by using rafts or small boats and have settled in Florida. The primary language spoken by these refugees is Spanish.

Burundi- In 2008, about 5% of refugees were from Burundi. Burundi is located in central Africa, just south of Rwanda. Between 1972 and 1993, over 700,000 Burundians were forced to flee due to widespread genocide. Although a ceasefire was implemented in 2005 and the violence has greatly decreased, Burundi still remains a poverty-stricken country that greatly lacks resources. The primary language spoken by these refugees is Kirundi, although French is also spoken by many people.

Refugee Children

Refugee children may remember living in an unsafe environment while growing up in their country of origin. They probably lacked adequate food or shelter. They may also have witnessed violence, acts of war or genocide, or famine. Refugee child may have lived in refugee camps before coming to the United States. Everyday aspects of life were probably uncertain, and basic necessities may have been very limited. Children are often required to fulfill adult roles, especially if they have younger siblings. These experiences may cause children to lack trust and to view the world as an unstable, scary place that they have no control over. Research indicates that refugee children are often anxious and may have difficulty sleeping, appear tense, and be easily startled. They may have difficulty with impulse control because they are always in "survival mode" and do not feel safe.

Adjusting to American Culture

Refugees may have problems readjusting to American culture, since it may be extremely different from their country of origin. Many refugees have concerns about their ability to discipline and receive respect from their children. According to interviews with refugee parents by BRYCS (Bridging Refugee Youth Children's Services) staff, most parents knew that corporal punishment was

discouraged in the United States, but several parents viewed alternative discipline methods as ineffective. Refugee parents may be afraid that if they do not use corporal punishment, their children will become disrespectful. Being respectful towards elders is often very important in the countries from which where refugees may come. Refugee parents may fear that they will not be able to control their children and that they will be looked down upon by their other family members for not raising disciplined children. Refugee parents may view American citizens as having disrespectful children who talk back to their parents.

Refugee parents must also deal with the different roles of family members present in American culture. Refugees often come from countries where hard work of all members, including children, is emphasized. Refugee parents may feel that American children spend too much time playing and that they do not have enough chores or responsibilities. This can create family conflict, especially as the children of refugees learn about the responsibilities that their American friends may have.

Refugees also noticed the emphasis of American culture on independence. In many other countries, there is the belief that children belong to the extended family. Adult children often remain very close to their parents and do not move away. This may create problems if the teenagers of refugees plan to move away for college, as is common in American culture. Some refugee families struggle with balancing their two cultures. Protective factors in refugee families that reduced the likelihood of child maltreatment include having social connections, knowledge of parenting, support in times of need, knowledge of child development, and parental resilience.

Cultural Competency

It is important for monitors to be aware of their own cultural biases when interacting with refugees who may come from an unfamiliar culture. Monitors should be cognizant of some common cultural differences, so that they are not perceived as being disrespectful to the family's customs or culture. Monitors should try to accommodate certain customs, so that the family can feel more comfortable. For example, certain cultures perceive having too much eye contact as a sign of disrespect, whereas in American culture eye contact is usually viewed as a sign of respect. If a refugee family is not giving the monitor much eye contact, the monitor may want to reduce their eye contact with the family so that the family will be more comfortable in their environment. Also, the amount of personal space desired by a refugee when dealing with service providers often varies with the person's culture. Monitors can accommodate this cultural difference by letting the family members decide the amount of personal space they need in order to feel comfortable. In some American cultures, it is common to touch people on the arm while talking to them. However, monitors may want to avoid physical touch with refugee families because the families may feel uncomfortable with that amount of closeness between strangers. When working with people from different cultures, it is important to let them decide the amount of closeness they feel comfortable showing.

Case Example & Discussion Questions

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

35 year old Mr. Nyein is visiting his 14 year old son, Maung, and his 6 year old daughter, Cho, at the visitation center. The family members are refugees from Burma who came to the United States two years ago. Mr. and Mrs. Nyein were divorced over a year ago, and the children live with their mother. Mr. Nyein has been accused of being a chronic alcoholic. He had been involved in a car accident with the children and was charged with DUI. The driver of the other car was severely injured. After the accident, the court ordered supervised visitation pending the outcome of the criminal case against Mr. Nyein.

Although the visit monitor tried to be very friendly while introducing herself before the first visit, Mr. Nyein was reluctant to shake her hand and would not make eye contact with her. The monitor perceived Mr. Nyein as being very rude, and she glared at him during the visit. The children asked their father why "the lady" didn't like him.

During the visit, Mr. Nyein asked his children many questions about the chores they had been doing while staying with their mother. He scolded Cho for not helping out more around the house. He told her that she was lazy to spend the day "socializing" at school. Mr. Nyein told Maung that it was time for him to act more like a man and that he should go look for a job to help out the family. Mr. Nyein stated that he started his first job in the rice fields when he was only 7 years old. He told his children that they were being spoiled by the public school system, which allowed them sit around all day long.

The visit monitor wrote: "Mr. Nyein continuously made negative comments to the children during the visit. He nagged them about their lives, and shamed them in front of the other children in the room. They seemed afraid of him."

Questions for Discussion

1. What might be affecting the visit monitor's perception of Mr. Nyein?
2. Why do you think Mr. Nyein believed that his children were being lazy?
3. How might the visit monitor have handled the situation differently?

Possible Answers

1. The monitor may feel that Mr. Myein is uncooperative during the service. She may also mistake his statements for verbal abuse, or humiliation. Instead, he may be trying to parent his children, and guide them. This does not mean that the monitor must tolerate yelling or abusive language.
2. Mr. Nyein may believe that America is spoiling his children. He grew up working hard, and he may believe that his children are not receiving the direction they need to grow up to be responsible adults.
3. This case scenario highlights the importance of communication, which begins at intake. SV staff should sit with Mr. Nyein and talk about his expectations for the visit. They should also ask him how he wants to be addressed, and talk about how the program staff care about being sensitive to any cultural difference that might exist between staff and the family. Staff should look for cues in eye contact, and refrain from forcing Mr. Nyein to look eye to eye during conversation. Staff should help Mr. Nyein choose activities for the visit, and should re-direct him if his discussions with the children seem to upset the children. Although he can't be allowed to traumatize or threaten them during visits, there is some room for him to discuss his feelings with his children. If the visit monitor writes down statements, they should not be summaries, but the actual words, with context, if possible, for clarity. There are many different types of parenting styles, and SV staff should be sensitive to those differences, absent abuse.

Quiz

1. What are some reasons that a refugee may have fled their country of origin?
2. What countries are refugees coming into the United States from? Name two countries and in which part of the world they are located.
3. What are some challenges that refugee parents face when adjusting to American culture?
4. How can visit monitors be respectful of a refugee's family's culture and customs?
5. What challenges do refugee children face?

Answers

1. Refugees may have fled their country of origin due to persecution based on race, ethnicity, religion, or membership in a political group. Oftentimes their country of origin is very violent and dangerous, and there may be a lack of food and jobs.

2. Most refugees in the United States are coming from Burma/Myanmar (Southern Asia), Iraq (Middle East), Bhutan (in between India and China), Iran (Middle East), Cuba (south of Florida), and Burundi (central Africa).
3. Parents must readjust to differences in gender roles, parenting styles, language barriers, customs, and the American emphasis on independence.
4. Let the refugee family determine what amount of eye contact, personal space, and closeness is the most comfortable for them. Be respectful of the family's cultural differences.
5. Refugee children may come from a violent country with little food or resources. Children may be fearful and anxious around new situations. They may be required to fulfill adult roles, such as translating for their parents. They may have difficulty with impulse control.

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MARCH 2010 EPRESS

****Please note the changes to the upcoming phone conferences, identified in the boxes below.****

MARCH PHONE CONFERENCE
WEDNESDAY, MARCH 17

*****9:00AM, EST*****
NEW PHONE NUMBER!!
DIAL 719-457-0816 TO PARTICIPATE, YOU WILL NEED TO ENTER A PASS CODE TO PARTICIPATE. THE PASS CODE IS 635786#

NOTE: THIS IS A NEW TIME AND NUMBER! – DIFFERENT FROM FEBRUARY

APRIL PHONE CONFERENCE
WEDNESDAY, APRIL 14

*****9:00AM, EST*****

DIAL 719-457-0816 TO PARTICIPATE, YOU WILL NEED TO ENTER A PASS CODE TO PARTICIPATE. THE PASS CODE IS 635786#

NOTE: THIS IS A NEW TIME AND NUMBER!

IMPORTANT ANNOUCEMENT!

The Clearinghouse on Supervised Visitation has mailed out 2 NEW posters that cover great material on Family-Centered Practice and Multiple Intelligences. If you want to receive these, you must *email your current mailing address* to Karen Oehme at fsuvisit@aol.com. Be sure to put **SV POSTERS** in the subject line.

(If you have done this in the last month and received your posters, you do not need to do it again.)

South Florida Training: Who's Interested?

Ft. Pierce vs. Miami

As you know, we do not have any funds for training conferences. However, from time to time, directors offer us a space to come and train, and we accept the offer. This last occurred in September, when Trish Waterman reserved the Children's Bureau Conference Room and over 60 people from around the region came to be trained on Family-Centered Practice.

Now the Valued Visits Program in Ft Pierce (St. Lucie County) is offering to pull together a South Florida Training at the end of March. In order for this to work, we need to have at least 25 people interested in the training, and willing to drive to Ft Pierce for one day.

If you did not come to Tampa, can you come to Ft Pierce? If you are likely to come to a South Florida training on Friday, March 26, please send me an E mail immediately. I only want Jenene McFadden to plan this if there are enough Southeast Florida people interested.

Alternatively, if you can't come to **Ft. Pierce, would you come to a Miami training?**

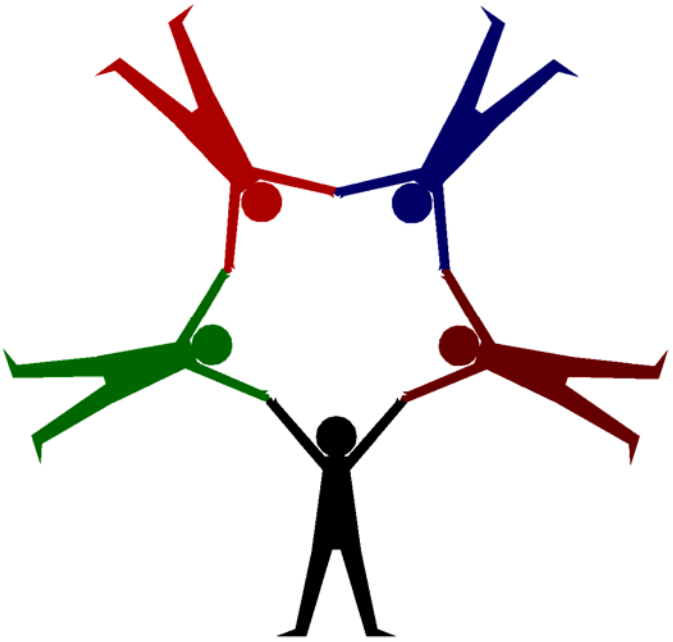
The training topics will include professionalism, safety, ethics, and Family-Centered Practice.

Please email me about **which training** you could come to.
Thank you! My email is fsuvisit@aol.com or koehme@fsu.edu

A Gold Mine of Audio Free Trainings

The National Resource Center for Permanency and Family Connections hosts a series of teleconferences for state program managers in foster care and adoption and for others working, involved, or interested in the field of child welfare. These calls provide information on topics of interest in child welfare to participants. You will be amazed and delighted at the marvelous range of trainings available. So click on this link and start planning your in-house in-service trainings!
http://www.hunter.cuny.edu/socwork/nrcfcpp/teleconferences/rss.xml

Permanency: More than Just Homes



This article on achieving timely permanency intended for CASA volunteers also offers guidance to child welfare workers and others. Permanency: More Than Just Homes was authored by Martin Westerman.

The article begins by describing the importance of permanency for foster children, and goes on to detail several concrete strategies for practice, including concurrent planning and dual licensing of foster and adoptive parents.

Two tools are described for identifying important connections and potential permanency options for children who cannot reunify: The Connectedness Map, developed by Santa Cruz County, California helps children identify their important personal connections, which are then noted and color coded to describe biological, love, spiritual and mental relationships.

A Connections Circle tool utilized in a National CASA research study is another method to assist young people in identifying their important relationships, and the degree of closeness of each one. Permanency: More Than Just Homes appears in the Summer 2009 issue of The Connection, published by the National CASA Association.

http://nc.casaforchildren.org/files/public/site/publications/theconnection/Summer2009/Connection_CoverStory_Summer2009.pdf

Developing Permanent, Supportive Connections While in Care: Foster Youth's Perspectives

A recent California study examined the experiences with permanency services of youth in foster care, as told by the youth themselves. The findings are reported in Developing Permanent, Supportive Connections While in Care: Foster Youth's Perspectives, authored by Sonja T. Lenz-Rashid and available from the Child & Family Policy Institute of California.

The study gathered information from 27 young adults regarding the child welfare permanency services they had received while in foster care. As a central finding, most of the youth reported that they did not receive support from their child welfare workers about making connections to family or other adults while in care.

To improve permanency services, the report recommends the following action steps for child welfare agencies: Implementing "Family and Permanent Connection Finding" services for youth in foster care who are not placed with kin, especially those over age 13; training new social workers, supervisors, and managers about the importance of promoting family placements; assigning siblings in foster care the same social worker; ensuring all foster care youth have a voice in their placements; linking youth with mentors in the community.

www.cfpic.org/pdfs/Permanency-Report-Lenz-Rashid092009.pdf

$30 Webinars on Family Issues

The American Humane Association has high quality webinars for $30 per line. You can train an entire group for $30. Participants will learn practices that have enhanced the engagement process between child welfare practitioners and their clients. http://www.americanhumane.org/protecting-children/conferences-trainings/family-group-decision-making-teleconference-series.html

A Reminder of Danger:

Police: Man stabs, kills estranged wife at Walmart

Associated Press

Mon Feb 15

SUWANEE, Ga. – Police in Georgia say a man stabbed his estranged wife to death in a Walmart parking lot where they met to exchange custody of their two children.

A Suwanee police news release says the couple began arguing Sunday outside of the store in the city about 30 miles northeast of Atlanta.

Phillip Chad Dunn, 28, of Lawrenceville stabbed his wife during the argument then stabbed himself, according to the

release. Police say Shelley Dyan Dunn, 27, of Buford, died of her wounds at a nearby hospital.

Police say their children were present. Their ages weren't immediately disclosed.

Phillip Dunn was in custody and expected to survive.

Police Captain Cass Mooney says charges were pending Sunday night against Phillip Dunn. Mooney didn't know if he had a lawyer.

DCF Family Safety Training Video Summaries

The Center for Child Welfare has posted videos of January 2010 Regional Training – Child Welfare Professional Development Series on its website (http://centerforchildwelfare.fmhi.usf.edu/videos/Pages/famsafety.aspx). Below are short summaries of the training videos that may interest you. Each video runs 1-hour, 1.5-hours, or 2-hours. Most come with downloadable PowerPoint Presentations that the presenters use. Feel free to use these summaries to find the sessions that best meet your needs before you dive into watching all of the videos. THEY ARE FREE!!

DCF Regional Training: General Welcome Session

The welcome is a short 5-minute video introducing the conference sessions and the topics that will be covered. The importance of Family-Centered Practice is emphasized noting that it is the foundation and framework around which all workshops are designed. As speakers from various backgrounds are introduced the importance of collaboration is stressed as a crucial element to a successful experience for these families.

Another Planned Permanent Living Arrangement (APPLA) as a Permanency Goal: What Does it Mean?

This presentation on Another Planned Permanent Living Arrangement (APPLA) as an alternate permanency goal outlines Florida Statute 39.6241. An emphasis is placed on proving the suitability for APPLA placements as a placement option preferentially preceded by reunification, adoption, permanent guardianship, or permanent placement with a willing and fit relative. Therefore, conditions under which APPLA is acceptable, as well as compelling reasons and benefits for which such placements are pursued must be determined according to specified Florida statutes. Included in the presentation is a checklist for professionals seeking to place a child in an APPLA where no other form of placement is feasible. The checklist serves as a tool which outlines all information needed in order to assess whether an APPLA is an appropriate placement for a given child.

The Baker and Marchman Acts

In this two-part presentation on the Baker and Marchman Acts, a brief introduction and history on the Baker Act (1972) is provided. The subjects covered include explanations concerning the meaning of the Baker Act and several reasons for its development. Rights of persons receiving treatment for mental illnesses are explicitly stated and defined within the context of voluntary and involuntary mental health clients. In the second part of the presentation, the Baker Act and Marchman Act (provisions for involuntary assessment and treatment for substance abuse) are compared and contrasted. A further explanation about the Marchman Act is also provided with such highlights as non-court options, emergency admissions, parental participation in cases involving minors, court options, provider-initiated petitions, involuntary and voluntary assessments and stabilizations, as well as court-ordered and involuntary treatments.

Children at Risk: Understanding Substance Abuse and Facilitating Recovery – A Guide for Child Welfare Workers

In this online training viewers are exposed to the statistics of substance abuse and their impact on children. Further information is provided on the many aspects of child development, from prenatal to adolescence, and on cognitive, behavioral, health, and the emotional impact of parental substance abuse. The speaker outlines the difference between substance abuse and substance dependence, the prevalence of co-occurring disorders, and many tips/best practices to use when working with these families and children. Things to be aware of that are mentioned include cultural sensitivity and motivational strategies for change. All in all this is a very solid training that emphasizes the importance of collaboration as we work with individuals and families through treatment and support services.

Federal Funding: Basic Expectations and New Title IV-E Implications from the "Fostering Connections" Act

Perhaps one of the more technical presentations, the Federal Funding session focuses on the IV-E foster care and IV-E adoption subsidies. The most drastic change that workers will notice is that the system has moved to an automated system for efficiency. Major areas covered are the responsibilities for Child in Care (CIC) staff, Community Based Care (CBC) staff, and Revenue Maximization staff. Additional topics for Aid to Families with Dependent Children included judicial, technical, and financial requirements as well as applicable child requirements. Exercises provide the opportunity for multiple people to engage with the topic and finally, helpful hints conclude the presentation.

Florida Safe Families Network (FSFN) 2010: Integration and Alignment

This video walks through the implementation of FSFN Policy. It outlines important aspects of this policy to clear up any confusing aspects or misunderstandings, such as safety planning, the family assessment, and the case plan. It also walks through the Unified Home Study and the Reunification Study. This video also specifically addresses inquiries about the Firearm policy and Race and Ethnicity categorization.

Foster Connections to Success: Educational Requirements and the Law and How the Interagency Agreement Can Help You Meet Those Needs

In this session the speaker takes you through the impact foster care potentially has on school change for children. Recognizing that this is an often difficult time, stability should be a primary focus for working with children. In order to provide the best services that can ensure stability while at school the legal statutes are reviewed, followed by ideas and strategies for services that could be helpful including various links that connect you with sites designed to “foster connections” for school stability and success.

Preparing Youth for Court

This video stresses the importance of involving children in the dependency process. It describes some of the resources available to help all persons involved better understand the dependency process, including books for elementary aged children, brochures for older youth, brochures for parents, brochures for caregivers, and a video that describes the dependency process and key players aimed at youth. The video then spends time describing and discussing cases, highlighting the reasons it is important for the children to be involved in their dependency process.

Psychotropic Medications Institute

This presentation discussed the issues surrounding prescribing medication to children with psychiatric disorders. There was an emphasis on understanding that not all behaviors from children are a result of mental illness and should not be treated as such. Also highlighted was the importance of including all appropriate parties in the process of assigning medications to children. The speaker covered the seriousness of authorization, parental consent, and proper documentation which are all crucial aspects of administering medications to children.

What Lawyers Can Do for Youth with Development Disabilities and Cognitive Impairments

This presentation explored the aspects of transition planning for youth with disabilities who are about to turn 18 years old. Alternatives were given for youth who have either been adopted out or have not been adopted out via the system. Also discussed were advanced directives, different types of guardianships, benefits, social security regulations, and different resources, including housing opportunities, available to these youth with disabilities as they are about to transition.

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1206 Third Street, San Rafael, CA 94901
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NATIONAL COALITION AGAINST DOMESTIC VIOLENCE
NCADV
Every Home A Safe Home
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Family Courts Implicated in Infants' Murders: Two Young Boys Killed by Two Divorcing Dads in Past 10 Days, Points to Massive System Failure

SAN RAFAEL- National and local advocacy groups are expressing outrage over what has become a disturbing national trend of divorcing Dads killing their children and themselves. 8-month-old baby Bekm was shot and killed by his father, Nicholas Bacon, in Meridian, Idaho just 48 hours ago, while 9-month-old baby Wyatt was killed by his father Stephen Garcia just ten days ago in San Bernardino County. Details are still emerging about the tragic Idaho murder-suicide of baby Bekm on Monday night.

In the Garcia case, three different judges refused multiple requests by the child's mother for restraining orders to protect her child, despite police reports and documented death threats by the father in text messages and on Facebook.

"The system failed Wyatt Garcia and Katie Tagle," said California Assemblymember Jim Beall, Jr., the lead sponsor of Assembly Bill 612, which aims to prevent the use of non-scientific theories in California family courts. "Wyatt's tragic death was completely avoidable."

Numerous sources report a significant spike in murder suicides across the country by violent fathers who kill their children and themselves, frequently after mothers' requests for protection of their children are denied by family court judges. In addition, the Leadership Council on Child Abuse & Interpersonal Violence estimates that more than 58,000 children per year in America are ordered by family courts into unsupervised contact with physically or sexually abusive parents following divorce.

"The time has come for us as a society to speak out and put a stop to this growing national body count. Across the country, women and children are being killed because of judges' personal biases and junk science that tells them to disbelieve women's legitimate claims and evidence of abuse," said Rita Smith, the Executive Director of the National Coalition Against Domestic Violence.

According to court transcripts and eyewitness accounts, judges reacted with disbelief when mother Katie Tagle presented them with evidence of death threats against her son by the father.

Judge David Mazurek stated, "I get concerned when there's a pending child custody and visitation issue and in between that, one party or the other claims that there's some violence in between. It raises the court's eyebrows because based on my experience, it's a way for one party to try to gain an advantage over the other," he said.

"This attitude permeates the courts, that women are lying about the danger they are in," said Kathleen Russell from the Center for Judicial Excellence. "This attitude causes judges to ignore tangible evidence of death threats and abuse. The abusers' lobby has convinced judges that shared custody is always the answer, and sadly, this case points out how deadly that approach can be," she said.

According to a family member who was in the courtroom when Ms. Tagle last sought protection for her son, the judge reportedly said, "One of you is lying, and I think it's you," while pointing at Katie. Transcripts from this hearing are not yet available.

The National Coalition Against Domestic Violence and the Center for Judicial Excellence are part of a growing national advocacy movement to educate the public as well as litigants, lawmakers, judges, and social service providers about the need for comprehensive family court reform. The Center for Judicial Excellence and their allies worked with California State Senator Mark Leno and others to pass an audit request through the state legislature last July. The California State Auditor is currently investigating the use of court appointees in family courts because of growing evidence that children are being harmed there. The California Legislature is slated to consider additional family court reform bills being presented by the Center and the California Protective Parents Association in the coming months.

"We must assess what's happening in our family courts, and that's why I've requested a state audit to take a hard look at the performance and effectiveness of the family court system," said Assemblymember Beall.

The State Auditor's report about the California Family Courts has an expected release date of June 2010.

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NCADV - The Mission of the National Coalition Against Domestic Violence (NCADV) is to organize for collective power by advancing transformative work, thinking and leadership of communities and individuals working to end the violence in our lives.

CJE - The Center for Judicial Excellence (CJE) was established to improve the judiciary's public accountability and strengthen and maintain the integrity of the courts. CJE has made a special commitment to protect the rights of children and other vulnerable populations in the courts.

Clearinghouse Training

Personality Disorders and Supervised Visitation

By: Heather Howard

Introduction

Children who utilize the services of supervised visitation have often been exposed to traumatic experiences at home. This trauma can be increased when one or more parent has a personality disorder. A child may feel responsible for a parent's condition or may be confused about a parent's behaviors: these are just two ways that children can be impacted.

Supervised visitation programs allow parents and children to interact in a safe environment. However, when this interaction involves a parent with a personality disorder, there is a possibility that contact may negatively affect the child. Safe interaction is more likely to occur if visit monitors understand personality disorders, the side effects that are associated for their treatment, and the possible risks involved for children whose parents are afflicted.

Overview

This chapter provides an overview of personality disorders. It also discusses how children who have parents with a personality disorder are impacted. The

information provided is intended to help visitation staff anticipate and react to the behavior of those with personality disorders.

Objectives

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

1. Define a personality disorder.
2. Discuss likely causes of personality disorders.
3. Discuss the prevalence of personality disorders and who is at risk.
4. Define each cluster and type of personality disorder and the symptoms that are associated with each.
5. Understand how children of parents with personality disorders are affected.

Snapshots

- Most people with a personality disorders are distressed about their lives and have impaired work and or social relationships. They are often infuriating to people around them, including their own doctors.
- People with a personality disorder might have inconsistent, detached, overemotional, abusive or irresponsible styles of parenting. This can lead to physical and mental problems in their children.
- Many people with personality disorders were also found to have co-occurring major mental disorders such as anxiety disorders, impulse control disorders, and substance abuse or dependence. (National Institute of Mental Health, 2007)
- Personality disorders can be anywhere from “mild” to more severe in regards to what extent a person exhibits features of the personality disorder. (Dombeck, 2005)

What is a Personality Disorder?

- A personality disorder is:
    - An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, had an onset in adolescence or early adulthood, is stable over time, and leads to distress and impairment (The Diagnostic and Statistical Manual Disorder, 4th Ed).
- People with a personality disorder often have difficulty dealing with other people and are unable to respond to the changes that life brings.
- A person with a personality disorder may:
    - Have a narrow view of the world

- Continuously see their way of thinking as the right way
- Find it difficult to engage in social activities although they feel that their behavior patterns are “normal” and “correct”.

Causes of Personality Disorders

- The exact cause of personality disorders are not known however, it is thought that an individual develops a personality disorder due to:
  - exposure to one or many traumatic environmental factors
  - biological/genetic factors, or
  - a combination of the two.
- In some cases, environmental factors may cause or trigger a person to develop a personality disorder who is already genetically vulnerable to develop a personality disorder.
- Examples of environmental factors that MAY trigger an individual to develop a personality disorder:
  - Verbal, physical or sexual abuse during childhood
  - An unstable or chaotic family life during childhood
  - Being diagnosed with childhood misconduct disorder
- Diagnosed childhood misconduct disorder is a psychiatric syndrome that occurs in childhood and adolescence. It is characterized by a longstanding pattern of violations of rules and antisocial behavior. Features of it include aggression, theft, lying, and violating rules. (American Family Physician, 2005)
  - Loss of parents through death or divorce during childhood
- Studies on twins who were separated at birth and were exposed to different environmental factors have shown that genetic factors contribute to the cause of personality disorders. (American Journal of Psychiatry, 2003)
- Traumatic brain injury is often thought to be another reason for an individual to develop a personality disorder. However, it is debated whether the brain injury is the reason for the personality disorder or other factors that accompany the disorder such as pain, losses and hopelessness. (The Journal of Neuropsychiatry and Clinical Neurosciences, 2000)
  - A study on 100 individuals with traumatic brain injury showed that 66% of them suffered from a personality disorder after their injury. The most common were:
    - Borderline personality disorder
    - Obsessive compulsive disorder

- Paranoid, avoidant and antisocial.

Who is Affected by Personality Disorders?

- Personality disorders are prevalent worldwide and affect 10 to 13 percent of people at some point throughout their life.
- About 9 percent of people in the United States have a personality disorder. (National Institute of Mental Health, 2007)
- Risk factors for personality disorders include being Native American or Black, being a young adult, having low socioeconomic status, and being divorced, separated, widowed, or never married.

Classification of Personality Disorders

Personality disorders are grouped in three separate clusters:

- Cluster A
- Cluster B
- Cluster C

- **Cluster A: These personality disorders are characterized by odd or eccentric behaviors. This includes**:
  - Paranoid personality – People with a paranoid personality disorder may show characteristics involving:
    - Distrust and suspicion of others
    - Believing that others are trying to harm them
    - Emotional detachment
    - Finding hostile or malicious motives behind other's actions and will retaliate in ways that others find baffling.
    - This behavior leads to rejection, which justifies original assumptions.
    - Are unable to see their role clearly in a conflict
  - Schizoid personality – People with a schizoid personality disorder may show characteristics involving:
    - Being socially and emotionally detached
    - Lack of interests in social relationships, fear of intimacy
    - Limited range of emotional expression
    - Being emotionally cold
    - Inability to pick up on social cues

        - Appear dull or indifferent to others
        - Absorbed with their own thoughts and feelings
    - Schizotypical personality – People with a schizotypical personality disorder may show characteristics involving:
        - Socially and emotionally detached
        - "Magical thinking"-Believing that they can control someone or something.
            - Example: Someone may think they can harm someone else by thinking angry thoughts.
        - Peculiar dress, thinking or behavior
        - Display oddities of thinking, perceiving and communicating (similar to those with schizophrenia)

Note: Schizotypical personality is sometimes present in people before they develop schizophrenia but most adults with a schizotypical personality do not develop schizophrenia.

- **Cluster B: These personality disorders are characterized by dramatic and erratic behavior. This cluster includes**:
    - Histrionic (hysterical) personality – People with a histrionic personality may show characteristics involving:
        - Constantly seeking attention
        - Being overly emotional
        - Extreme sensitivity to the approval of other's
        - Unstable mood
        - Excessive concern with physical appearance
        - Prone to sexually provocative behavior
        - Sexualizing non-sexual relationships
        - They may not want to actually be in a sexual relationship. Instead, their sexual behavior may be hiding their desire to be dependent and protected.
        - Exaggerate their physical problems to get the attention they need
    - Narcissistic Personality Disorder – People with a narcissistic personality may show characteristics involving:
        - Sense of superiority
        - Need for admiration

        - Lack of empathy
        - Exaggerated belief of their own importance (therapists call this grandiosity)
        - Very sensitive to failure, defeat or criticism
        - Often expect others to envy them
        - Feel that their needs should be met without waiting which leads them to exploit other's whose needs that they think are less important
        - Typically occurs in high achievers but can also occur in those with few achievements
    - Antisocial Personality (previously called psychopathic or sociopathic personality) – People with an antisocial personality may likely:
        - Show disregard for the feelings and rights of others
        - Defeat or exploit others for material gain or personal gratification
        - Act out their conflicts impulsively or irresponsibly
        - Be prone to alcoholism, drug addiction, sexual deviation, promiscuity, and imprisonment
        - May have been neglected or abused as a child
        - Have a family history of antisocial behavior
        - Be intolerant to frustration of others
        - Be hostile or violent
        - Frequent lying or stealing
    - Borderline Personality Disorder – People with a Borderline Personality may show symptoms such as:
        - Impulsive or risky behavior
        - Unstable self image
        - Unstable mood
        - Turning aggression toward themselves
        - Showing confusion about their identity
        - Express inappropriate and intense anger when they fear abandonment by a caring person.
        - Viewing relationship and events as good or bad, black or white but never neutral.

        - Thinking that they do not exist when they feel abandoned or alone
        - Being out of touch with reality which can lead to:
            - Hallucinations
            - Paranoia
            - Psychotic thinking
        - Visiting doctors often and relentlessly seek care from others
        - Fear being alone

Cluster C: These personality disorders are characterized by anxious behavior. This includes:

- Avoidant Personality – People with an Avoidant Personality may have symptoms that include:
    - Being sensitive to rejection
    - Fear of starting relationships or anything new
    - A strong desire for affection and acceptance but will avoid intimate relationship due to fear of disappointment and criticism
    - Respond to rejection by becoming withdrawn and appearing shy and timid
    - Feeling inadequate
- Dependent Personality – People with a Dependent Personality may have symptoms that include:
    - Lack of self-confidence
    - A desire to be taken care of
    - Seeing others as more capable than themselves
- Tolerance to inadequate or abusive care

Note: A dependent personality is sometimes developed by adults who have a prolonged illness or physical handicap

- Obsessive Compulsive Personality – People with an Obsessive Compulsive Personality may have symptoms that include:
    - Preoccupied with rules, orderliness and perfectionism
    - Being very reliable and dependable yet inflexible to change
    - Being extremely careful in their decision making

- Intolerance to their own mistakes and imperfections which may make it hard for them to complete tasks
- Are uncomfortable in situations that they lack control of

Note: Obsessive Compulsive Personality Disorder is different from Obsessive Compulsive Disorder (OCD), which is an anxiety disorder. Unlike the OCD, Obsessive Compulsive Personality Disorder DOES NOT include repeated, unwanted obsessions and behaviors.

How are Personality Disorders Treated?

Treatment for personality disorders is usually long term and differs for each type of personality disorder and is unique for each person. However, treatment options include:

- Psychotherapy – This helps people with a personality disorder to learn about their condition and to learn how to manage the symptoms. Types of psychotherapy include:
  - Cognitive Behavioral therapy: Focuses on present thinking, behavior and communication and works toward problem solving.
  - Dialectal Behavioral therapy: Teaches behavioral skills to tolerate stress, regulate emotions and improve relationship.
  - Psychodynamic psychotherapy: Based on increasing awareness of unconscious thoughts and behaviors and resolving conflicts to live a happier life.
  - Psycho education: This is meant to teach a person, and often their family and friends, with a personality disorder about the illness. Includes information about:
    - Treatment
    - Coping strategies
    - Problem solving skills
- Medications – Many different psychiatric medications are used to treat the symptoms of personality disorders. These include:
  - Antidepressants

  Commonly prescribed antidepressants:
    - Citalpram (Celexa)
    - Escitalopram (Lexapro)
    - Fluoxetine (Prozac)
    - Fluvocamine (Luvox)

- Paroxetine (Paxil)
- Sertraline (Zoloft)
- Venlafaxine (Effexor, Effexor XR)
- Desvenlafaxine (Pristiq)
- Duloxetine (Cymbalta)
- Upropion (Wellbutrin) – May be given to a person who is trying to quit smoking
- Trazodonen (Desyrel) – Sometimes given as a sleep aid because it can be more **sedating** than other antidepressants**.**
- Mirtazapine (Remeron) – Can also be **sedating** to those who take it.

Side effects of antidepressants that may interfere with supervised visitation include:

- Drowsiness and fatigue in the daytime
- Nausea
- Feeling nervous or on edge
- Recent research has shown that some antidepressants can increase the risk of suicide and self-destructive thoughts.
- The side effects of antidepressants sometimes last only a few weeks after a person begins taking them.
- A person should consult a doctor before reducing or stopping the use of antidepressants since this may put one at risk of withdrawal like symptoms.

o Mood Stabilizers

Commonly prescribed mood stabilizers:

- Lithium (Lithobid)
- Divalproex sodium (Depakote and Epival)
- Carbamazepine (Tegretol, Tegretol)
- Valproate sodium (Depakene Syrup)
- Lamotrigine (Lamictal)

Side effects of mood stabilizers that may impact supervised visitation:

- Blacking out (lithium)
- Headaches

- Drowsiness
- Dizziness and nausea
- Low energy
- Diarrhea
- Nausea
- Upset stomach
- Slurred speech
- Confusion, disorientation
- Easy bruising and unusual bleeding (divalproex)
- Odd eye movements (divalproex)
- Increased thirst and increased need to urinate (lithium)
- Trembling
- Anti-Anxiety Medications

Some commonly prescribed anti-anxiety medications are:

- Xanax (alprazolam)
- Klonopin (clonazepam)
- Valium (diazepam)
- Ativan (lorazepam)

Side effects of anti-anxiety medications that may interfere with supervised visitation:

- Drowsiness
- Clumsiness
- Slurred speech
- Confusion and disorientation
- Dizziness
- Impaired thinking
- Memory loss
- Nausea
- Blurred or double vision
- Antipsychotic Medications

Some commonly prescribed antipsychotic medications are:

- Clozaril (clozapine)
- Compazine (prochlorperazine)
- Haldol (haloperidol)
- Mellaril (thioridazine)
- Navane (thiothixene)

Side effects of anti-psychotic medications that may interfere with supervised visitation:

- Dizziness
- Involuntary muscle spasms
- Disorientation
- Drowsiness
- Fatigue
- Seizures

Although it may not be possible to eliminate the side effects of medications prescribed for personality disorders, a few ways to minimize them are:

- Drowsiness and fatigue in the daytime
  - Take a short nap during the day.
  - Get mild exercise, such as walking.
  - Take medication one to two hours before going to bed.
- Nausea
  - Take antidepressants with food.
  - Suck on sugarless hard candy.
  - Drink sugarless fluids.
  - Take an antacid or bismuth subsalicylate (Pept-Bismol)
- Feeling nervous or on edge
  - Get vigorous exercise.
  - Practice deep breathing exercises and muscle relaxation.
  - Consult a doctor about temporarily taking a relaxing medication.

Note: Hospitalization and residential treatment programs may be necessary if a person cannot care for themselves or is a harm to themselves or others.

Case Example and Discussion Questions

Read the case example below and then answer the questions about the case:
A single father recently lost custody of his 6 year old son, Jacob. This occurred one month ago, after neighbors reported that Jacob's father was asleep on his front porch while Jacob played in the front yard, a few feet away from a busy road. Jacob's maternal grandparents, who live an hour from his father, now have temporary custody of him. Jacob and his father have contact through supervised visitation on a weekly basis; however, the father often falls asleep during visitation. Jacob often realizes that his Dad is asleep and tries to wake him up by tapping his arm and shouting "Dad."

During the intake, the father disclosed that he was taking Desyrel since he was diagnosed with antisocial personality disorder three months ago by his doctor. When asked how the side effects were making him feel in the intake, he stated that he did not know of any that were associated the Desyrel.

Discussion Questions

1. What are possible reasons for this father's behavior?
2. How has Jacob been affected by his father's behavior?
3. Is there anything that the program can do for this family?

Answers to Discussion Questions

1. Jacob's father is taking Desyrel, the brand name version of Trazodonen which is known to be sedating. Other reasons may exist for his behavior but this is a possible reason for his frequent "naps".
2. Jacob seems to be recognizing that his father is not giving him the amount of attention he needs and is confused about why he no longer lives with his father. Jacob might be wondering if he did something to create this change. Since Jacob's grandparents live an hour away, he has to change elementary schools in the middle of the school year, and leave neighborhood friends, etc.
3. Personality disorders can be treated in a number of ways, including a number of different medications and therapy. Desyrel may not be the best choice for this father to be taking since it is known to be sedating. If the side effects of Desyrel are the reason for Jacob's father's behavior, a change of prescription or taking the medication at a different time of day may helpful. The doctor may be able to intervene with an alternative way of treating the disorder, which may be significantly beneficial to both Jacob and his father. It would be a good idea in this case for the visitor monitor to contact the case manager, and make the case manager aware fo what is occurring at the visits and what

information the father has shared with the monitor. The case manager can then contact this father's doctor.

Notes about Children of Parents with Personality Disorders

- Parents with a Narcissistic Personality Disorder are just as "needy" as their child or children. This can lead to children's emotional and physical needs going unmet, and can cause a child to grow up with power and attention struggles. (Gladen, 2008).
- Children of a parent(s) with a personality disorder may believe that they are to blame for the parent's illness.
- Parents may tell the child that he or she is the reason that they have a personality disorder.
- If the parent and child were separated, the parent may try to explain why he or she is not to blame for the separation, which may be very confusing and difficult for the child to tolerate.
- The actions of a parent with a personality disorder can range from disruptive and abusive to criminal. Because of this, the entire network around the children needs to remain on alert.
- Making excuses for a parent with personality disorders creates more problems for the children than allowing them to see and recognize the behavior for what it actually is which can be abusive and manipulative.

Ideas for Service Providers: It may be necessary to have the parent, a guardian ad litem, the case manager, or a mental health professional explain the parent's condition to the child, depending on the child's age, maturity, and level of understanding. This can be done sensitively, to explain that the illness is not the fault of the child or the parent. Each case is different, so supervised visitation providers should staff each case to discuss how best to proceed.

Quiz

1. Define a personality disorder, as it is described in the Diagnostic and Statistical Manual, fourth edition (DSM IV).
2. Give examples of environmental factors that may trigger someone to have a personality disorder.
3. Describe a few risk factors that may put someone at risk of having a personality disorder.

4. Which personality disorders are included in Cluster A?
5. How are the personality disorders in Cluster B characterized?
6. How might someone with an Avoidant Personality respond to rejection?
7. Describe common side effects that are associated with antidepressants that may interfere with supervised visitation.
8. Discuss how a parent with a Narcissistic Personality Disorder can affect his or her child.

Answers to Quiz Questions

1. According to the Diagnostic and Statistical Manual, fourth edition, a personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, had an onset in adolescence or early adulthood, is stable over time, and leads to distress and impairment.
2. Environmental factors that may trigger someone to have a personality disorder are verbal, physical or sexual abuse during childhood, an unstable or chaotic family life during childhood, being diagnosed with childhood misconduct disorder, or loss of parents through death or divorce during childhood.
3. Risk factors for personality disorders include being Native American or Black, being a young adult, having low socioeconomic status, and being divorced, separated, widowed, or never married.
4. Personality disorders in Cluster A include Paranoid Personality Disorder, Schizoid Personality Disorder and Schizotypical Personality Disorder.
5. These personality disorders are characterized by dramatic and erratic behavior.
6. A person with an Avoidant personality might respond to rejection by becoming withdrawn and appearing shy and timid.
7. Common side effects associated with antidepressants that may interfere with supervised visitation are drowsiness and fatigue in the daytime**,** nausea**,** feeling nervous or on edge.
8. Parents with a Narcissistic Personality Disorder are just as "needy" as their child or children. This can lead to children's emotional and physical needs going unmet, and can cause a child to grow up with power and attention struggles. (Gladen, 2008).

For more information:

The Merck Manual Online Medical Library. (2009). Personality Disorders. Retrieved from: http://www.merck.com/mmhe/sec07/ch105/ch105a.html#sec07-ch105-ch105a-427

The Mayo Clinic. (2009). Personality Disorders. Retrieved from: http://www.mayoclinic.com/health/personality-disorders/DS00562

Human Trafficking: The Modern Face of Slavery

By: Kayla Wesighan and Lisa Langenderfer

Introduction

Editor's Note: 2010 marks the first year we have seen children at supervised visitation who were formerly victims of human trafficking. This training is an introduction to the tragedy of human trafficking.

In what is commonly known as modern-day slavery, severe forms of human trafficking have been defined by the United States' Trafficking Victims Protection Act of 2000 (TVPA) as:

> "a. sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age; or
>
> b. the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery."

Human traffickers use tactics such as manipulation, control, and fear to recruit and enslave their victims. Whether transported within their own country or across international borders, those sold into this modern-day slavery have their freedoms stripped from them and their human rights callously violated. The actual number of people whom traffickers exploit is unknown due to issues such as underreporting, however estimates have approximated that anywhere between 4 and 27 million individuals are enslaved worldwide. This form of slavery knows no boundaries. It has been documented in both developing and modern industrial nations, including the United States.

Overview

This training aims to provide participants with information and strategies to aid in understanding human trafficking and its effects on victims. Specifically, it will focus on the reintegration of children into society after they have escaped or been rescued from this enslavement.

Objectives

Once completed with this training, a participant should be able to:

- Understand the concept of human trafficking and who it affects;
- Indentify where human trafficking takes places;
- Describe why human trafficking occurs and how it is carried out;
- Identify the role children play in human trafficking; and
- Understand issues that affect victims if they are rescued and reintegrated.

Snapshots

- Human trafficking data estimates that there are currently 12.3 million victims worldwide.
- Human trafficking has been documented in developing regions such as South and South Eastern Asia, the former Soviet Union, Africa, the Pacific Islands, and Central and South America as well as developed regions, including the Middle East and North America.
- Cases of human trafficking have been reported in all 50 states of the U.S.
- It is estimated that, each year, 14,500 to 17,500 individuals are trafficked into the United States.
- The majority of individuals enslaved by human trafficking are women and children.
- Women also comprise a significant portion of alleged perpetrators. The United Nations found that in 1/3 of the 155 nations surveyed, women were the primary traffickers. Also, women accounted for more than 60% of human trafficking convictions in Eastern Europe and Central Asia.
- 293,000 youth are currently considered at risk of commercial sexual exploitation in the United States.

The Business Behind Human Trafficking

Traffickers have created a multimillion-dollar industry. Globally, it is the quickest growing underground business and is considered the second highest criminal activity behind drug trafficking. Traffickers manipulate their victims into believing they are offering them a better life, including exceptional education, saving them from a life in poverty, and allowing them to escape from political conflict. Many times, they coerce their victims into feeling dependent on them by creating a sense “debt-bondage.”

Sex Trafficking

Sex trafficking, one type of human trafficking, can take many forms. Most commonly, victims work on the streets, in brothels, as mail-order brides or

dancers, and in the pornography or sex tourism industries. This can occur on both a commercial and private level. Worldwide, the demand for this type of trafficking is high. The International Labor Organization has estimated that at least 1.39 million people are enslaved by sexual servitude. It is not uncommon for a victim to be purchased and resold many times. In the United States, the average age of children first trafficked into the commercial sex industry is 13.

Case Example:

"When I was fourteen, a man came to my parents' house in Veracruz, Mexico and asked me if I was interested in making money in the United States. He said I could make many times as much money doing the same things that I was doing in Mexico. At the time, I was working in a hotel cleaning rooms and I also helped around my house by watching my brothers and sisters. He said I would be in good hands, and would meet many other Mexican girls who had taken advantage of this great opportunity. My parents didn't want me to go, but I persuaded them.

A week later, I was smuggled into the United States through Texas to Orlando, Florida. It was then the men told me that my employment would consist of having sex with men for money. I had never had sex before, and I had never imagined selling my body.

And so my nightmare began. Because I was a virgin, the men decided to initiate me by raping me again and again, to teach me how to have sex. Over the next three months, I was taken to a different trailer every 15 days. Every night I had to sleep in the same bed in which I had been forced to service customers all day.

I couldn't do anything to stop it. I wasn't allowed to go outside without a guard. Many of the bosses had guns. I was constantly afraid. One of the bosses carried me off to a hotel one night, where he raped me. I could do nothing to stop him.

Because I was so young, I was always in demand with the customers. It was awful. Although the men were supposed to wear condoms, some didn't, so

eventually I became pregnant and was forced to have an abortion. They sent me back to the brothel almost immediately.

I cannot forget what has happened. I can't put it behind me. I find it nearly impossible to trust people. I still feel shame. I was a decent girl in Mexico. I used to go to church with my family. I only wish none of this had ever happened."
- Rosa, Age 14, trafficked in Florida, originally from Mexico;
Testimony before US Senate Foreign Relations Committee, 2000
http://actioncenter.polarisproject.org/the-frontlines/survivor-testimonies?start=50

Labor Trafficking

The other form of human trafficking, labor trafficking, includes activities such as agricultural and sweatshop labor, begging, and domestic slavery. It is common for individuals to be both labor and sexual slaves for those who exploit them.

Case Example:

INDIA: Shadir, a boy of 15 years, was offered a job that included good clothes and an education; he accepted. Instead of being given a job, Shadir was sold to a slave trader who took him to a remote village in India to produce hand-woven carpets. He was frequently beaten. He worked 12 to 14 hours a day and he was poorly fed. One day, Shadir was rescued by a nongovernmental organization working to combat slavery. It took several days for him to realize he was no longer enslaved. He returned to his village, was reunited with his mother, and resumed his schooling. Now Shadir warns fellow village children about the risks of becoming a child slave.
http://www.state.gov/g/tip/c16482.htm

Repercussions of Victimization

Human trafficking is accompanied by a plethora of risk factors and harmful consequences, both physical and psychological. Those enslaved for labor purposes are in jeopardy of injury due to factors including, but not limited to, long hours and demanding work, malnutrition, harm in the form of punishment, and little medical attention. Others who fall victim to sexual servitude are at risk of

sexually transmitted diseases in addition to the aforementioned problems. As for the emotional and psychological aspect of those who are trafficked, they typically suffer from abuse, isolation, trauma, and threats to self and/or others. Many display symptoms of depression, anxiety, guilt and shame, cultural shock, and traumatic bonding (Stockholm Syndrome). If a victim escapes or is rescued, posttraumatic stress disorder is another possible repercussion that needs to be considered.

Signs of Human Trafficking Activity

In addition to the physical and psychological symptoms listed above, there are environmental and behavioral signs that may serve as clues as to their involvement in human trafficking. Children living at their workplace or with their employer, living in overcrowded conditions, and missing school frequently may be victims of trafficking, as well as runaways. These children have also been known to refer to the trafficker as his or her family member, such as “aunt” or “uncle” (close family members can also be perpetrators). Furthermore, traffickers typically instill a fear of law enforcement and government officials into their victims.

Reintegration

Experts in human trafficking have developed what is known as the “victim-centered” approach to help those who have been enslaved. The “three R’s,” rescue, rehabilitation, and reintegration, identify important steps of the recovery process. Victims of human trafficking may be suffering from multiple setbacks and need to be given correct care and assistance to heal. If you suspect or know of a victim of human trafficking, call the National Human Trafficking Resource Center at 1-888-3737-888.

Treatment/Therapy for Children

The average age of those first trafficked into the commercial sex industry is 13 in the United States. Children represent about fifty percent of those trafficked worldwide. In the US, victims under the age of 18 are automatically eligible for benefits, including housing, food, and income assistance, healthcare, mental health treatment, and language education through “T” visas. However, the child’s past needs to be researched to see whether he or she has a family to return to.

In specific regard to mental health treatment, the most important aspect of therapy when working with human trafficking victims is the development of trust between the therapist and client. This may take time and require flexibility, often

acting as a major barrier to success because victims tend to be very suspicious of any authority figure. Nonetheless, it is needed to start on the path to effective treatment. The primary goal of therapy should be empowerment and recovery. Treatment providers need to be well versed in the issues that victims face as well as possible cultural impacts. Translators may be a necessity if there are language differences. It is imperative, however, to remember that before any of this is attempted, the provider is certain that the individual is free from harm and is having his or her basic needs met, including medical attention. Individual and group therapy are commonly used in mental health practices, and specific techniques such as art therapy have been supported.

Breaking the Human Trafficking Ring

Most victims of trafficking are lured in because they are vulnerable for one reason or another. They are looking to make contacts for a better life through education, employment, and marriage, among other reasons. One way to break the human trafficking ring is through prevention efforts. The United Nations Office on Drug and Crime began the Global TV Campaign on Human Trafficking. The campaign broadcasts public service announcements all over the world to warn vulnerable persons of potential luring tactics used by traffickers. Domestically, the Victims of Trafficking and Violence Protection Act of 2000 (VTVPA) was implemented to enhance existing slavery laws, in addition to providing new resources to fight human trafficking and provide aid to victims.

In Florida, the second largest U.S. destination of human trafficking, the Florida State University established the Center for the Advancement of Human Rights. Since its inception in 2004, the center has published an in-depth needs assessment of trafficking victims, specifying identification and assistance procedures. While prosecuting those within trafficking rings is important, attention must be paid to eliminating the demand for this modern-day slavery. Human trafficking exists because there is a demand for it. More research needs to be conducted on issues surrounding demand in order to understand and, eventually, eliminate it.

If supervised visitation staff suspect human trafficking, they should contact the local law enforcement agency.

For more information, visit:
www.acf.hhs.gov/trafficking
http://www.acf.hhs.gov/programs/orr/programs/anti_trafficking.htm
www.endhumantrafficking.org
http://www.state.gov/g/tip/rls/tiprpt/2009/123123.htm

http://www.amnestyusa.org
http://www.unodc.org/unodc/en/human-trafficking/prevention.html
http://www.humantrafficking.org/combat_trafficking/prevention
http://www.stophumantrafficking.org/activism.html
http://www.captivedaughters.org/demand.htm
http://aspe.hhs.gov/hsp/07/humantrafficking/Treating/ib.htm
http://www.actioncenter.polarisproject.org/learn/the-victims-of-human-trafficking

Review Quiz

1. In the United States, what is the average age of those first trafficked into the commercial sex industry?
    a. 7
    b. 13
    c. 19
    d. 25
2. Which of the following are common signs and symptoms of someone who has been the victim of human trafficking?
    a. Depression
    b. Cultural shock
    c. Traumatic bonding
    d. A & B only
    e. All of the above
3. Which of the following is *not* one of the three "R's" of the victim-centered approach?
    a. Rescue
    b. Rehabilitation
    c. Remind
    d. Reintegration
4. Which organization began the Global TV Campaign on Human Trafficking, which provides warnings to potential human trafficking victims?
    a. The Florida State University Center for the Advancement of Human Rights
    b. The United Nations Office on Drug and Crime
    c. National Human Trafficking Resource Center
    d. The International Labor Organization

Answer Key: 1—B, 2—E, 3—C, 4—B

APRIL 2010 EPRESS

****Please note the changes to the upcoming phone conferences, identified in the boxes below****

Due to popular demand, beginning in May we will try to schedule all phone conferences for the 3rd Wednesday of the month. Because of the complaints about the 9 am time slot, all calls for the next six months will be at NOON EDT.

APRIL PHONE CONFERENCE
WEDNESDAY, APRIL 14TH

12:00 NOON, EDT

BACK TO THE OLD TIME!

DIAL 719-457-0816 TO PARTICIPATE, YOU WILL NEED TO ENTER A PASS CODE TO PARTICIPATE. THE PASS CODE IS 635786#

MAY PHONE CONFERENCE
WEDNESDAY, MAY 19TH

12:00 NOON, EDT

DIAL 719-457-0816 TO PARTICIPATE, YOU WILL NEED TO ENTER A PASS CODE TO PARTICIPATE. THE PASS CODE IS 635786#

Announcing…

Miami Training Date: July 12th

Sign up by April 30!

Linda Fieldstone in Miami has graciously offered to host a Supervised Visitation Training on July 12th at the **Miami Courthouse (175 NW Ave, Miami, off of I-95 exit SW 8th St – public parking is across the street).** The training will last from **10am – 3pm**. This opportunity will give everyone in Dade, Broward, Monroe, and Palm Beach counties a chance to receive free training.

Your only cost will be $10.00 for pizza lunch. Please remember to bring $10 cash.

We will cover topics including Family Centered Practice, Best Practices (based on the Standards), and Ethical Issues. All participants will receive certificates of training.

If you and/or people from your office plan to attend, please email Karen Oehme IMMEDIATELY!
fsuvisit@aol.com OR koehme@fsu.edu

2010 National Child Abuse Prevention Month Website

April is National Child Abuse Prevention Month, a time to raise awareness about child abuse and neglect and encourage individuals and communities to support children and families. Visit the 2010 National Child Abuse Prevention Month website to learn more about the history of the month, see examples of Presidential and State proclamations, and find strategies for engaging communities and supporting families. The site features: Strengthening Families and Communities: 2010 Resource Guide, a guide to help service providers strengthen families by promoting key protective factors that prevent abuse; a calendar with activities for each day related to the Five Protective Factors that help protect children and strengthen families; a video showing how the Child Welfare Information Gateway helps connect professionals with information and resources on preventing child abuse and neglect.
http://www.childwelfare.gov/preventing/preventionmonth/

Remember, if you know or suspect that a child is being abused or neglected, you must call 1-800-96ABUSE and report it!

Sexual Abuse Issues Curriculum

Below is the information collected from those who completed the online Child Sexual Abuse curriculum during August 2009 – February 2010 solely online, and printed a Certificate of Completion. If you have staff/volunteers at your Supervised Visitation Center who have not completed this, remember that it is a required training.

August 2009 – February 2010

- 61 total participants
  - 24 identified themselves as CWW/CPI
  - 12 as Guardian Ad Litem or GAL staff
  - 22 participants gave no information
  - 3 as Other (Case Managers)
- geographic information
  - 31 Central Florida (Gainesville south to Sarasota)
  - 2 NE Florida (Tallahassee East, Gainesville North)
  - 0 NW Florida (Tallahassee West & Panhandle)
  - 1 South Florida (Sarasota South)
  - 27 no information listed
- supervised visitation personnel
  - 22 total participants identified, 10 organizations represented

Program Director Needs Your Input

Brenda K. Green, M.Ed.

Office: 941-708-5893

Fax: 941-741-3578

Bradenton, FL 34205

Bgreen@family-resources.org

Brenda in Bradenton has a program that allows families to visit for 24 weeks. She would like directors to write or call her to tell her how many weeks other programs allow families to visit. For example, some programs require a new court order after 16 weeks. Others have open-ended schedules determined by the court or DCF. If you would like to respond to her, please call or write. Her information is at left.

Upcoming Trainings: Opportunities from Florida Council Against Sexual Violence (FCASV)

Registration is now open for the 2010 Sexual Violence Conference in Sarasota, FL June 9-11th at the Hyatt Regency Sarasota. This year's conference features an outstanding line-up of keynote speakers and workshops.

Keynote Speakers:

- Dorothy Edwards – "Green Dot: A Comprehensive Approach to Violence Prevention"
- Byron Hurt – "Game Changers: Can Men Shift the Momentum of Gender Violence Prevention?"
- Loretta Ross – "Ending Violence Against Women through Human Rights"

Highlights Include:

- Three-part clinical series featuring Steven Gold, Ph.D. – "Contextual Therapy for Prolonged Child Sexual Abuse Survivors"
- Domestic violence track hosted by Florida Coalition Against Domestic Violence
- Theatrical performance by Amy Marschak – "An Angel Cried a Tear Last Night"

You can view the full registration brochure at http://www.fcasv.org/sites/default/files/Final%20Conference%20Brochure%202010.pdf.

Online registration is now available and can be accessed on the FCASV conference web page: http://www.fcasv.org/training/together-we-can.

Or contact:

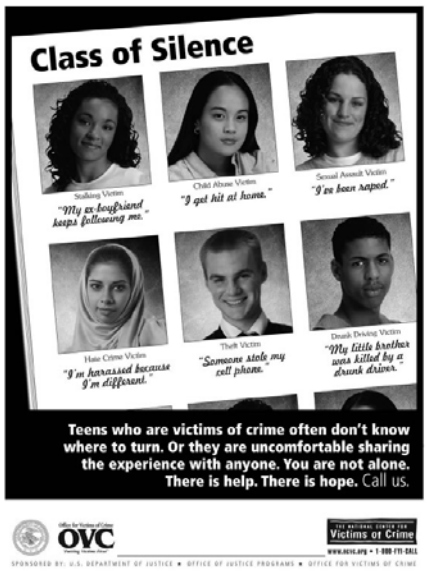
Grace Frances
Director of Training and Technical Assistance
Florida Council Against Sexual Violence
Tallahassee, FL 32301
tel: (850) 297-2000
fax: (850) 297-2002

Spruce Up for Spring

Does your facility need an updated look? Are you tired of looking at the same old posters and brochures, many of which are outdated? If this sounds like you, then you may benefit from the free, online posters offered by the Office for Victims of Crime.

Go to their Poster Gallery at http://ovc.ncjrs.gov/gallery/posters/index.html to access over 20 printable posters, all of which are printed in English and Spanish.

Below are a few highlights of the available posters.



Class of Silence

Stalking victim: "My ex-boyfriend keeps following me."
Child abuse victim: "I get hit at home."
Sexual assault victim: "I've been raped."
Hate crime victim: "I'm harassed because I'm different."
Theft victim: "Someone stole my cell phone."
Drunk driving victim: "My little brother was killed by a drunk driver."

Teens who are victims of crime often don't know where to turn. Or they are uncomfortable sharing the experience with anyone. You are not alone. There is help. There is hope. Call us.

Link:
http://ovc.ncjrs.gov/gallery/posters/pdfs/ClassofSilence.pdf

It Doesn't Matter

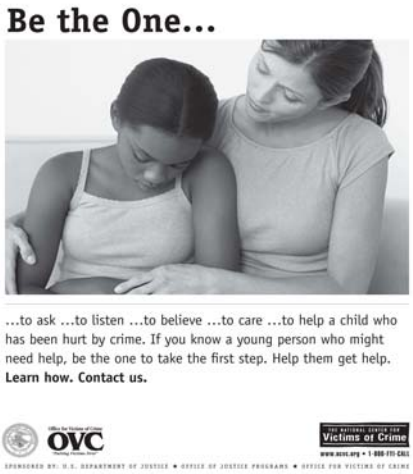
It doesn't matter: who it was; what you were wearing; what your sexual orientation is; what you were doing; whether you were drinking; whether you are male or female. For a sexual assault victim, being believed and supported does matter. Whether you choose to report it or not, we can help.

Link
http://ovc.ncjrs.gov/gallery/posters/pdfs/ItDoesntMatter.pdf

The One

Be the One… to ask… to listen… to believe… to care… to help a child who has been hurt by crime. If you know a young person who might need help, be the one to take the first step. Help them get help. Learn how. Contact us.

Link:
http://ovc.ncjrs.gov/gallery/posters/pdfs/TheOne_Eng.pdf



Every Family Should be a Safe Family …because Every Family Deserves to be Safe

Attached is a flyer that discusses the importance of keeping your home a violence-free zone. Topics include how to recognize all types of domestic violence, how law enforcement can help, in addition to internet resources and phone numbers for state agencies.

Please print as many copies of this flyer as you need.

Strengthening Families and Communities: 2010 Resource Guide

This free guide highlights strategies to strengthen families and prevent child abuse and neglect. It also includes tip sheets in both English and Spanish to share with parents. The Resource Guide is produced annually by the U.S. Department of Health and Human Services' Children's Bureau.

www.childwelfare.gov/pubs/res_guide_2010.

Victim/Witness Assistance Programs for Florida's Criminal Cases

By: Lisa Langenderfer

Introduction

Being a victim of or a witness to of a crime can be a very daunting experience. Depending on the nature of the crime, cases can take several months, even years, before being resolved. Fortunately, each of the twenty State Attorney's Offices throughout the state offer victim/witness assistance programs. These programs guide the victim through the legal system, while offering crisis intervention and referral services.

What are the Rights of the Victim?

When a crime is committed and an arrest is made, the victim of the case has certain rights within the legal realm. These rights have been made explicit in state law and the State Constitution. As a victim, you have a right:

- To be informed, present, and heard when relevant, at all crucial stages of criminal proceedings, to the extent it does not interfere with the constitutional rights of the accused. (Incarcerated victims have the right to be informed and submit written statements at all crucial stages.)
- The victim or next of kin of a victim may not be excluded from any portion of any hearing, trial, or proceeding pertaining to the offense based solely on the fact that such person is subpoenaed to testify, unless upon motion, the court determines such person's presence to be prejudicial.
- To receive advanced notification of proceedings in the prosecution of the accused as well as judicial proceedings relating to the arrest, release, work release, or release on community control of the accused.
- To have a prompt and timely disposition of the case, to the extent that this does not interfere with the constitutional rights of the accused.

- To have your employer notified that your cooperation may necessitate absences from work and to explain to creditors the reasons for your financial hardships when it is a direct result of a crime.
- To request and have the court appropriate restitution for your financial losses as a result of the crime and to receive information on the right to enforcement of the court's order.
- If you are the victim of a felony involving physical or emotional injury or trauma, the parent/guardian of a minor child or the next of kin of a homicide, you shall be consulted by the State Attorney to obtain views about the release of the accused pending judicial proceedings, plea arrangements, participation in pretrial diversion programs, and the sentencing of the accused.
- To submit (oral or written) a Victim Impact Statement to the Court prior to sentencing. This statement may include a request that a juvenile offender be required to attend a different school than that of the victim or the victim's siblings.
- If you are the victim in a sexual offense, you have the right to have the courtroom cleared during your testimony of all persons except those as provided by in Florida Statute 918.16.
- To receive notification of all schedule changes regarding your case as soon as possible.
- To be informed concerning the escape of the accused from prison, jail, juvenile detention facility or residential commitment facility.
- To be notified of a defendant's release from prison, jail, juvenile detention facility or residential treatment facility if you are the victim of domestic violence, any sexual offense, stalking, attempted murder or if you are the next of kin of a homicide victim.
- To have property that was held for evidentiary purposes returned, unless there is a compelling reason for retaining it.
- To review a copy of the pre-sentence investigation report upon request, excluding confidential information pertaining to the offender's medical history, mental health, substance abuse, or information pertaining to another victim.

http://www.co.leon.fl.us/statty/What_are_the_Rights_of_a_Victim.htm

First Appearance

After a suspect has been arrested, a judge will review the case with the suspect, typically over closed-circuit television. There is an attorney present from both the prosecution and the defense teams.

- The victim advocate attends and speaks with any victims present and gathers information from police reports on any reported victims of violent crimes.
- Following first appearance, the advocate attempts to contact any named victims via phone and/or mail.
- All victims are attempted to be contacted following first appearance, but typically felony cases are the cases the advocates assist. Victims of misdemeanor cases are welcome to utilize services if necessary.
- If and when the advocate makes contact with the victim, the victim is asked to participate in an intake with an advocate.

Intake

At an intake, the victim and the advocate meet to discuss the case. In certain cases, the Assistant State Attorney who is prosecuting the case may decide to join the intake. During the intake, the advocate:

- Clearly explains the role of the advocate in the legal process. It is emphasized that the advocate is part of the prosecution team and that there is not strict confidentiality between the victim and the advocate.
- Advises the victim of his/her rights regarding the case.
- Obtains background information from the victim regarding the relationship, if any, to the suspect or defendant.
- Goes over police reports, probable cause affidavits, and prior sworn statements regarding the case. The advocate allows the victim to clarify any inconsistencies between his/her memory and these documents.
- Asks what the victim would like to see happen with regard to the case. This can include requesting to drop the charges.
- Provides crisis intervention and referrals to the victim as needed.
- Helps the victim file for an injunction, if necessary.
- Helps the victim file for Victim's Compensation, if necessary.

After an intake is completed, the advocate uses the information obtained to create a memo for the Assistant State Attorney handling the case. It provides all the pertinent details of the case from the victim's perspective. This document is entered into the official case file.

Requesting to Drop the Charges

Many victims, particularly those involved in domestic violence cases, come into the victim/witness office requesting to drop the charges. It is a victim's right to indicate that this is his or her wish and can even sign a sworn statement to that effect. However, it has to be explicitly explained to the victim that there is no guarantee that the charge will be dropped. Once an arrest has been made and a prosecutor has been assigned, it is up to the individual prosecutor what charges, if any, will be filed.

While it may seem odd, when there is a defendant and a victim, the case is not "Victim vs. Defendant," but "The State of Florida vs. the Defendant." The prosecutor's job is to protect the people of Florida, including the victim, from those individuals who break the law. The prosecutor has to use his or her best judgment when determining how to proceed with each case. While the victim's input is very valuable to the prosecution team, there is no guarantee that the victim's wishes will be supported.

Injunctions

Injunctions, or restraining orders, are useful in protecting victims of violent crimes from the person(s) putting him or her in danger. Injunctions provide a court order that the respondent (offender) cannot have contact with the petitioner (victim). If the order is violated by the respondent, he/she can be arrested if it is reported. Injunctions are commonly filed for by victims of domestic violence, although they can be filed by those who have experienced repeat violence at the hands of the same offender (e.g., dating violence victims in which the victim and offender do not live together). To obtain an injunction for protection for repeat violence, two or more violent incidences have to have occurred, one within the last six months. The victim can request that an advocate assist him/her in filing for the injunction as well as accompanying him/her to the injunction hearings. To obtain an injunction:

- The petitioner must go to the Clerk of Courts to fill out a form requesting the injunction.
- The respondent will be given notice and a temporary injunction will be granted.
- A court date will be set for the final injunction hearing. At this hearing, the petitioner *must* be present or the order will automatically be dismissed.
- The respondent can choose to be there if he/she would like to explain why he/she opposes the injunction.
- If the respondent does not appear at the final hearing, a permanent injunction is automatically granted.
- If granted, the injunction is typically in place indefinitely, until a motion is made to drop it.

Victim's Compensation and Restitution

Some victims of crimes experience financial loss and need assistance to help them recover from their situation. In this case, the advocate can help the victim (or the victim's next of kin) file for Victim's Compensation. If the application is accepted, funds will be dispersed to the victim. Victim's Compensation covers the following:

- Disability
- Wage loss (if employed prior to the incident)
- Loss of support (for next of kin in the case of victim's death)
- Expenses (funeral/burial, medical/dental, mental health counseling)
- Emergency assistance
- Property loss
- Domestic violence relocation assistance (for victims of domestic violence who are attempting to relocate to a safe location)

Restitution is something that can be ordered in court, either through a plea deal or sentencing. As a condition of the plea or sentence, the defendant is ordered to repay the victim for any financial losses. However, the defendant typically does not have to pay any case-related fines or fees until after being released from custody. If he/she has been sentenced to jail or prison time, it may be a while before the victim sees his/her restitution money.

Court Proceedings

Throughout the case, there will be multiple types of hearings. With the exception of a trial, the victim is not required to attend any of these hearings. However, he/she has a right to be present, as well as heard, when appropriate. The victim also has a right to have an advocate with him or her at these proceedings. These hearings include:

- First appearance
- Arraignment
- Case management conferences
- Pre-trial hearings
- Plea hearings
- Sentencing

Depositions

The defense attorney has a right to subpoena the victim for a deposition. Legally, the victim must cooperate with the attorney. However, he/she has a right to have an attorney and/or a victim advocate present for the deposition.

Trial

If a case makes it to trial, the victim is often subpoenaed to testify in court. This can be a traumatic experience for the victim, which is why he/she has the right to have a victim advocate present in the courtroom.

Trial is the only exception to the victim's right to be included in all court proceedings. During trial, the victim cannot discuss the details of the case with anyone since he/she is testifying. Because of this, until he/she testifies, the victim is to remain outside of the courtroom. After testifying, if the victim is released, he or she will no longer need to testify and may stay in the courtroom for the rest of the trial if he/she chooses. However, if the victim is retained, he/she must leave the courtroom and wait, as he/she may be called back to the witness stand. If it is the victim's wish, he or she can ask the advocate to stay in the courtroom to see what happens. Once the victim is released, the advocate is allowed to discuss with the victim what happened when he/she was not in the courtroom, as this would not interfere with the victim's testimony.

Victim Impact Statement

If the defendant is convicted of a crime in a trial by jury, the judge will set another court date for sentencing. At the sentencing, the victim can provide a "Victim Impact" statement to the judge. This statement can be very powerful and can aid the judge in determining the proper sentence. Some victims do not want to attend the sentencing, but still want to be heard. In this instance, the prosecutor or the victim advocate can present the statement on behalf of the victim.

Websites of Interest

http://myfloridalegal.com/directory
http://www.co.leon.fl.us/statty/Victim_Witness_Unit.htm
http://www.myfloridalegal.com/Compapp.pdf

Technology and Supervised Visitation

By: Lisa Langenderfer

What are Social Networking Websites?

- Websites designed to foster connections between members ages 13 and older
- Used primarily for sharing information, building and reconnecting relationships, publishing photographs, and giving status updates

- Three of the most popular sites are Facebook, MySpace, and Twitter

Youth and Social Networking

Despite being aimed at users ages 13 and older, anyone can enter a false birth date to open an account.

- Custodial parent may not be aware that the child has an active profile
- Children and teens can access these sites outside of the home (e.g., libraries, schools)

The Dangers of Social Networking Sites

- Cyber-bullying is a form of online harassment typically associated with peers and strangers.
- Sexual solicitation and sexual harassment
    - Sexual predators can easily seek out young users' profiles
    - Predators typically present a false profile

Non-custodial Parents and Technology

If the non-custodial parent wants to contact the child without anyone knowing, it is entirely possible that he or she will succeed. This contact goes beyond an unsupervised phone call.

- Ways of Communication
    - Text messaging
    - Instant messaging
    - E-mail
    - Social Network private messaging functions

The non-custodial parent could take this time to give information or messages to the child that would be deemed inappropriate if said in front of the visitation supervisor. Speaking poorly of the custodial parent or making promises to the child are just two inappropriate tactics that may be used.

- *Creating "accidental" meetings*: The parent checks the child's whereabouts through status updates and goes to where the child will be.
- *Cyber-bullying*: The parent has contact with the child and convinces the child to keep conversations private by use of threat.
- *Bribery*: The parent may use bribery as a tactic to keep the conversations private.

What Can the Custodial Parent Do?

- Keep an open dialogue about the Internet and include its advantages and dangers.
- Warn your child that the content he or she puts online is largely public.
- Ensure your child has privacy filters set on his or her profile.
- Create a profile for yourself so you can periodically check the content on your child's page.
- Check the web browser history on the computer. This can give you a general idea about what websites and profiles are being looked at by your child.
- Talk to your child about the rules of visitation with the non-custodial parent.

Websites of Interest:

www.enough.org
www.isolutions4kids.org
www.cyberbully411.com

Updates on

Holding Batterers Accountable

Strides are being made to hold batterers accountable. Organizations such as The Non-Violence Alliance and A Call to Men are advocating for change in everyone to end violence against women. DCF has hired David Mandel, a member of The Non-Violence Alliance, to assist in foster care designs. David Mandel & Associates, LLC provide training and consultation to increase the safety and well-being of families. A Call to Men has held a conference in Florida. This organization aims to change men's behaviors through a re-education and training process that promotes healthy manhood. The message is also being delivered via billboard in Largo. The billboard will state, "REAL MEN DON'T HIT WOMEN & CHILDREN."

Batterer intervention programs also aim to end violence against women. These programs are sometimes mandated by court after violence has occurred in the home. There is some concern that these programs are not effective enough due to low attendance rates and the short length of the programs. Some programs have been cut, such as the domestic violence intervention program in Bay Pines VA Medical Center. Due to the low attendance, they decided that the resources would be better deployed in other departments. Advocates for ending violence against women are disappointed because it sends a message that the program is not important. Currently, experts believe that more research is needed to determine the best intervention for batterers.

Best Practices for Batterers' Intervention Programs

Experts on BIPs have made a number of best practice recommendations for program improvement and court action to improve the consistency of system response and to increase batterer accountability:

- If BIPs are to be utilized, courts should send batterers to BIPs as quickly as possible, and should require the batterers to check in with the court on a regular basis to ensure their compliance with the court order.
- A BIP should be more intense in frequency and content in the first few weeks, so that the batterer is educated, supervised and monitored for noncompliance during the time of greatest need and motivation.
- Contact with batterers should include a systematic monitoring of their behavior and compliance so that new interventions could be developed in accordance with their needs. New treatment alternatives should be developed, such as halfway houses or mentoring programs.
- Screening for severe alcohol, drug, and psychological problems should take place immediately. Treatment should occur outside the BIP.
- BIPs should perform regular lethality assessments.
- BIPs should have clear, written policies on what will happen if the batterer commits new offenses, misses a BIP meeting, or BIP staff believe that he is going to harm a current or past partner in some way.
- A BIP should never advocate for a participant, except to help the batterer to seek other services he or she might need such as substance abuse or employment assistance.

- Contact with victims should be systematic and comprehensive. A BIP should give the victim a checklist which will help the victim to assess the batterer's changing behavior. The victim should be encouraged to call the BIP if he or she has questions or concerns.
- The person who is contacting the partner of a batterer should be a trained victim's advocate.
- When a batterer completes a BIP or is terminated from a BIP, the victim should be provided with a written record of the abusive behaviors which the batterer admitted during the BIP. This may prove important to the victim in future court actions, such as custody, visitation, or another protective order. Batterers should not be told that information will be kept confidential.
- BIPs worldwide should make efforts to become more culturally compatible to diverse offenders, including same-sex BIPs.
- BIPs should cooperate with state agencies supporting and protecting the child.
- Child abuse prevention must be addressed, as well as the effect of abuse upon child witnesses.
- Procedures must be established for regular inspection and monitoring of BIPs.

Batterer Interventions Programs in Florida

Bridgeway Center	137 Hospital Drive Ft. Walton Beach, FL 32548	850-833-7500
C.O.P.E. Center	3686 US Highway 331 South DeFuniak Springs, FL 32433	850-892-8045
Cordova Counseling Center	4400 Bayou Blvd., Suite 8-D Pensacola, FL 32503	850-474-9882
FavorHouse of Northwest FL. Inc.	2001 W. Blount Street Pensacola, FL 32501	850-434-1177
FavorHouse of Northwest Fl. Inc.	6852 Caroline Street Milton, Fl 32570	850 626-5600
Hope Counseling Services Inc.	14 W. Jordan Street, Suite 1-G Pensacola, FL 32501	850 791-6952
Hurlburt Field Family Advocacy Program	1SOMDOS/SGOWF Hurlburt Field, FL 32544	850-881-5061
Pattison Professional Counseling Center	7 Vine Avenue NE Ft. Walton Beach, FL 32548	850-863-2873
Creative Counseling Services of Florida	1106 Thomasville Road Suite K Tallahassee, FL 32303	850-510-5133
Joanna Johnson and Associates	3295 Crawfordville Highway Suite 10 Crawfordville, FL 32327	850-926-4953
New Hope Intervention Programs	339 East Jefferson Street Quincy, Fl 32351	850 386-9313
New Hope Intervention Programs	1114 Thomasville Road Suite E5 Tallahassee, FL 32303	850 270-9686
Creative Counseling Services of Florida	1476 S.W. Main Street c/o Big Bend Community Based Care Greenville, FL 32331	850-510-5133
Resolutions Health	1688 E. Baya Avenue Suites 102-103	(386) 754-9005

Alliance, P.A.	Lake City, Fl 32025	
Clear View Concepts, Inc.	501 Center Street Suite 108 Fernandina Beach, Fl 32034	(904) 335-0333
First Step, Hubbard House, Inc.	P. O. Box 4909 Jacksonville, FL 32201	904-354-0076
New Beginnings: DV Options	9140 Golfside Drive, # 6N Jacksonville, Fl 32256	904 707-4710
Quigley House, Inc.	P.O. Box 142 Orange Park, FL 32067	904-284-0340
Salvation Army	191 Nassau Place Yulee, FL 32041	904-301-4834
Salvation Army	328 North Ocean Street Jacksonville, FL 32202	904-301-4834
Another Perspective	1158 West Jefferson Street Brooksville, FL 34601	(352) 442-4921
Another Perspective	Sumterville Community Bldg. Hwy 301 Sumterville, Fl	(352) 442-4921
Choices	821 NE 36th Terrace Unit 5/6 Ocala, FL 34470	352-622-0062
Court Educational Programs	1179 E. Alfred Street Tavares, FL 32778	352-343-9399
Families Against Abuse	282 Short Avenue, # 112 Longwood, FL 32750	(407) 260-6343
Growing Center Counseling	275 West Jefferson Street Brooksville, FL 34601	352-544-5833
Western Judicial Services, Inc.	12355 S.E. US Hwy 441 Belleview, FL 34420-4	(352) 347-6850
Western Judicial Services, Inc.	2300 S. Pine Avenue # C Ocala, FL 34474	352-622-9006
Western Judicial Services, Inc.	888 South Duncan Drive Tavares, FL 32778	352-742-9317
Western Judicial Services, Inc.	610 W. Jefferson Street Brooksville, Fl 34601	352 796-1378
A First Step/Stepping Stones to Independence	8406 Massachusetts Avenue Suite B-3 New Port Richey, FL 34653	727-841-0229
ADR Adult Services	3350 Ulmerton Road Suite 24 Clearwater, FL 33762	727-573-1844
Alpha Counseling Services	10730 U. S. Highway 19 N Suite 4 Port Richey, FL 34668	727-862-0111
Barbara Chism, LMHC	8383 Seminole Blvd Suite B Seminole, FL 33772	727-393-8702
Clinicians Group, P.A.	1661 East Bay Drive d/b/a Batterers’	727-582-8000

	Intervention Project Largo , FL 33771	
David Swindall, LMFT	5580 Park Blvd Suite 6 Pinellas Park, FL 33781	727-544-9305
Glover and Associates	7017 Central Avenue St. Petersburg, FL 33710	727-343-5158
Lifesource Counseling, Inc.	5006 Trouble Creek Rd Suite 104 New Port Richey, FL 34652	727-845-3355
Mac Associates	1501 ALT 19 South Suite A Tarpon Springs, FL 34689	727-937-7900
Men’s Work	8601 4th Street North Suite 300-A St. Petersburg, FL 33702	727-515-8482
Men's Work	18395 Gulf Blvd Suite 202 Indian Shores, FL 33785	727 515-8482
Prevention Projects, Inc.	13743 US 98 Bypass Dade City, FL 33525	352-523-0024
Psychological Management Group	7621 Little Road Suite 100 New Port Richey, FL	727-848-0311
Wellness Center	8800 49th Street, North Suite 312 Pinellas Park, FL 33782	727-544-3352
Wellness Center	2235 22nd Avenue S St. Petersburg, Fl	
Change/Safety Shelter of St. Johns County, Inc.	P. O. Box 3319 St. Augustine, FL 32085	904-808-8544
Deltona Counseling Associates	75 Fox Ridge Court, Suite C Deltona, FL 32713	386-668-6989
Domestic Abuse Council, Inc	Family Intervention Program P.O. Box 142 Daytona Beach, FL 32115	386-257-2297
New Horizons Domestic Violence Program	570 Memorial Circle Suite 150 Ormond Beach , FL 32174	386-760-1501
Positive Changes	2001 S. Ridgewood Ave. South Daytona, FL 32118	386-767-0523
Responsible Choices	1834 Mason Avenue Daytona Beach, FL 32117	386-274-5232
A Time for Change Counseling and Repositioning, LLC	3131 N.W. 13th Street Unit 56, Liberty Center Gainesville, Fl 32609	352 371-1979
Creative Counseling Services	4001 Newberry Road, D-4 Gainesville, FL 32607	352-373-1218
Diversified Program Services, Inc.	7003 NW 11th Place Suite 105, Bldg C Gainesville, FL 32605	352-332-9960
First Step/Hubbard	The Family Service Center 418 8th	904-354-0076

House, Inc.	Street South MacClenny, FL 32063	
Peaceful Paths	P. O. Box 5099 Gainesville, FL 32627	352-377-5690
A No Abuse Program Inc.	813 N. Ferncreek Avenue Orlando, FL 32803	407-228-9503
Abolish Abuse	4851 S. Apopka-Vineland Rd. Orlando, FL 32819	407-876-7757
After Court Solutions, LLC	16 Broadway Ave. Kissimmee, Fl 34741	(407) 944-1155
Beltran Behavioral Health	3214 Hillsdale Lane Kissimmee, FL 34741	407-518-9161
Families Against Abuse	4465 Edgewater Drive Orlando, Fl 32804	(407) 260-6343
Families Against Abuse	427 N. Primrose Drive Orlando, FL 32803	407-260-6343
Family Court Education & Mediation Srvs., Inc.	8 Broadway Street, Suite 226 Kissimmee, FL 34741	407-931-1778
New Options, Inc	3203 Lawton Road Suite 150 Orlando, Fl	407 894-8410
New Options, Inc.	254 Wilshire Blvd. Casselberry, Fl	407 830 1662
New Options, Inc.	3203 Lawton Road, Suite 150 Orlando, FL 32803	407-894-8410
Better Life Counseling, LLC	930 Alicia Road Lakeland, Fl	863 680-1950
Confidential Counseling Agency	5110 South Florida Avenue Building A Suite 104 Lakeland, FL 33813	(863) 899-6844
Reflections Wellness Center of Florida's Heartland, Inc.	154 South Commerce Drive Sebring, Fl 33870	863 386-9181
Social Solutions, Inc.	1570 Lakeview Drive, Suite 110 Sebring, FL 33870	863-402-1088
Step of Faith Counseling Services, Inc.	223 East Oak Street, Suite 2 Arcadia, FL 34266	863-990-3259
Alliance for Psychological Services	8750 SW 132 Street Miami, FL 33176	305-251-3464
Alliance for Psychological Services	2369 West 80th Street, Bay 5 Hialeah, FL 33016	305 251-3464
Anaga Psychotherapy Center, Inc.	6801 N.W. 77th Avenue Suite 106 Miami, Fl 33166	305 663-0013
Anaga Psychotherapy Center, Inc.	1450 North Krome Avenue Suite 101F Florida City, Fl	305 663-0013
Anaga Psychotherapy Center, Inc.	1663 Washington Avenue 2nd Floor Miami Beach, Fl 33139	305 663-0013

Anaga Psychotherapy Center, Inc.	5001 SW 74th Court Suite 105 Miami, FL 33155	305-663-0013
Dade Family Counseling, Inc.	1490 West 49th Place, Suite 410 Hialeah, FL 33012	305-827-3252
Dade Family Counseling, Inc.	8352 SW 8th Street Miami, Fl 33144	305 267-0205
Families In Action, Inc.	1800 SW 1st Street Suite 323 Miami, Fl 33135	305 827-3252
Families in Action, Inc.	3968 NW 167th Street Miami Gardents, FL 33054	305-621-6160
Full Circle Counseling, Inc.	7900 N.W. 27th Avenue # 229 Miami, Fl 33147	(305) 975-8766
Full Circle Counseling, Inc.	220 71st Street, Suite 206 Miami Beach, FL 33141	305-975-8766
Lifeline of Miami, Inc	822 NE 125th Street, Suite 110 North Miami, FL 33161	954 791-5484
Reflections Wellness Center	5753 Miami Lakes Drive E Miami Lakes, FL 33014	305-403-0006
The Recovery Project	10300 Sunset Drive Suite 160 Miami, FL 33173	305-271-5722
Behavior Management Services, Inc.	200 S. Washington Blvd., Suite 9 Sarasota, FL 34236	941-954-1105
C & C Family Services of Manatee, Inc.	544 12th Street West Bradenton, FL 32405	941-750-0430
Cambridge Health Assoc. Domestic Abuse Program	333 Tamiami Trail South, Suite 265 Venice, FL 34285	941-486-1990
Domestic Abuse Intervention Project	4506 26th Street West, Suites A & B Bradenton, FL 34207	941-746-6778
Fisher Counseling & Mediation Services, Inc.	Wildwood Professional Park 3653 Cortez Rd. W, Suite 110 C Bradenton, FL 34210	941-758-2529
Fisher Counseling and Mediation Services, Inc.	750 South Orange Avenue Sarasota, FL 34236	941-758-2529
Lighthouse Addiction Services	2021 Englewood Road, Suite D Englewood, FL 34223	941-475-7337
Mayra Cestero Counseling Services, Inc.	4301 32nd Street West, Suite A-7 Bradenton, FL 34205	941-545-6511
Mental Health Counseling Services, Inc.	2828 McCall Road Suite 116 Englewood, Fl	941 400-3677
Step of Faith Counseling Services, Inc.	223 East Oak Street, Suite 2 Arcadia, FL 34266	863-990-3259

Brandon Psychiatric Associates	1463 Oakfield Drive Suite 127 Brandon, FL 33511	813-684-7627
Interventions Enterprises, Inc.	718 West Martin Luther King Blvd Suite 200 Tampa, FL 33603	813-933-8865
Joni Stewart Domestic Violence Intervention Program	310 E. Oak Ave Tampa, FL 33602	813-277-0080
MacDill Air Force Base	3240 Zemke Avenue 6th Medical Group/6MDOS MacDill AFB, FL 33621	813-827-9172
Psychological Management Group	15436 N. Florida Ave., Suite 102 Tampa, FL 33613	813-963-1016
Veteran's DVIP James A. Haley VA Hospital	13000 Bruce B. Downs Blvd. Tampa, FL 33612	813-631-7135
Western Judicial Services, Inc.	7829 North Dale Mabry, Suite 104 Tampa, FL 33614	813-930-9595
ADVISE, LLC	2682 Chapman Drive Panama City, Fl 32405	850 258-5549
All-N-One Therapy	120 Library Drive Port St. Joe, FL 32456	850-784-7888
All-N-One Therapy	17773 N. Pear Street Blountstown, FL 32424	850-784-7888
All-N-One Therapy, Inc.	1011 Grace Avenue Panama City, FL 32401	850-784-7888
Community Services of North Florida	4878 Blue Springs Road Marianna, FL 32446	850-526-1172
Cottage House, Inc.	1117 Jenks Avenue Panama City, FL 32401	(850) 215-2370
Abusive Partners of Palm Beach County	1700 N. Dixie Highway Suite 111 Boca Raton, FL 33432	561-750-9710
Alternative/Relapse Treatment Services	3900 Woodlake Blvd. Suite 207 Greenacres, FL 33463	561-434-4410
Counseling Services of Lake Worth, Inc.	416 N. Dixie Highway Lake Worth, FL 33460	561-547-0303
D.A.R.T.	8895 N. Military Trail, Bldg. E, Room 106 Palm Beach Gardens, FL 33410	561-624-6130
Drug Testing & Counseling Services.	2677 Forest Hill Boulevard, Suite 102 West Palm Beach, FL 33406	561-433-0123
Florida Family Care, Inc	400 South Federal Highway, Suite 417 Boynton Beach, Fl 33432	(561) 447-9121
Florida Family Care, Inc.	370 Camino Gardens Blvd., Suite 204 Boca Raton, FL 33432	561-447-9121

Knowledge Is Power	4401 Garden Avenue West Palm Beach, FL 33405	561-845-1919
Let’s Grow Together	851 S.E. 6th Avenue Suite 108 Delray Beach, FL 33483	561-279-2080
New Options of Royal Palm Beach	12794 West Forest Hill Blvd Suite 18B Wellington, FL 33414	561-790-3200
New Options of Royal Palm Beach, Inc	2990 North Main Street Room 32 and Lobby Belle Glade, Fl 33430	561 790-3200
Wellington Counseling and Consulting	12794 W. Forest Hill Blvd., Suite 18G Wellington, FL 33414	561-795-1518
Alliance for Psychological Services	8750 SW 132nd Street Miami, FL 33176	305-251-3464
Anaga Psychotherapy Center, Inc.	11400 Overseas Highway Town Square Mall #203 Marathon, FL 33050	305-743-9588
Alliance for Psychological Services	8750 SW 132nd Street Miami, FL 33176	305-251-3464
Family Therapy Center of West Broward	9950 Stirling Road, Suite 108 Pembroke Pines, FL 33024	954-436-1222
Family Therapy Center of West Broward	2425 University Drive Coral Springs, Fl 33065	954 345-6222
Fifth Street Counseling	130 E. McNabb Road Pompano Beach, FL 33060	(954) 797-5222
Fifth Street Counseling	4121 NW 5th Street, Suite 206 Plantation, FL 33317	954-797-5222
Florida Family Care, Inc.	4555 Sol Press Blvd Coconut Creek, FL 33073	(954) 421-0494
Florida Family Care, Inc.	441 South State Road 7, Suite 5 Margate, FL 33435	(954) 421-0494
Florida Family Care, Inc.	5461 University Drive Suite 104 Coral Springs, Fl 33067	954 421-0494
Florida Family Options, Inc.	233 N. Federal Highway Suite 69 Dania Beach, Fl 33004	954 665-4115
Lifeline of Miami, Inc.	4495 SW 67th Terrace Suite 204 Davie, FL 33314	954-791-5484
Professional Counseling & Consulting	2632 Hollywood Blvd, Suite 304 Hollywood, Fl 33024	(954) 761-9333
Professional Counseling & Consulting Group	1326 SE 3rd Avenue Ft. Lauderdale, FL 33316	954-761-9333
Reflections Wellness Center of Broward, Inc.	6848 Stirling Road Davie, FL 33024	954-362-0104

The Community	16 NE 4th Street Suite 130 Ft. Lauderdale, Fl 33301	(954) 533-9818
The Glass House	4700 N. State Road 7 Building A, Suite 221 Ft. Lauderdale, FL 33309	954-938-0055
A No Abuse Program, Inc.	813 N. Ferncreek Avenue Orlando, FL 32803	407-228-9503
Abolish Abuse/Resolution Counseling	1450 W. SR 434 Longwood, FL 32750	407-830-7903
Central Florida Psychological Services	200 N. Park Avenue Sanford, FL 32772	407-330-0418
Families Against Abuse	282 Short Avenue, Suite 112 Longwood, FL 32750	407-260-6343
Families Against Abuse	1520 Edgewater Drive, Suite J Orlando, Fl 32804	(407) 260-6343
Families Against Abuse, Inc	427 N. Primrose Drive Orlando, Fl 32803	(407) 260-6343
Family Counseling Center	840 Brevard Avenue Rockledge, FL 32955	321-632-5792
Family Counseling Center	4880 Stack Blvd. Melbourne, Fl	(321) 632-5792
Family Counseling Center	725 DeLeon Street Titusville, Fl	(321) 632-5792
New Life Connections	404 W. 25th Street Sanford, FL 32771	407-322-7779
New Life Connections	320 N. Central Ave Oviedo, Fl	(407) 322-7779
New Options Inc	3203 Lawton Rd Suite 150 Orlando, Fl 32803	
New Options, Inc.	254 Wilshire Blvd Casselberry, FL 32707	407-830-1662
Serenity Counseling	300 Wilshire Boulevard, Suite 237 Casselberry, Fl 32707	321 441-3720
Western Judicial Services	1600 Sarno Road, Suite 110 Melbourne, FL 32935	321-752-7557
Western Judicial Services, Inc.	310 Brunson Blvd. Suite 102 Cocoa, FL 32922	(321) 631-6976
Alcohol & Drug Abuse Program (ADAP)	959 SE Central Parkway Stuart, FL 34997	772-287-6310
Alcohol and Drug Abuse Program (ADAP)	357 S.E. Port St. Lucie Blvd. Port St. Lucie , FL 34982	772 204-9085
Alcohol and Drug Abuse Program (ADAP)	800 Virginia Avenue Suite 11 Ft. Pierce, FL 34982	772 879-7777
Alcohol and Drug Abuse Program (ADAP)	638 Old Dixie Highway Vero Beach , Fl 32962	772 879-7777

Breakthrough Recovery Services, Inc	202 NW 5th Avenue Okeechobee, FL 34972	863-467-2300
Breakthrough Recovery Services, Inc.	1623 U.S. Highway 1 Suite B2 Sebastian, FL 32958	772-581-0610
Breakthrough Recovery Services, Inc.	2142 N. US Highway 1 Ft. Pierce, FL 34950	772-489-0005
D.A.R.T.	1005 10th Street Lake Park, FL 33403	561-881-1411
Mental Health Association of Indian River County	820 37th Place Vero Beach, FL 32960	772-569-9788
Recovery Associates, Inc.	8241 South U.S. 1 Port St. Lucie, FL 34952	772-878-9368
Western Judicial Services Inc.	1111 Delaware Avenue Fort Pierce, Fl 34950	772 595-6025
Western Judicial Services, Inc.	1414 Old Dixie Highway Vero Beach, FL	772 595-6025
Abuse Counseling & Treatment, Inc.	P. O. Box 60401 Ft. Myers, FL 33906	239-939-2553
AIM Target Programs, Inc.	3677 Central Avenue, Suite H Ft. Myers, FL 33901	239-939-3363
Alcoholism Treatment Services	Aztec Realty Plaza, Suite A5 4456 Tamiami Trail Charlotte Harbor, FL 33980	941 505-1187
Collier County Counseling/Peace Program	3375 Tamiami Trail East, Suite 300 Naples, FL 34112	239-417-0181
Lighthouse Addiction Services, LLC	2804 Del Prado Blvd, Suite 104 Cape Coral, Fl 33904	239 540-8011
Lighthouse Addiction Services	3596 Tamiami Trail #203 Port Charlotte, FL 33952	941-255-5900
Mental Health Counseling Services, Inc.	Tiffany Square 2828 McCall Road Englewood, FL	(941) 400-3677
S.A.F.E. The David Lawrence Center	6075 Bathey Lane Naples, FL 34116	239-643-6101
Step of Faith Counseling Services, Inc.	223 East Oak Street, Suite 2 Arcadia, FL 34266	863-990-3259
Treatment Works!	211 Airport Road South Naples, Fl 34104	239 263-1161
Treatment Works!	3651 Evans Avenue #105 Fort Myers, Fl 33901	239-263-1161
Valerie Sciaretta, LMFT	207 Cross Street Punta Gorda, Fl 33950	941 204 4451

Resources:

DFC site with statutes on programs
http://www.dcf.state.fl.us/domesticviolence/bip/laws.shtml

Best practices for BIPs
http://www.stopvaw.org/Best_Practices_for_Batterers_Intervention_Programs.html

Nonviolence Alliance
http://www.endingviolence.com/services/direct.php

A Call to Men: Encouraging non-batterers to end violence against women.
http://www.acalltomen.com/

FCADV
http://www.fcadv.org/

Etiquette for Interactions Involving Persons with Physical Disabilities

Do not feel awkward if you have questions about interacting with people who have disabilities. The fact that you care about communicating fully with all of your clients shows that you are trying to be inclusive, sensitive, and fair-minded.

- The United States Department of Labor lists the following guidelines for interacting with a person with a disability:

  - When introduced to a person with a disability, it is appropriate to offer to shake hands. People with limited hand use or who wear an artificial limb can usually shake hands. (Shaking hands with the left hand is an acceptable greeting.)
  - If you offer assistance, wait until the offer is accepted. Then listen to or ask for instructions.
  - Treat adults as adults. Address people who have disabilities by their first names only when extending the same familiarity to all others.
  - Relax. Don't be embarrassed if you happen to use common expressions such as “See you later,” or “Did you hear about that?” that seem to relate to a person's disability.
  - Don't be afraid to ask questions when you're unsure of what to do.

- In addition to the previous guidelines, the U.S. Department of Labor also provided tips for communication with people who specifically have a mobility disability:

  - If possible, put yourself at the wheelchair user's eye level.
  - Do not lean on a wheelchair or any other assistive device.

- Never patronize people who use wheelchairs by patting them on the head or shoulder.
- Do not assume the individual wants to be pushed —ask first.
- Offer assistance if the individual appears to be having difficulty opening a door.
- If you telephone the individual, allow the phone to ring longer than usual to allow extra time for the person to reach the telephone.

o It is recommended to always use people-first language when referring to someone with a disability. The Illinois Department of Human Services has created a pamphlet that outlines the proper use of language, which seeks to empower rather than demean those with disabilities. Examples include *person with disability* instead of *handicapped* and *nondisabled* as opposed to *normal.*

When in doubt, ask: May I help?

References

Illinois Department of Human Services. (n.d.) People first: A guide to interacting with people with disabilities. Retrieved from: http://www.dhs.state.il.us/OneNetLibrary/27897/documents/Brochures/4151%20(N-7-05).pdf

Sagatun, I.J. (1985). The effects of acknowledging a disability and initiating contact on interaction between disabled and non-disabled persons. *The Social Science Journal, 22*(4), 33-43.

United States Department of Labor. (2002). *Communicating with and about people with disabilities.* Retrieved from http://www.dol.gov/odep/pubs/fact/comucate.htm

Updates on Legislation

Senate Bill 1298 and House Bill 777 continue to pass committees without controversy or negative votes. There have been several amendments to the bills; these deal with the requirement (in effect since 1999) that supervised visitation program staff/volunteers who work with families have FBI background checks. The Standards currently require this, but the language has been added directly to the bill, so that Florida Statute 753 includes the background check language.

Gail Tunnock, Stella Johnson, and Sharon Rogers have been actively tracking the bill for the Florida Chapter of SVN.

You can track the bills at http://www.leg.state.fl.us
or

http://www.flsenate.gov/session/index.cfm?BI_Mode=ViewBillInfo&Mode=Bills&ElementID=JumpToBox&SubMenu=1&Year=2010&billnum=1298

Homophobia and Heterocentrism

Editor's Note: This article is included in response to the several phone calls we received after last month's phone conference.

This is a train-the- trainer guide to prepare for an hour-long LGBT training.
Please read it completely before using it with your staff.

Before this training begins it would be useful to have everyone read *Lesbian, Gay, Bisexual, Transgender, & Questioning Youth* and *Working with LGBTQ Parents*, both of which can be found in the Spring 2010 Newsletter.

Purpose of Training

The trainer will start by introducing the purpose of the training:

One of the primary principles for supervised visitation programs is respecting the cultural diversity of the population. In order to uphold that principle in our organizations, it is essential for us to remain sensitive to all people, no matter what their background, ethnicity, gender, age, or sexual orientation. For generations, the world has battled with prejudices. It would be nearly impossible to find an era in history when some identified group was not hated, feared, ostracized, oppressed, stereotyped, marginalized, or discriminated against. Throughout this workshop, let us agree as a group to use respectful conversation as we talk openly and honestly about a potentially sensitive topic.

This training's purpose is not to debate individual beliefs or opinions regarding whether homosexuality is "right or wrong." That is not the issue. The purpose of the training is to understand that each person deserves the right to be respected and not discriminated against based on his or her sexual orientation. According to many people's personal belief systems at that time, Rosa Parks was "wrong" for sitting in the front of the bus. Likewise, women who fought for their right to vote or join the workforce were also "wrong" in the eyes of many at the time of suffrage. Do your best throughout

this training to avoid using the belief that homosexuality is "wrong" as an excuse for exhibiting discriminating behaviors and attitudes.

Objectives

1. Consider our own experiences with LGBT persons.
2. Explore prejudices throughout history and discuss their origins.
3. Apply understandings regarding historical prejudices to the prejudice that currently exists towards the LGBT population.
4. Assess our own homophobia and how it influences our behaviors toward LBGT individuals.
5. Counteract homophobic attitudes with thoughtful arguments.

Exercise #1 –

Experiences with LGBT Population

Start the training off with a simple exercise to get people to think about their own experiences with the LGBT population.

1. Stand if you enjoy working around and with other people.
2. Stand if you have watched a movie or TV show that has an LGBT character in it.
3. Stand if you have (or have ever had) an LGBT friend.
4. Stand if someone in your family is LGBT.
5. Stand if you have ever heard derogatory or negative terms referring to LGBT individuals.
6. Stand if you believe the supervised visitation program for which you work is a safe place for someone who is openly LGBT to come to for assistance.
7. Stand if you believe that every supervised visitation program should be an environment that is free from discrimination based on age, sexual orientation, race, ethnicity, or gender.
8. Stand if you are willing to commit to learning more about how you can be a part of making your program a safe environment for LGBT individuals.

By the time the ninth item is read, the entire room should be standing. Now make the point that we share much common ground, and we are working for the same goals.

Exercise #2 –

Prejudice throughout History

*Ask the group to name some examples of prejudice from our history. Write them on the board as they say them (examples will include: Jews in Nazi Germany, Slavery and Segregation, Attitudes towards Women, Racism/Profiling of Middle Easterners, and Japanese internment during WWII). If there are enough people, break into 3 groups and give each group **ONE** of the following examples of prejudice and the discussion questions on an index card. Otherwise go over each of them with the whole group. Have them discuss the questions that follow as a group.*

- **Racism towards African Americans**
- **Oppression of women**
- **Anti-Semitism**

Discussion questions:

1. How did this particular prejudice look to people at the time?
2. Do you think we as a society or as individuals have gotten past our prejudice towards this population?
3. If it still exists, why do you believe that is?
4. Does fear have anything to do with this prejudice? Why/why not? In what ways?
5. How are these historical attitudes similar to those currently displayed towards LGBT persons?

Trainers can use the following in promoting group discussion for the above activity if necessary.

At one point in our world's history, Nazi Germany was responsible for attempting to extinguish an entire race of people. The Holocaust remains a tragic reality in which approximately 6 million Jewish men, women, and children were taken from their lives where they had homes and jobs and families and

put into concentration camps. They were then made to endure unimaginable atrocities, and eventual death for many. While few see this time in history as anything other than human behavior at its most corrupt and detestable, some groups of extremists still exhibit anti-Semitic behaviors today.

It is astounding that only 50 years ago, blacks and whites were not allowed access to the same educational institutes, the same stores, the same bathrooms, or the same water fountains. They were not *allowed*. Why? Because society, influenced mostly by powerful white people at that time, told them they could not. Back up a few decades and we are forced to acknowledge the reality of slavery, which remains a very tragic blemish on the face of American history. This reality fed a poisonous mentality which allowed segregation and racist behavior to continue long after the abolishment of slavery. All that hatred…and yet our nation has evolved enough to vote a man of African American descent into the White House.

Again, it is astonishing that only 60 years ago women were still discouraged from working outside of the home. Their "role" was clearly defined and they rarely deviated from taking care of the household chores and the children, both very demanding jobs and both highly underappreciated. Back up another few decades to before 1920, and we see that women did not even have the right to vote, powerless to promote change in their own society. Laws to which women were subject were laws in which they were unable to have any voice. Choices were not given to women, because women were not seen as competent contributors to social culture. All that oppression…and yet our nation has evolved enough to have women running major corporations and even running for President of the United States…against a black man. We have come far…in many ways. And yet we still have work to do.

Definitions:

Trainer should go over the following definitions.

Homophobia – Irrational fear of, aversion to, discrimination against, or contempt for homosexual individuals and homosexuality. Examples of homophobia include hate crimes, derogatory comments, and any action, belief, or opinion which would qualify as negative towards homosexual people.

Heterosexism – Much like racism or sexism, this is a system which marginalizes, stigmatizes, oppresses, and denies rights based on sexual orientation. *Explain that you will be using the term homophobia throughout the training to describe negative attitudes and actions towards LGBT individuals.*

Exercise #3 –

Brainstorming Derogatory Phrases of LGBT

Explain to the group that you are now going to brainstorm as many derogatory/negative names, phrases, or words that refer to the LBGT population as they can think of. Get this out in the open so that you can really talk about the word. Write them on a flip chart at the front of the room for everyone to see. Remind them that many of them stood in the opening exercise when they were asked if they had ever heard these phrases. Some people will refuse to say the word, and instead say: "the F word" or something similar. Also, remind participants of the guidelines of respect and to be as open as possible so that they can explore the root of such phrases. Have examples ready to get them started in case they need a push. Once the list is complete, have them look at the list then ask the following rhetorical questions:

1. **How many of these phrases have you heard used in *your organization*?**
2. **How would you feel if such a word was used against someone you loved?**
3. **How do you think it feels to a person to be called these words?**
4. **How are these words dehumanizing?**
5. **Differences: Why do we focus on sexuality, rather than the whole person, when judging LGBT people, but we rarely think in terms of a heterosexual person's sexuality? In other words, why do we look at a person and wonder if he or she is LGBT? What does it matter to us? What are we afraid of?**

Explain that while many of these phrases are used "jokingly" they still represent discriminatory attitudes and judgments toward LGBT individuals and are driven by negative feelings regarding homosexuality. This is a clear example of homophobia and creates an environment of judgment within a program that should not exist.

Optional Exercise #4 –

Assessing Your Own Feelings

Option: Send everyone home with a worksheet of the following questions which will help them assess their own level of homophobia. There is no score, but it will serve as a way to help them start thinking about their own behaviors and attitudes. Alternatively, ask everyone to take this home the day BEFORE the training, to get people to start thinking about their own feelings.

1. Do you laugh at jokes when the humor depends upon put downs and stereotypes of gays, lesbians, or bisexuals?

2. Do you automatically think of gays, lesbians, or bisexuals only in terms of sexuality rather than seeing them as complex people who have, among other significant features, a bisexual or same sex orientation?

3. Do you use dehumanizing slang to refer to LGBT persons?

4. Do you assume that a lesbian, gay man, or bisexual is interested in you sexually, regardless of your sexual orientation? Do you think that if a lesbian, gay man, or bisexual touches you, she or he is making sexual advances?

5. Do you react negatively when lesbians, gay men, and bisexuals discuss their same sex relationships, when you do not react negatively to discussions of opposite sex relationships?

6. Do you feel it is important to make others aware that you are not gay, lesbian or bisexual?

7. Do you fail to confront anti-gay remarks or behaviors for fear of being labeled gay yourself? Do you assume that people speaking up for gay rights or against gay oppression are themselves gay?

Answer the following statements:

1. I would feel comfortable working closely with a male homosexual.
    - Agree
    - No Opinion
    - Disagree

2. I would enjoy attending social functions at which homosexuals were present.

- Agree
- No Opinion
- Disagree

3. I would feel uncomfortable if l learned that my neighbor was a homosexual.
    - Agree
    - No Opinion
    - Disagree

4. I would feel uncomfortable if a member of my sex was attracted to me.
    - Agree
    - No Opinion
    - Disagree

5. I would be disappointed if I learned that my child was homosexual.
    - Agree
    - No Opinion
    - Disagree

6. I would feel nervous being in a group of homosexuals.
    - Agree
    - No Opinion
    - Disagree

7. I would be upset if I learned that my brother or sister was a homosexual.
    - Agree
    - No Opinion
    - Disagree

8. I would feel I failed as a parent if I learned my child was gay.
    - Agree
    - No Opinion
    - Disagree

9. If I saw two men holding hands in public, I would feel disgusted.
    - Agree
    - No Opinion
    - Disagree

10. I would feel comfortable if I learned my daughter's teacher was a lesbian.
    - Agree
    - No Opinion
    - Disagree

11. I would feel at ease talking with a homosexual person at a social function.
    - Agree
    - No Opinion
    - Disagree

12. I would feel uncomfortable if I learned that my boss was a homosexual.
    - Agree
    - No Opinion
    - Disagree

13. It would not bother me to walk through a predominantly gay section of town.
    - Agree
    - No Opinion
    - Disagree

14. It would disturb me to find out that my doctor was a homosexual.
    - Agree
    - No Opinion
    - Disagree

15. I would feel comfortable if I learned that my best friend of my sex was homosexual.
    - Agree
    - No Opinion
    - Disagree

16. I would feel uncomfortable knowing that my son's male teacher was a homosexual.
    - Agree
    - No Opinion
    - Disagree

17. I would feel comfortable working closely with a female homosexual.
    - Agree
    - No Opinion
    - Disagree

When you look back at your answers, think about how a person who is LGBT would feel while reading them. Now think about what efforts you can make and what work you can do to become more sensitive to the diverse community that you serve.

May 2010 EPRESS

Due to popular demand, beginning in May we will try to schedule all phone conferences for the 3rd Wednesday of the month. All calls for the next six months will be at NOON ET.

MAY PHONE CONFERENCE
WEDNESDAY, MAY 19TH

*****12:00 NOON, ET*****

DIAL 719-457-0816 TO PARTICIPATE, YOU WILL NEED TO ENTER A PASS CODE TO PARTICIPATE. THE PASS CODE IS 635786#

JUNE PHONE CONFERENCE:
WEDNESDAY, JUNE 16TH

*****12:00 NOON, ET*****

DIAL 719-457-0816 TO PARTICIPATE, YOU WILL NEED TO ENTER A PASS CODE TO PARTICIPATE. THE PASS CODE IS 635786#

What? 7th Annual Multidisciplinary Conference on Child Abuse

Where? Caribe Royale Orlando, Orlando, Florida

When? Wednesday, August 04, 2010 - Friday, August 06, 2010

THURSDAY IS THE SUPERVISED VISITATION TRACK

The MEETING OF THE FLORIDA CHAPTER WILL OCCUR ON THURSDAY

Karen Oehme has a session from 3:30- 5:00 pm. Any sessions of this conference attended by SV staff will count toward training certificates and credit from the Clearinghouse on Supervised Visitation.

How much? Individual $300, group of 4 or more $275

The first multidisciplinary conference was held in 2004, and the annual event has now become a favorite for many professionals, including:

- Law enforcement personnel
- Medical professionals
- Attorneys, therapists
- Counselors
- Social Workers

With more than 25 speakers and workshops, this year's conference promises to provide something for everyone. Our faculty includes presenters who are recognized for their passion and expertise.

TO REGISTER FOLLOW THE LINK

PDF form to print Conference Registration Form

Or register online click here

House Bill 777 Fails in the Florida Legislature

Despite the fact that Senate Bill 1298, relating to Supervised Visitation, passed the Florida Senate, it failed to be called out of Messages in the House of Representatives. Thus, House Bill 777 – the companion bill – was never sent to the House floor for a vote. The "death" of the bill was largely due to running out of time, as the Legislature left many bills unaddressed at closing. There was bipartisan support for the bill, and no "nay" votes in any of the committees that heard it.

Many people worked on these Bills, and the failure of 777 sorely disappointed them. If any legislators pick up a supervised visitation bill in the fall, we will let you know.

Child Welfare Outcomes 2003-2006 Now Available Online

Child Welfare Outcomes 2003-2006: Report to Congress is the eighth in a series of reports from the U.S. Department of Health and Human Services. The publication is designed to inform Congress and professionals in the child welfare field about the current performance of the States on several measures of outcomes for children served by child welfare systems throughout the country. The outcomes address the safety, permanency, and well-being of the children, and focus on widely accepted performance objectives for child welfare practice. Child Welfare Outcomes 2003-2006 is solely available in electronic format at the Children's Bureau's website. Here you can find the full report, along with an 8-page Executive Summary.
http://www.acf.hhs.gov/programs/cb/pubs/cwo03-06/

Miami SV Training Date: July 12th

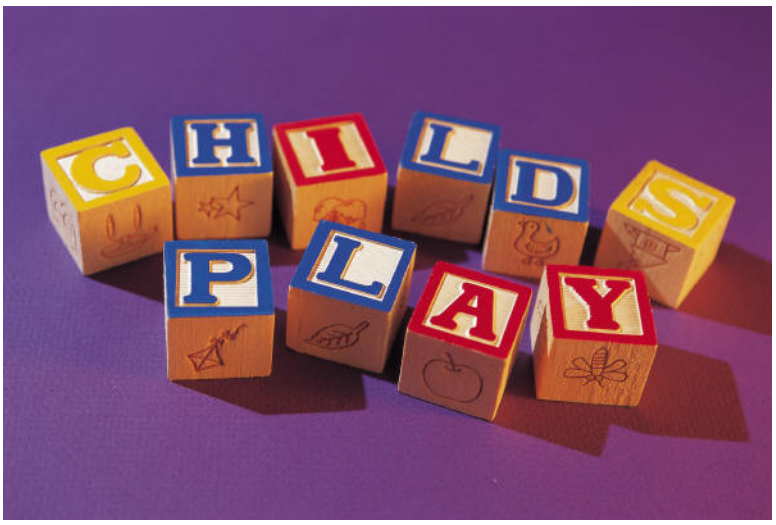
Sign up by April 30!

Linda Fieldstone in Miami has graciously offered to host a Supervised Visitation Training on July 12th at the Miami Courthouse (175 NW Ave, Miami, off of I-95 exit SW 8th St – public parking is across the street). The training by Karen Oehme will last from 10am – 3pm. This opportunity will give everyone in Dade, Broward, Monroe, and Palm Beach counties a chance to receive free training.

Your only cost will be $10.00 for pizza lunch. Please remember to bring $10 *cash.*

We will cover topics including Family Centered Practice, Best Practices (based on the Best Practices), and Ethical Issues. All participants will receive certificates of training.

If you and/or people from your office plan to attend, please email Karen Oehme IMMEDIATELY!
fsuvisit@aol.com OR koehme@fsu.edu



Basics of Play Therapy

By Laura Cassels Summerlin

What is the Purpose of Play Therapy?

Those who work closely with children know and understand that children act out or express feelings, wishes, or ideas through play. Children also use their play to imagine themselves in certain situations or circumstances. Having this understanding of the purpose of Play Therapy may seem obvious. Therapists use Play Therapy strategically with children to help them identify and express emotion or pain. When used appropriately in a safe and warm relationship, it can be used to bring about healing and problem-solving for children who have experienced trauma or distress.

Who Benefits from Play Therapy?

Play Therapy is used mostly with children from ages 3 through 12 years. However, some adults and teenagers have also benefited from Play Therapy in healthcare and mental health settings. Play Therapy is used at large to benefit children with a variety of emotional and developmental concerns.

When is Play Therapy Used?

Play Therapy is used when children have undergone some sort of difficult or traumatic event or situation. The following are some examples of concerns where Play Therapy might be used with children:

1. Anger
2. Behavioral issues
3. Grief and loss
4. Divorce or family dissolution
5. Physical or sexual abuse
6. Chronic illness
7. Anxiety or depression
8. Developmental issues such as autism, ADHD, academic or social concerns, learning disabilities, etc.

How does Play Therapy Help?

Play Therapy is meant to subtly equip children to do the following:

1. Learn to experience and express emotion.
2. Develop new and creative solutions to problems.
3. Learn new social skills and relational skills with family.
4. Become more responsible for behaviors and develop more positive strategies.
5. Develop respect and acceptance of self and others.
6. Cultivate empathy and respect for thoughts and feelings of others.
7. Develop self-efficacy and confidence in their own abilities.

What are Some Tools of Play Therapy?

Play Therapy uses a variety of techniques and tools to initiate play with children. Here are just a few examples that are used most often:

1. Dress-up/Role-play
2. Card Games/Ball Games
3. Sandtrays/Moon Sand
4. Puppets/Dolls
5. Sensory Activities
6. Art (painting, play dough, etc.)
7. Toys
8. Books

Play Therapy is meant to be used by trained professionals in a therapeutic setting that is safe for the children who are engaged in the process. Many times the therapist will work with the families of the children as well. The sessions usually last around 30-50 minutes and are held about once a week. They will last approximately 20 weeks, but will go shorter or longer depending on the severity of the case and how quickly the clients progress.

For more information:

1. Association for Play Therapy: http://www.a4pt.org/ps.index.cfm?ID=1653
2. http://counselingoutfitters.com/vistas/ACAPCD/ACAPCD-12.pdf

New Report Shows Child Maltreatment Decreased in 2008; Prevention efforts to be intensified

The U.S. Department of Health and Human Services' (HHS) Administration for Children and Families (ACF) announced today that 2008 saw the lowest child victimization rate in five years. In addition, the number of children who suffered maltreatment decreased for the second year in a row. These findings are contained in "Child Maltreatment 2008," an annual report issued every April marking the start of National Child Abuse Prevention Month.

The recent data show an estimated 772,000 children were victims of child abuse and neglect, a rate of 10.3 per 1,000 children. Data from the states continue to indicate that almost a third of the victims are younger than four years old. More than three million reports of suspected child abuse and neglect were received in 2008, involving six million children nationwide.

"Although we are encouraged by the decrease in child maltreatment, the results show too many children still suffer from abuse and neglect, and we have not yet experienced the full impact from the economic situation," said Carmen R. Nazario, HHS assistant secretary for children and families. "As our commitment, we will continue to strengthen prevention strategies that target critical resources for families and communities at risk."

One such strategy is in the recently-signed health care law. The act provides funding to states, territories and tribes, beginning with $100 million in FY 2010 and increasing to $400 million in FY 2014, for home visiting programs to improve children's health and well-being related outcomes, including the prevention of child abuse and neglect.

Another strategy is a foster care initiative that began this fiscal year and is proposed at $20 million per year over five years. It is designed to implement innovative approaches to reducing long-term foster care and finding a permanent placement for children who are victims of child abuse and neglect.

One of ACF's latest prevention efforts involves The National Quality Improvement Center on Early Childhood (QIC-EC). This is a $10 million dollar, five-year project launched in 2008 to address the nation's urgent need to find innovative, effective approaches for reducing the likelihood of abuse and neglect for children from birth through five years of age.

The QIC-EC recently awarded four new research and demonstration projects to test the impact of collaborations across sectors on promoting optimal child development, strengthening families and reducing the likelihood of maltreatment. The new projects will include partnerships with IDEA Part C early intervention services, substance abuse programs for pregnant women, legal services and family support within a primary health care setting, and a multi-faceted neighborhood mobilization, led by residents and including businesses, faith communities and human services. These grants were awarded to the Boston Medical Center (Boston, Mass.), Catholic Community Services (Salem, Ore.), the University of Colorado (Aurora, Colo.), and the University of South Carolina (Columbia, S.C.).

"These new grants reflect our conviction that stable communities with well-coordinated service systems are the best environments for preventing child maltreatment among the youngest children, while promoting the potential of all children. When we capitalize on the strengths within communities and families, we can create not only healthier homes, but also stronger, more vigorous neighborhoods where economic development can thrive," said Bryan Samuels, ACF commissioner of children, youth and families.

The full report, "Child Maltreatment 2008," is available at: http://www.acf.hhs.gov/programs/cb/pubs/cm08/.

For more information about the QIC-EC, visit: www.qic-ec.org.

Additional information on National Child Abuse Prevention Month and child abuse prevention in general is available at the Child Welfare Information Gateway: http://www.childwelfare.gov/preventing.

Anti-Meth Campaign

Several directors have noticed the new anti-meth campaign on television and billboards, especially in North Florida. These very graphic and intentionally disturbing ads emphasize the danger of methamphetamine, and are part of a Georgia Meth Project aimed at keeping kids from trying meth "even once."

According to abovetheinfluence.com-

- Methamphetamine is a highly addictive drug that can be snorted, smoked, injected, or swallowed.
- It acts as a stimulant on the body that leads to increased heart rate, blood pressure, and respiration. There is also a risk of hyperthermia.
- Psychotic features, such as paranoia, hallucinations, and delusions, can accompany meth use. One common example of this is the feeling of "Meth bugs" crawling underneath the user's skin.
- Street names for methamphetamine include, but are not limited to, chalk, speed, crystal meth, black beauties, ice, tweak, and crank.
- Florida is a prominent state in international trafficking of meth from illegal Mexican organizations. More recently, methamphetamine labs have been on the rise in the state.

Supervised Visitation program staff should be aware of the "epidemic" of meth use.

- In 2008, Florida had 125 "laboratory incidents," which include the findings of labs, dumpsites, and/or equipment.
- 26,426 arrests involving methamphetamine were made in the United States in 2008. That number has increased over the last two years.

PREVENTION EFFORTS

ONDCP's Anti-Meth Campaign

In September of 2009, the Office of National Drug Control Policy's Anti-Meth Campaign was initially implemented. It targeted young adults ranging in age from 18 to 34 and those of any age who are close to a possible user. The campaign was designed to increase prevention knowledge as well as raise awareness on treatment and recovery. Through the use of social media (television, radio, etc.), the creators of the campaign intended to reach those most at risk of methamphetamine usage. The campaign ran for one month, and was implemented more rigorously in the sixteen states with the highest current usage, including Arkansas and Kentucky. For more information on the ONDCP's Anti-Meth Campaign, please visit: http://www.meth resources.gov/index.html.

Georgia Meth Project

The Georgia Meth Project launched its statewide prevention campaign on March 8, 2010. According to their website, it is a "large scale-prevention program aimed at significantly reducing first-time meth use through public service messaging, public policy, and community outreach." These advertisements have also reached areas such as Tallahassee in north Florida. The Georgia Meth Project has labeled Meth as a dangerous drug that acts on the central nervous system and that has the power to drastically change areas of the brain. The campaign was designed through research-based messaging techniques that "graphically" depict possible consequences of meth use. Specific ads can be found at: http://www.georgiamethproject.org/ View_Ads/index.php#. Funding for the campaign was attributed to individuals, corporations, and foundations.

Resources

Above the Influence: http://www.abovetheinfluence.com/facts/drugs-meth.aspx?id=search_properMeth#
United States Drug Enforcement: http://www.justice.gov/dea/statistics.html
Georgia Meth Project: http://www.georgiamethproject.org/index.php
ONDCP's Anti-Meth Campaign: http://www.methresources.gov/Index.html

MAY IS SUPERVISED VISITATION MONTH: What is your program doing to celebrate? Tune in to the monthly phone call to share your ideas and activities.

Effects of Alcoholism on Families

By: Kayla Wesighan

Introduction

While alcohol is legal in most areas of the United States, it is still considered a drug. According to abovetheinfluence.com, alcohol "alters a person's perceptions, emotions, movement, vision, and hearing." Different forms of alcohol are used for a variety of purposes. When it is consumed by people in the form known as ethanol, it goes directly into the bloodstream and affects the central nervous system. Due to the pervasiveness of alcohol in the United States, April is known as Alcohol Awareness Month. This month aims to educate the public on alcohol use and abuse. For those who struggle with alcoholism, it is important to remember that the consequences are wide-ranging. Not only does alcohol dependence negatively affect the consumer, but it also impacts others around that individual, most importantly those in his or her family.

Overview

This article aims to provide the reader with information on how alcoholism affects families. Alcoholic families tend to function in a less healthy manner and, as a result, break up more often due to divorce, child abandonment, participation in the child welfare system, etc. There is help available, which has proven successful for recovering alcoholics; however, for many it is a hard journey toward sobriety.

Objectives

After reviewing this article, the reader should be able to:

- Understand the causes of alcoholism.
- List environmental problems in alcoholic families.
- Recognize alcoholism's relationship to abuse and neglect.
- Know how alcoholism affects children's mental health.
- Be conscious of long-lasting effects on adult children of alcoholics.
- Understand some of the effects of alcohol use by pregnant women.

Snapshots

- Alcoholism is also known as "alcohol dependence." (SAMSHA)
- The four symptoms of alcoholism include cravings, loss of control, physical dependence, and tolerance. (SAMSHA)
- The majority of people with alcoholism need some form of treatment to gain and maintain sobriety. (SAMSHA)
- To accomplish recovery from alcoholism, it is much more than a matter of "will power." (SAMSHA)
- Fifty percent of adults are considered current regular drinkers, consuming at least 12 drinks in the past year. (CDC)
- In 2006, there were 22,073 alcohol-induced deaths, not including accidents and homicides. (CDC)
- Over 76 million people at one time or another have considered themselves addicted to alcohol. (Gitundu)
- "Adult Children of Alcoholics" refers to alcoholism as a "family disease" because of its negative effects on all involved. (ACOA)
- Over 28 million Americans are children of alcoholics. (NACOA)
- Almost 20 percent of adults lived with an alcoholic growing up. (NACOA)
- Alcoholic families tend to function in an unhealthy manner compared to families without alcohol dependence. Common occurrences include communication issues, unstable environments, and violence (NACOA).

Case Vignette:

When Mary Smith pulled the car off the road to answer her mobile and hear the news of her father's death, she felt just "a calm relief".

"Really, I had lost my dad many years before. His mind had gone at least four years before," said Smith

(not her real name). "Sometimes I think about what we went through and I can't quite believe that we got through it. There were a lot of bad times."

Her father was an alcoholic who drank himself to death. All the help his young daughters and his wife tried to get him, from detox programs, to rehab, to psychiatric sessions, had failed. "He chose to drink, and he chose that over us. It took me a long, long time to accept he had a disease, but my anger had gone before he died." Smith, now 27, spent her late teenage years trying to protect her younger sisters, support her mother and get help for her father. There was little time for her to enjoy her youth.

"I did take the brunt of it. No one should have to beg their mother to get a divorce, or their father to stop drinking and choose them over alcohol."

-From News Portal, Hidden Burden of Alcoholic Parents

Causes of Alcoholism

Children who grow up in alcoholic families are at a high risk of having alcohol and/or other addiction problems. They are four times more likely to develop alcoholism than other children. This has been attributed to both genetic and environmental factors. Studies have been conducted on adopted children of biological parents who were alcoholics and results show they are at an increased risk of future dependence, leading researchers to believe there is a genetic component to alcoholism. Genetic predispositions have also been researched in other studies, some of which have found an especially high risk in male children with alcoholic fathers. Additionally, parent attitudes have been attributed to a child's future use and/or abuse. Alcoholic parents tend to monitor their children less, and combined with the negative environment, children are more likely to experiment with alcohol, in particular at earlier ages. About 33 percent of current alcoholics claim to have grown up with an alcoholic parent.

Environments of Alcoholic Families

Forty-three percent of children in the United States have lived with, or are currently living with, at least one person with an alcohol abuse or dependence problem. There are many aspects of this environment that may prove to be detrimental to children. For example, it is common for alcoholic families to have more significant communication problems than families without a member struggling with alcoholism. They typically show less signs of warmth and more intense spurts of anger. Fighting, blaming, and arguing are much more common as well. Because children cannot count on their alcoholic parent to act in a predictable manner, relationships are strained and healthy family functioning diminishes. Additionally, families with alcoholic members are more likely to have boundary issues and children who have to take on the role of caretaker. For all of these reasons, as well as many others, stress in families with alcoholism tends to be substantially high. However, it must be noted that each family deals with these issues differently and that resiliency plays an important role in how each individual copes.

Abuse and Neglect Related to Alcoholism

All forms of child abuse and neglect have a much greater prevalence rate in alcoholic families. Over 70% of child welfare professionals claim that substance abuse is the primary reason for the influx in child maltreatment in the United States. Because of this, children from alcoholic parents are at a much

greater likelihood of either running away, being turned over to the child welfare system, and/or being abandoned by their parent(s). Alcoholism has also been present in the majority of incest cases.

In addition, domestic violence between partners has been linked to alcoholism. Research has estimated that between 60 and 70 percent of all assault cases had some form of alcohol involvement. While many claim that there is no proof of causation, the strong correlation between alcohol and domestic violence has remained high over the years and numerous research projects have aimed to understand the exact relationship between the two. However, the issue will most likely continue to be debated in the future.

Mental Health of Individuals in Alcoholic Families

Children are affected by familial alcoholism in all areas of their lives. Most display greater levels of anxiety and depression than children without an alcoholic parent or other family member. Low self-esteem in these children is all too common as well. According to the National Association for Children of Alcoholics (NACOA), younger children are prone to bed-wetting, uncontrollable crying, and sleeping difficulties, whereas older children cope in other ways, including the tendency to either keep to themselves or try to compensate by becoming perfectionists. In general, children of all ages also present with higher rates of behavioral disorders and mental illnesses. Due to these factors, children often fall behind in school and lack positive relationships with their peers. The NACOA has reported that the overall health care costs for children of alcoholics are almost one third higher than those without alcoholic parents.

Spouses of alcoholics must often take on the roles of both individuals in the relationship. Especially if there are children, the non-alcoholic spouse can become overwhelmed with the extra duties, financial strain, and ill-feelings toward his or her significant other. If violence is involved, spouses are at a higher risk of physical harm and mental illness than in other families. Unfortunately, co-dependency is also common in alcoholic families, which may unintentionally result in enabling behavior. Families try to hide the problem and appear perfect to others, often believing the problem will be resolved soon.

Case Vignette:

The moment my car turns down the road leading to our house, I feel my nerves tighten, my stomach clench, and my hands to start to shake. Pulling into the driveway I shut off the car. I sit there for a moment gathering my courage to face whatever I may find when I walk through the door.

He greets me with a smile and a kiss, and I breathe a sigh of relief. Today he is sober. It has been almost six months since his last drink, I want to believe this time he will make it. This time he will stay clean and sober for good. But, I know, as everyone who has ever lived with an alcoholic does, how easy it is for them to slip off the wagon.

One day at a time, they teach in AA. That philosophy not only applies to the alcoholic, but to the person who lives with and loves them. You learn to be grateful for each day he is sober, and not to fall apart each day he is not.

It wasn't always like that. In the beginning there were the tears, the recriminations, the begging. I must have said a hundred times if you really loved me you would stop. He would of course promise to quit and he would keep that promise a day, a week, sometimes a month and I would think, It is over.

Then I would open a drawer to put away clothes and there would be a bottle that had not been there the day before. Or he would be late coming home from work and I would imagine him lying on the road a bloody unrecognizable mess. When he did arrive, drunk and stumbling, he would take himself off to bed and fall instantly asleep, while I would lie awake all night and cry or pray.

When I was home, I wanted to be at work to escape the compulsion to watch him every minute of every day. Then, at work, I would long to be home to make sure he was safe. It was a vicious circle that had no end.

-Martie Lownsberry (from Testimonies: Living with Alcohol)

Adults who Experienced Parental Alcoholism Growing Up

According to Adult Children of Alcoholics (ACOA), many adults who grew up as children of alcoholics are still feelings its effects. Often, these adults feel isolated, depressed, either become alcoholics themselves, or marry an alcoholic spouse. Aggressiveness and impulsiveness are also commonly found in adult children of alcoholics. Trust is very hard for them because of their unpredictable childhood experiences. ACOA considers these adults "co-victims" of alcoholism because, even if they did not drink as children, they still have suffered many consequences of their parents' dependence.

ACOA provides adult children of alcoholics with "promises" and "steps" to aid in their acceptance and attempt to overcome the high risk factors of alcoholism and lead healthy lives. The steps are tailored to fit ACOAs from the original Alcoholics Anonymous 12-step therapy, some of which include the following:

"1. We admitted we were powerless over the effects of alcoholism or other family dysfunction, that our lives had become unmanageable.

2. Came to believe that a power greater than ourselves could restore us to sanity."

Prenatal Alcohol Effects

The number of women who consume alcohol during their pregnancy has been on the rise, including alcoholics as well as non-alcoholics. Alcohol can have many serious consequences for the fetus at all stages of pregnancy. According to NACOA, about six percent of alcoholic women have babies with Fetal Alcohol Syndrome (FAS). This lasts for the baby's entire life and typically requires special services. Babies born with FAS can experience a host of problems, some of which include (from Medline Plus):

- Mental Retardation
- Birth Defects
- Growth Problems
- Behavioral Problems
- Cognitive Impairments

It is important to note that cognitive impairments appear to be less severe if the mother stops drinking early in her pregnancy, although even early exposure can pose harm to the fetus.

Resources:

Above the Influence: Alcohol
http://www.abovetheinfluence.com
Adult Children of Alcoholics World Service Organization, Inc.
http://www.adultchildren.org/index.s
Centers for Disease Control and Prevention
Alcohol Use
http://www.cdc.gov/nchs/fastats/alcohol.htm
Domestic Abuse and Alcohol
http://alcoholism.about.com/cs/abuse/a/aa990331.htm
Gitundu, Peter
Alcoholism Statistics
http://ezinearticles.com/?Alcoholism-Statistics&id=1893582
Medline Plus, s service of the U.S. National Library of Medicine and the National Institutes of Health
http://www.nlm.nih.gov/medlineplus/fetalalcoholsyndrome.html
National Association for Children of Alcoholics
Children Of Alcoholics: Important Facts
http://www.nacoa.net/impfacts.htm
News Portal
Hidden Burden of Alcoholic Parents
http://worldnews.hometips4u.com/hidden-burden-of-alcoholic-parents
Parsons, Tetyana (2003). *Alcoholism and its effects on the family.* AllPsych Journal.
http://allpsych.com/journal/alcoholism.html
SAMSHA
Alcoholism
http://ncadistore.samhsa.gov/catalog/facts.aspx?topic=3
Testimonies: Living with Alcohol
http://www.helium.com/items/1455043-alcoholism-living-with-an-alcoholic-effects-of-drinking-on-an-alcoholics-family

Child Abuse Prevention Effort: An Overview

By: Lisa Langenderfer

Each year nearly one million children are victims of child abuse, defined as doing something that harms a child or failing to protect a child from a harmful situation. This problem knows no bounds; it is prevalent in all races, ethnicities, socioeconomic statuses, regions, religions, and education levels. In the United States, a child abuse report is made every ten seconds and it is estimated that nearly five children die each day from abuse. Even those who survive childhood abuse often go on to experience more problematic life situations than their non-abused counterparts. Beyond the child, the abuse affects everyone; in 2007, it was reported that child abuse and neglect cost the U.S. $104 billion. One of the best ways to alleviate this epidemic is to ensure prevention efforts are made.

Forms of Child Abuse

Child abuse can take many forms, including physical, emotional, or sexual abuse, as well as neglect.

Long-Term Effects of Childhood Abuse

If a child survives childhood abuse, there are still many long-term consequences he or she may face. The type of consequences is related to the severity, type, and duration of the abuse endured. Some of these consequences include:

- Impaired brain development
- Psychiatric problems and disorders (e.g., depression, eating disorders, suicide)
- Social Interaction problems
- Legal problems, including criminality in youth and adulthood
- Substance abuse
- Abusive behavior toward others

The Financial Cost of Child Abuse

Abuse is very costly to all Americans. The funding needed to maintain child welfare organizations as well as medical, legal, and psychiatric services falls on everyone. In 2001, (last data available) the annual direct and indirect costs were estimated to be $24 billion and $69 billion, respectively.

Child Abuse Factors

Research has shown that there are certain patterns when it comes to child abuse, including both risk and protective factors.

Risk Factors

- Parental mental health problems
- History of abuse, including domestic violence
- Substance abuse
- Teen parents
- Single-parent homes
- Financial stressors
- Disabled Child
- Social isolation

Protective Factors

- Affection beginning at birth
- Strong parenting skills
- Parental stress-management skills
- Social/emotional support

Types of Prevention

There are three levels of prevention commonly utilized with regards to child maltreatment:

- *Primary Prevention*: efforts are aimed at the entire population and are created to prevent child maltreatment before it occurs (e.g., public service announcements)
- *Secondary Prevention:* efforts are aimed at at-risk individuals (and populations) to prevent child maltreatment before it occurs (e.g., parent education classes for at-risk parents)
- *Tertiary Prevention:* efforts are aimed at individuals and families where abuse has already occurred in order to decrease the negative consequences associated with the abuse and to

prevent further abuse from occurring (e.g., mental health counseling for parents and children involved in maltreatment)

Prevention Efforts

Based on research conducted on the risk and protective factors of child abuse, prevention efforts are being implemented to stop the abuse and promote overall child wellness. Through education and family programs, child abuse rates have the potential to decrease and money –as well as lives --could be saved.

National Organizations

National Child Abuse Hotline
1-800-4-A-CHILD
http://www.childhelp.org/

The National Child Abuse Hotline is a free, anonymous, and confidential hotline for anyone suspecting abuse or experiencing abuse. Serving the U.S., U.S. territories, and Canada, counselors are available 24 hours a day, seven days a week and speak over 100 different languages. They offer crisis counseling, education, and referrals to their callers.

Prevent Child Abuse America
http://www.preventchildabuse.org/index.shtml

Since its inception in 1972, PCA America has provided research, education, and advocacy for child abuse on both national and local levels. Their website offers information on current projects and programs, publications, upcoming events, and links to more information regarding child abuse.

Women, Infants, and Children Nutrition Program
http://www.fns.usda.gov/wic/

The WIC program provides nutritional education and counseling, as well as financial support for food for low-income women and their children (under age five). Each state receives individual funding to provide for its citizens. Because the program is need-based, it helps alleviate some of the stressors experienced by low-income families, therefore decreasing the risk for child abuse.

Pinwheels for Prevention
http://www.pinwheelsforprevention.org/

Prevent Child Abuse America has recently launched this national campaign to stop child maltreatment before it begins through new public policy and motivating individual communities to get involved. In addition to adopting the pinwheel as a symbol of prevention, the program uses the popular children's book characters the Berenstain Bears as "spokesbears" for the campaign.

The American Professional Society on the Abuse of Children (APSAC)
http://www.apsac.org/

APSAC is the premier national organization for professionals whose goal is to provide the utmost care for individuals and families that have been affected by child maltreatment. Currently, nine states, including Florida, have individual chapters. Some of the resources APSAC provides include:

- Annual colloquiums for professionals to learn tools for working with maltreated children to improve care
- Various publications for professional use
- Free web-training for trauma-related cognitive behavioral therapy, funded through the U.S. Department of Health and Human Services

Florida Organizations and Programs

Child Abuse Prevention and Permanency Advisory Council, Office of the Governor
http://www.flgov.com/child_abuse_prevention

In 2008, the Florida Legislature developed an 18-month plan to run from January 2009 through June 2010 that addresses child maltreatment prevention in Florida. The 32-member Council is using this plan as a launching point for a more extensive five-year plan.
A primary goal for the Council is to obtain permanent placements for foster children, either through biological family reunion or adoptive placement. To do this, the council promotes:

- Prevention of child maltreatment
- Adoption
- Support for adoptive parents and families

Children's Medical Services
http://www.doh.state.fl.us/Cms/HProviderPIAbusePrev.html

This organization boasts a prevention unit that identifies, creates, and organizes ways to prevent child abuse and neglect before it begins.

- Operates using primary and secondary prevention techniques
- Utilizes materials that can be easily distributed to individuals and organizations that have vested interests in ending child abuse, such as the Department of Health or individuals attending health-related affairs

The Ounce of Prevention Fund of Florida
http://www.ounce.org/index.asp

"Ounce," a private, non-profit corporation has contributed to child maltreatment prevention policies and funded new prevention programs since 1989. Some of these programs include:

- YoungLives Tallahassee
- Leading Toward Safer Schools
- Turtle Nest Village
- Teen Males Health Tour
- Nuestras Familias

The "Ounce" website offers various links to resources on child maltreatment prevention. Some of the topics include:

- Shaken Baby Syndrome
- Circle of Parents support groups
- Local events for prevention efforts
- Public service announcements featuring Florida residents, including Dwight Howard of the Orlando Magic

Department of Children and Families Florida Abuse Hotline
1-800-96-ABUSE
1-800-914-0004 (Fax)
http://www.dcf.state.fl.us/programs/abuse/

The Florida Abuse Hotline is a central intake for any suspected child abuse concerns. The caller provides information about the suspected abuse; if it meets criteria determined by the Department of Children and Families (DCF), the operator will accept the report and an investigation will begin within 24 hours. If the child is believed to be in immediate danger, every effort is made to make contact with the child immediately. Any citizen or professional acting in good faith is exempt from any legal liability. All reports are confidential and the reporter is only required to provide their name and agency if he or she is a "professionally mandatory reporter." To fax a report, one needs to obtain the necessary form from the website. Online reports can be made if danger to the child is not immediate.

Florida Coalition for Children
http://www.flchildren.org/

The Coalition advocates for abused and neglected children and supports the agencies that serve this population. The goal of the organization is to ensure safe and healthy environments for Florida's families.

Child Abuse Council
http://www.childabusecouncil.com/

This organization is a private, non-profit agency that deals with both prevention and treatment of child abuse, as well as providing education. In 2008, the Council served 60,000 children and adults. The prevention programs are aimed at potentially abusive parents or those experiencing substantial stress.

Individual Efforts

There is a wide variety of ways that each of us can help end child abuse and neglect. Some examples include:

- Volunteer for programs that aim to end child maltreatment
- Offer to help a parent who is struggling or simply needs a break
- Write a piece for your local newspaper to educate others on what you know

- Stay alert to both risk factors and warning signs of potential child maltreatment
- Report suspected child abuse

Websites of Interest:
http://www.nlm.nih.gov/medlineplus/childabuse.html
http://www.childhelp.org/pages/statistics
http://safechild.org/childabuse2.htm
http://safechild.org/childabuse3.htm
http://safechild.org/childabuse1.htm
http://safechild.org/childabuse4.htm
http://www.childwelfare.gov/pubs/factsheets/long_term_consequences.cfm
http://www.childwelfare.gov/can/factors/
http://www.flgov.com/adoption_abuse_prevention
http://www.flgov.com/pdfs/ChildAdvocacy/flplcapp122008.pdf
http://www.doh.state.fl.us/Cms/HProviderPIAbusePrev.html
http://www.ounce.org/index.asp
http://www.pinwheelsforprevention.org/
http://www.pinwheelsforprevention.org/learn_more/reach_out.html
http://www.pinwheelsforprevention.org/learn_more/report_abuse_neglect.html
http://www.athealth.com/Consumer/issues/AbusePrev2.html

Facing Termination of Parental Rights: Rise Magazine Spring 2010

While the majority of children placed in foster care return home to family, many children do not. In some cases in which parental rights are terminated, children and parents may not see each other again. Other times, families stay connected despite termination. In the Spring 2010 issue of Rise Magazine, parents write about how they have handled termination. Rise magazine is written by and for parents involved in the child welfare system. Its mission is to help parents advocate for themselves and their children.

http://www.risemagazine.org/PDF/Rise_issue_15.pdf

June 2010 EPRESS

Due to popular demand, all phone conferences will be scheduled for the 3rd Wednesday of the month. All calls will be at NOON ET.

JUNE PHONE CONFERENCE:

WEDNESDAY, JUNE 16TH

*****12:00 NOON ET***DIAL 719-457-0816 TO PARTICIPATE, YOU WILL NEED TO ENTER A PASS CODE TO PARTICIPATE. THE PASS CODE IS 635786#**

Planning ahead?

JULY PHONE CONFERENCE

WEDNESDAY, JULY 21ST

*****12:00 NOON, ET*****

Remember to register for the August conference in Orlando – www.fncac.org

JUNE IS BIANNUAL PERFORMANCE MEASURE MONTH!

There is a one page survey at the end of this e press.

Please fill it out and email it back today! It should take two minutes! **Yes, staff, too!**

Family Counseling

Question from a Director: A father and his two adolescent sons were referred to family counseling. They have been going now for six weeks. What is it, exactly? I'm impressed with what I see at visits. It seems to be working with this family.

"What is family counseling?"

Family counseling is a form of solution-focused psychotherapy that concentrates on strengthening relationships and reducing conflict within the familial system. Its holistic approach can be considered very different from other forms of counseling, such as individual counseling. Overall goals usually center on increasing family functioning and creating healthy relationships between those who participate. Originally gaining popularity in the 1940s and 1950s, family counseling tends to minimize individual problems and stress the importance of family issues, specifically communication difficulties and/or breakdowns. Therefore, problems are approached from a group perspective and are rarely reduced to a single person. Sessions are typically held by licensed clinical social workers or marriage and family therapists and are relatively short-term, averaging 12 sessions. Additionally, participants in family counseling can vary from entire families (parents and children, one parent with his or her children), and occasionally individuals in one-on-one sessions with a clinician.

Reasons for Family Counseling

"Why do people go to family counseling?"

People use family counseling for a variety of purposes, ranging from financial problems and marital dissatisfaction to relationships between family members, and everything in between. In general, any family system that could benefit from improved functioning can benefit from family counseling. It is also common for family counseling to be used as a tool to supplement another form of counseling, such as an addition to individual counseling for a teenager with Anorexia Nervosa. The specific problems presented, taking into consideration those who are directly involved, will guide the goals of the sessions. However, most issues presented in counseling are attributed to faulty communication patterns and/or problematic relationship styles. This is often seen as the underlying dilemma, despite the specifics for which the client(s) are seeking counseling.

Types of Family Counseling

"What kinds of family counseling are available?"

Over the years, family counseling has taken on many different forms and focuses, including the six described below:

Structural: This approach emphasizes an adherence to a belief in a "normal" or conventional structural model of family functioning, based on family member hierarchies and semi-permeable boundaries, and attempts to replicate this in families seeking treatment.

Strategic: This approach is based on the hypothesis that the symptom is being maintained by behaviors that seek to suppress it.

Milan Systemic: This approach uses "circular and reflexive" questioning of participants on their beliefs and views of the relationships in the hope that it will change a family's interaction style, always taking a non-critical approach of others.

Narrative: This approach attempts to create new stories of previous events with a more positive form of analysis, focusing on strengths rather than problems.

Psychoeducational: Through this approach, participants are taught about the problem as well as effective ways to reduce or eliminate problematic coping mechanisms; endeavors to lessen emotional intensity.

Behavioral: Through this approach, behavioral change techniques are used, aiming to maximize pleasurable experiences and eliminate troublesome ones, using concrete goals and observable behaviors.

Techniques Utilized

"What happens in family counseling?"

Family counseling makes use of a variety of techniques to aid in accomplishing the goals and objectives agreed upon by family members in the initial session. At the beginning, listening and communication skills are enhanced through the practice of restating or paraphrasing another family member's statements, acknowledging another's feelings, expressing one's own feelings, and learning to "fight fairly." Here's an example of what you might hear if you listened in on a session. In week one, Dad says, "I am sick and tired of the way you take care of your pig pen room!" By week three, Dad is taught to make "I" statements such as "I feel tired of picking up your clothes after I washed and dried them. If I get a little more help around the house, I won't be so frustrated when I come home from work." The teenager then learns to rephrase and summarize what he hears: "I hear you saying, Dad, that you would like me to help out more. I'm going to try."

Cognitive restructuring and reframing are also commonly used to help family members view situations from a different perspective or see them through

another person's eyes. In order to gain a history of the family, the family therapist will often create a genogram collaboratively with the family. This graphically represents a picture of the family structure and other important background information. Furthermore, some therapists like to discuss family photos brought in by participants because they often reveal significant facets of family relationships and interaction patterns. In some cases, the empty chair technique helps a client to role play conversations between themselves and another family member, who is absent from the session. This list of techniques is in no way exhaustive, but represents some of the many techniques that clinicians utilize in family counseling to help families increase their level of successful functioning.

Effectiveness of Family Counseling

"Does family counseling work?"

Some studies have shown that about 90% of individuals who seek family counseling report positive progress in their psychological and emotional well-being. This includes both children and adults. As a whole, family counseling has proven to be more effective than no treatment and equally effective, if not more effective, than other therapies for a broad range of issues, including psychosis, mood disorders, and eating disorders. Additionally, studies showed that its effects continued after counseling was ended, however this diminished over time. As mentioned previously, family counseling is also effective when used in a multimodal treatment context with other types of counseling.

Resources

http://www.mayoclinic.com/health/family-counseling/MY00814

http://www.aamft.org/faqs/index_nm.asp

Meaningful Time with Infants

By: Heather Howard

Even though infants cannot communicate with us as much as older children, time spent with them can often be meaningful and beneficial to the child and the parent. If parents take certain steps, time spent together can become a bonding experience for the two, as well as a time for the baby to develop a sense of trust.

The bonding process:

- **Is crucial to an infant's development.**
- **Gives an infant a sense of security and has the potential to foster self-confidence.**
- **Helps an infant to be well-adjusted around others once he or she gets older.**
- **Is a gradual process that happens step-by-step and should not be rushed or forced.**

Tell your clients: Infants bond in many ways.

- **Touch - Babies respond to skin-to-skin contact at a very early age.**

- **Eye-to-Eye contact- Provides meaningful contact at a close range.**
    - **Babies can also follow moving objects with their eyes.**

- **Facial expressions - Even at a very early age, babies will try to imitate your facial expressions.**

- **Human voices - Babies prefer human voices and like to vocalize in their first efforts at communication. They often enjoy simply listening to conversation as well as listening to descriptions of their activities and surrounding environments. An infant may not respond, but talking to your baby has many benefits.**

Note: The best bonding often happens when the caregiver is relaxed, ready and wanting to spend time with the baby.

<u>Activities that Facilitate Bonding:</u>

- **Book sharing - This is a more involved, interactive process than simply reading a book out loud to an infant. When book sharing, asking baby about the pictures in the book and encouraging baby to point to pictures allows for both development and bonding. Book sharing can be interesting, rewarding and engaging to a baby when pictures and ideas in the book are related to experiences in the baby's life.**

    - **Benefits for baby include promoting security and trust, which leads to greater self-confidence. This activity also builds language and social skills.**

    - **Recommended books to share with baby include:**
        - **"Spanish Lullaby", illustrated by Kitty Harvill.**
            - **Can be helpful for developing baby's feelings of security.**

- **"Baby's Busy Day", illustrated by Catherine Pillinger**
  - **For developing baby's interest in faces, shapes and patterns.**

- **"Play with Me", illustrated by Bill Colrus**
  - **For developing motor and social skills**

- **"Joyful Noises", illustrated by Bill Colrus**
  - **for developing baby's early language skills by listening and repeating the sounds baby makes.**

- **Connect with music – Singing and dancing to music together can often help a caregiver and baby to connect.**

- **Play with your baby – Getting down on the floor with your baby and showing the baby toys, chatting about toys and talking to him or her can help the baby and the caregiver to bond.**

- **Show them the word! - Even when the babies are too young to communicate, they have the ability to learn about the world they are surrounded by. Simply carrying a baby around a room and explaining objects he or she is surrounded by can be extremely beneficial to an infant. This may include discussing posters on a wall, objects in a room or people nearby.**

- **Respond to your baby's cries – Crying is one of the few ways that babies are able to communicate. Comforting and holding your baby when he or she cries can help to develop a trusting relationship. Some may feel that it is a good idea to let your baby "cry it out" but your newborn is most likely too young to be manipulating. Your responsiveness will most likely not spoil the baby.**

Any length of time with an infant can be beneficial to both the caregiver and the baby. This occurs when there is direct, purposeful interaction between the two.

Further information can be found at the following websites:

Bondingwithbaby.org

Kidshealth.org

Family-friendly-fun.com

School Readiness: How to help parents prepare their kids

We discussed this at the last phone conference. Did you attend?

When a child starts school, it is an important event for a family. As a provider of family services, supervised visitation monitors can assist families in preparing their children for school. School readiness includes academic, social, independence, and communication skills. A list of activities is available below in handout form for parents. A visit monitor may practice these activities with the parents to ensure they understand the activities. This empowers the parent to teach and care for his or her children. The following are skills that children should acquire before beginning school:

• Ability to follow structured daily routines.

• Ability to dress independently.

• Ability to work independently with supervision.

• Ability to listen and pay attention to what someone else is saying.

• Ability to get along with and cooperate with other children.

• Ability to play with other children.

• Ability to follow simple rules.

• Ability to work with puzzles, safety scissors, coloring, paints, etc.

• Ability to write their own names or to acquire the skill with instruction.

• Ability to count or acquire the skill with instruction.

• Ability to recite the alphabet (or quickly learn with instruction).

• Ability to identify both shapes and colors.

• Ability to identify sound units in words and to recognize rhyme.

Attached are some cutouts for parents. Print them on colored paper, and explain how to use them.

Go over a few of these at intake with pre-school aged children. Then ask if parents would like help preparing their child for success in school. The activities on the next few pages will help children bond with and learn from their parents.

Sources:

Rafoth,M. A. PhD, NCSP, Buchenauer, E. L. MEd, Crissman,K. K. MEd, & Halko, J. L.,

Indiana University of Pennsylvania. School readiness- Preparing children for kindergarten and beyond: Information for parents. *School and Home.* Available:

http://www.nasponline.org/resources/handouts/schoolreadiness.pdf

Parent's guide to preparing your child for school. EducationAtlas.com. Available:

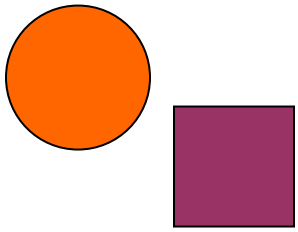
http://www.educationatlas.com/guide-to-preparing-your-child-for-school.html

Learn Alphabet and Numbers

Repeat the alphabet to your child and encourage them to say it with you. Say one letter at a time and have your child repeat and move to the next letter.

Start by counting to 10 with your child. Have him/her repeat each number from 1 to 10. Encourage your child to count to 10 alone.

Learn Shapes



Name shapes that you see in your environment. Some examples are:

"Look at the picture on the wall, it is a square." Ask your child, "What shape is the picture?" Be sure he/she can answer "square." Praise the child.

"The clock is a circle, can you tell me what else in the room is a circle?" Your child may answer "the rug," "the lamp," or any other circular objects. Repeat with other shapes and praise your child.

Learn Colors

Name the colors that you see in your environment. Some examples are:

"The grass is green, what color is the grass?" Be sure he/she can answer "green". Praise the child after he or she answers.

"This apple is red, what else in the kitchen is red?" Some answers may be "the napkin," "the book," or any other red object. Repeat with other colors. Again, praise the child.

Learn to Recognize Words and How to Read

Find a fun, colorful book with pictures and words. Sit with your child and read page by page in a fun and exciting voice. As you read, place your finger on each word as you read it. Read the same book a few times so your child notices the words and can say them. Also point out that the pictures match the words. The words may say "the cat is on the couch." Point to the picture and say "this is the cat and this is the couch."

Learn Sounds

Help your child recognize sounds and name them. Some examples are:

Ask your child what sound a cat makes. Help your child say "meow."

Have your child make animal noises and you guess what animal it is.

When a train goes by and makes the "choo-choo" sound, ask your child what makes the "choo-choo" sound.

Encourage Independence

Find clothes and shoes that are easy for your child to put on, such as

shoes that have Velcro and clothes with zippers and let your child dress him/herself.

Set simple chores for your child, such as picking up toys after playing with them or setting the table, and praise the child when he or she completes the task.

Have cups and eating utensils that are easy for your child to use.

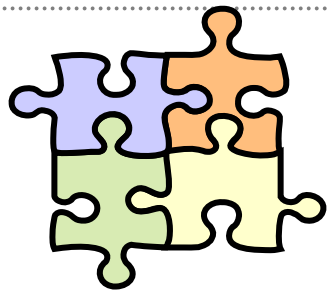
Learn How to Follow Rules

Make and enforce rules for your child. Some examples are:

Set a bedtime for your child, such as 7:00 p.m. Make sure that your child is in bed at that time every night. Make bedtime fun, maybe read a book before bed, and offer rewards for going to bed on time. Rewards could be as simple as reading a new book the next night.

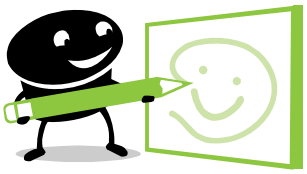
Enforce a no hitting, biting or any other physical harm rule. Punishments for not following rules may be a short time out from an activity.

Memory

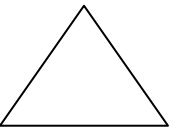


Show your child a picture and name all the objects in the picture with the child. Turn the picture over and have your child name as many objects as possible.

Have your child put a puzzle together many times. He/she will begin to remember where the pieces fit.

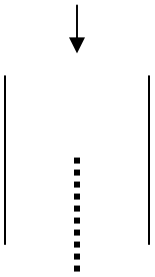


Learn How to Draw



Draw a simple shape, such as a triangle, while your child is watching. Have your child draw the same shape. You may need to guide your child's hand the first few times.

Draw two lines and have your child draw a line in between them.



Coming in June

Be on the lookout for *The Bar and Bench Visitation Report*, which will be sent to you electronically. Please be sure to email a copy to your court administrator and your judges.

Reinhold award goes to Family Center

Clay Today | May 25, 2010 | 1 Comments

By Stephen Kindland

Staff writer

ORANGE PARK – Stella Johnson was "shocked and thrilled" when her fledgling agency was announced as the winner of the 2010 Paul E. Reinhold Community Service Award.

Johnson, executive director of the Family Nurturing Center, was among 53 charitable agencies and individual volunteers recognized by the Paul E. & Klare N. Reinhold Foundation during the second annual Celebrate Clay awards breakfast held on Tuesday, May 25 at the Thrasher-Horne Center on College Drive.

Johnson said the $10,000 check that comes with Celebrate Clay's top honor will go a long way in helping her agency to continue providing supervised visits and exchanges between children and their non-custodial parents. Her center, which also has two Jacksonville locations, was established in the Orange Park area in 2009.

Johnson said the First Coast's high divorce rate, combined with increased tension during difficult economic times, can create "dangerous consequences" when divorced or unmarried parents meet, often in parking lots or other locations.

But the Family Nurturing Center offers a safe alternative, she said, as well as a chance to help divorced parents improve their relationships with each other and their child-rearing skills.

"We provide a vital service to the community," Johnson said. "I was shocked and I'm thrilled to win this award."

She said the center, which has three full-time staff members and about 25 part-time workers, has partnered with the Barclay-Clay YMCA on Moody Avenue to provide an economically sound location for non-custodial parent visits, many of which are court-ordered.

"It absolutely is" a win-win situation, Johnson said. "We're seeing already that [court] referrals are up."

Celebrate Clay is a new initiative of Reinhold foundation, which has a longstanding tradition of providing scholarships and rewarding community service within Clay County and Florida's First Coast area. The foundation has awarded close to $1.8 million in grants and contributions during the past six years.

VOLUNTEER AND EMPLOYEE CRIMINAL HISTORY SYSTEM (VECHS) NATIONAL CHILD PROTECTION ACT

Supervised Visitation Providers should use the VECHS system to obtain criminal history checks if they have no other way to obtain such checks for employees and volunteers. You can access more information about the costs associated with VECHS from the FDLE website. Call the Clearinghouse for more information.

What is the Volunteer and Employee Criminal History System (VECHS) program?
The VECHS program allows for qualified entities to obtain state and national criminal history record checks on individuals working with children, the elderly or the disabled. The authority for these checks is granted under the National Child Protection Act (NCPA), which is implemented through the VECHS program, under Section 943.0542, F.S.
NOTE: Entities required to conduct state and national criminal history record checks under other statutory provisions, on all or specific employees/volunteers, must continue to comply

with those statutes and the procedures that specifically apply to them. Requests for these required criminal history record checks may not be processed through the VECHS Program, pursuant to state and federal law.

What is the difference between the National Child Protection Act (NCPA) and the Volunteers for Children Act (VCA)?

The NCPA and VCA refer to the same basic law. For the purposes of criminal history record checks, the NCPA and VCA permits qualified entities working with children, the elderly and the disabled access to state and national criminal history information

What is a "qualified entity"? Who can obtain criminal history background checks under the NCPA and Section 943.0542, Florida Statutes?

To qualify for the VECHS Program, an entity must provide some type of "care" or "care placement services" for children, the elderly or the disabled; even if it is only a limited part of the entity's overall business. Once qualified to participate in the program, an entity may request criminal history information on all current and prospective employees and volunteers, not only those who work with vulnerable persons. A qualified entity may also request criminal history information on employees or volunteers who have or who seek to have unsupervised access to the populations described above.

"Qualified entities" are authorized to obtain criminal history record information as described under the NCPA and related federal guidelines. Under the NCPA and Florida statute, a "qualified entity" is a business or organization, whether public, private, for profit, not-for-profit, or voluntary, that provides care or care placement services, including a business or organization that licenses or certifies others to provide care or care placement services. "Care" means the provision of care, treatment, education, training, instruction, supervision, or recreation to children, the elderly, or individuals with disabilities.

How does an organization enroll in the VECHS program?

If an entity meets the criteria of a "qualified entity", they may download and complete a copy of the VECHS Qualified Entity Application and the VECHS User Agreement at http://www.fdle.state.fl.us/BackgroundChecks or contact the VECHS Unit at (850) 410-VECHS (850-410-8324), to request a copy of each document.

Can qualified entities share criminal history information with other qualified entities?

Yes. Criminal history information may be obtained from other VECHS entities, if the employee or volunteer agrees to this on the VECHS Waiver Statement and Agreement form, required to be signed when he/she was fingerprinted, and if the transfer of information is recorded by the other qualified entity on its Dissemination Log. The restrictions on this process are described in the User Agreement. Entities must contact the VECHS Unit at (850) 410-8324 for entity verification before sharing criminal history information.

Clearinghouse Biannual Performance Measure Survey

Please indicate the extent to which you agree that the information provided by the Clearinghouse on the Supervised Visitation assists you in performing your job. The satisfaction scale is indicated below for each product.

1. How satisfied were you with the information in the newsletter: **The Family Visitation Times?**

   □ Not Satisfied □ Satisfied □ Very Satisfied □ Not applicable

2. How satisfied are you with the information in the **Monthly E Press**?

   □ Not Satisfied □ Satisfied □ Very Satisfied □ Not applicable

3. How satisfied are you with the **Monthly Phone Conferences**?

   □ Not Satisfied □ Satisfied □ Very Satisfied □ Not applicable

4. How satisfied are you with the **Institute's Website** (with training materials, archive, and message board)?

   □ Not Satisfied □ Satisfied □ Very Satisfied □ Not applicable

5. How satisfied are you with the **Family Centered Practice Trainings and material?**

   □ Not Satisfied □ Satisfied □ Very Satisfied □ Not applicable

6. How satisfied are you with the Clearinghouse's **responsiveness** to your calls/questions?

   □ Not Satisfied □ Satisfied □ Very Satisfied □ Not applicable

7. How satisfied are you with the **Database** (and data reports)?

   □ Not Satisfied □ Satisfied □ Very Satisfied □ Not applicable

Thank you for completing the survey. You may return it by: email (clearinghouse@fsu.edu **or** fsuvisit@aol.com**; fax (850-644-8331), or regular mail to The Clearinghouse on Supervised Visitation, Florida State University, Room C2501 UCC 296, Champions Way, Tallahassee, FL 32306-2570.** *We would be happy to receive your comments and questions to improve our services at any time. Use the back of this form for comments, or send them directly to the Clearinghouse in any way described above.*

July 2010 EPRESS

JULY PHONE CONFERENCE:

WEDNESDAY, JULY 21ST

*****12:00 NOON ET*****

DIAL 719-457-0816 TO PARTICIPATE, YOU WILL NEED TO ENTER A PASS CODE TO PARTICIPATE. THE PASS CODE IS 635786#

PLEASE RSVP WHEN THE REMINDER EMAIL COMES OUT IF YOU PLAN TO ATTEND

PLAN AHEAD AND HAVE YOUR TEAM CALL IN…

AUGUST PHONE CONFERENCE, WEDNESDAY, AUGUST 11TH @ 12:00 NOON, ET

SEPTEMBER PHONE CONFERENCE, WEDNESDAY, SEPTEMBER 15TH @ 12:00 NOON, ET

LAST CHANCE!!

REMEMBER TO REGISTER FOR THE AUGUST CONFERENCE IN ORLANDO – WWW.FNCAC.ORG

The DCF Family Safety Training Videos from the June 2010 Regional Training are posted and available for viewing

By clicking on the link below you will be directed to the website containing the videos from the most recent regional training. Here you can select one of the eleven segments many of which including training hours. The listing includes:

- 2010 Legislative Updates
- Independent Living – The Game of Life

- FSFN, Safety Planning and Stability for Investigations to Permanency
- Trauma-Informed Responses to Children during and after Removal
- Children's Legal Services: APPLA – Another Planned Permanent Living Arrangement
- Psychotropic Medications
- Master Trust
- The Threat Continuum – Assessing for Risk and Safety
- The Civil Domestic Violence Injunction for Protection Process
- Enhancing Attachment and Infant Mental Health for Young Children in Child Welfare
- Children's Legal Services: Threats to Children

Check them out at
http://centerforchildwelfare.fmhi.usf.edu/videos/Pages/famsafety.aspx

Practice Issues with LGBT Families

(Archived NRCPFC and AdoptUsKids Teleconference)

This National Resource Center for Permanency and Family Connections (NRCPFC) Teleconference, co-sponsored by AdoptUsKids, which took place on June 16, 2010, focused on inclusive and affirming practice with LGBT (Lesbian, Gay, Bisexual, and Transgender) Resource Families, and highlighted the related areas of Training and Technical Assistance which are offered by the Children's Bureau One T&TA Network.

This free teleconference included an introduction to the topic and discussion of research about LGBT resource families' experiences, and addressed issues of inclusive practice with LGBT families at both the agency and case levels. The teleconference concluded with a discussion/question and answer session. Presenters: Dr. Gary Mallon, Executive Director, NRCPFC, Kathy Ledesma, Project Director, AdoptUsKids, Dr. Ruth McRoy, Principal Investigator, AdoptUsKids. Several SV programs expressed interest in this training.

The audio, PowerPoint presentation, and additional resources and materials are available for download from the NRCPFC website.

http://www.hunter.cuny.edu/socwork/nrcfcpp/teleconferences/index.html#6-16-10

The Impact of Having a Child in the Juvenile Justice System

I. Introduction

a. Having a child who is in some stage of the juvenile justice system has a large impact on a family. The responsibility that comes with parenting a delinquent youth is very time consuming. Typically, the parent/guardian is the eyes and ears of the court while the youth is living at home. However, once a juvenile has entered into the system, he or she will travel through a complicated map of stages. It is important to know what each stage entails and how the child can successfully complete the sanctions the juvenile is given by the court.

b. In some cases, parents may ask supervised visitation providers to explain the juvenile justice system; thus, it is important for directors to have this information as a reference. Remember, many families have overlapping problems, and families can have concurrent cases in dependency, delinquency, and divorce court.

II. Overview

This chapter is an overview of the juvenile justice system in Florida. The process can become confusing and seemingly never-ending to families. However, the process can be much less stressful if families have an understanding of the following: services available, the juvenile system map, the juvenile's rights, and what happens when the juvenile turns 18.

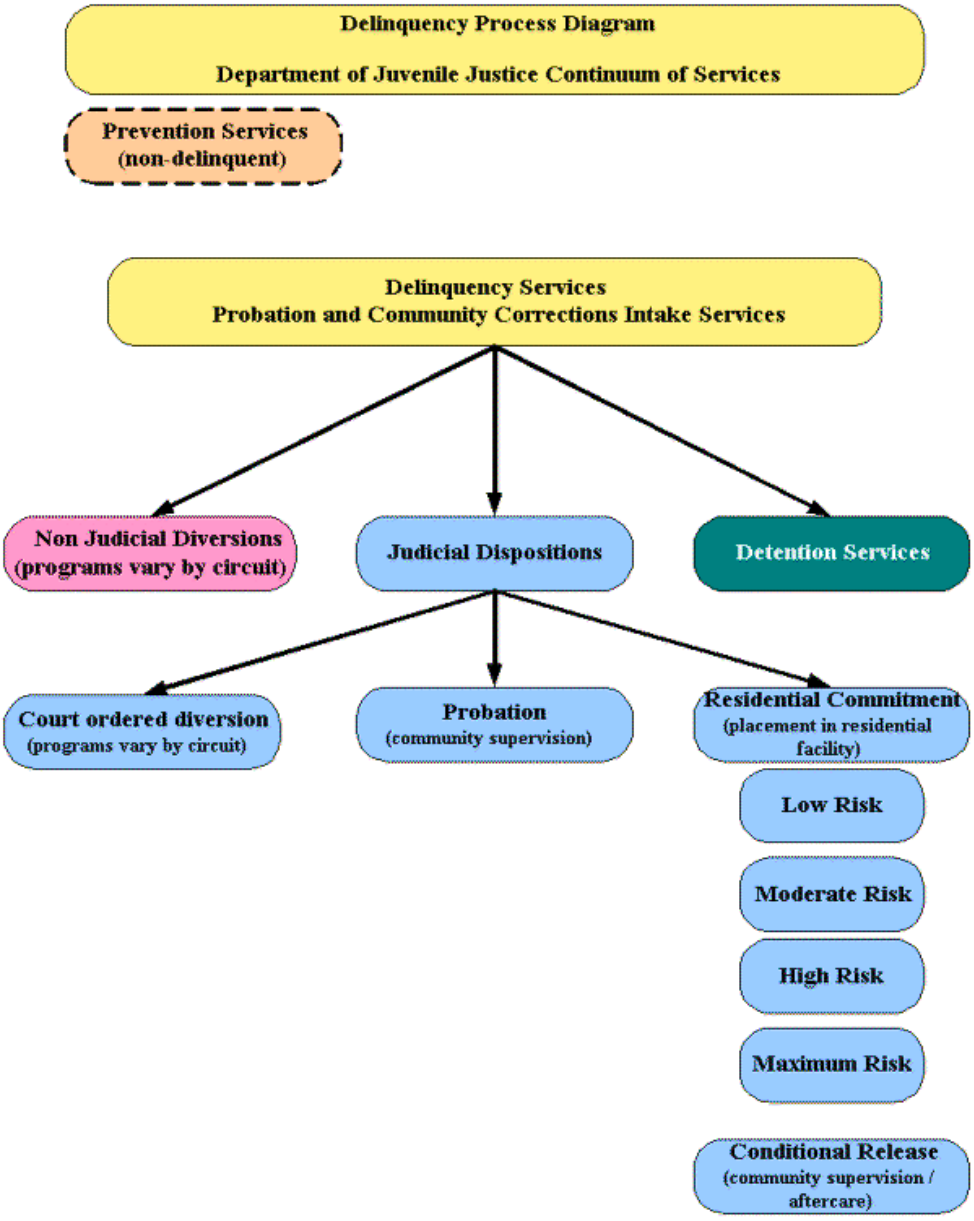
III. Objectives

a. Define "delinquency";
b. Define "adjudicated";
c. Identify and explain prevention services available to at-risk youths in Florida;
d. Describe the difference between a non-judicial diversion and a judicial diversion;
e. Create an understanding of the process a juvenile goes through while in the juvenile court system;
f. Discuss juvenile versus adult sanctions;
g. Identify and understand the various levels of residential commitment facilities;
h. Identify what the parent's responsibility is while his or her child is going through the process; and,
i. Describe impact of system on families and the children.

IV. Snapshots

a. In Florida, each year approximately 52,000 youth are temporarily judicially ordered to one of the state's 26 regional juvenile detention centers, each with a self-contained school funded by the local school district.
b. Over 37,000 youth participate in community-based prevention programs.
c. Approximately 15,000 youth are committed to the Department of Juvenile Justice (DJJ) and placed in mandatory day treatment or residential commitment programs.
d. In the 2003-2004 school year, 70% of detained juveniles in Florida were overage for their grade placement.
e. African American youth in Florida are more likely to receive judicial handling, be committed and transferred to adult court, than they are to receive other dispositions (Buildingblocksforyouth.org).
f. About 1 in 13 of Florida's 70,000 state prisoners entered the system for crimes they committed when they were 17 or younger (Buildingblocksforyouth.com).

V. Delinquency Process Diagram



Source: http://www.djj.state.fl.us/Parents/DJJProcess.html

Terminology

- Adjudicated- The court finds a youth guilty of committing a delinquent act. The court can commit the youth or place the youth on community supervision.
- Adjudication Withheld- The court finds that a youth committed a delinquent act, but withholds adjudication of delinquency. The court places the youth on community supervision.
- Commitment-A youth placed into a program for delinquent youth defined by Florida Statute. These programs range from low to maximum risk restrictiveness levels.
- Delinquent Act- Any illegal act committed by a youth under the age of 18 who has not been sentenced as an adult for a felony.
- Detention Care-The temporary care of a youth pending further action by the court. This may include secure, non-secure or home detention.
- Detention Center-A facility where youth are securely held pending court hearings, for contempt of court or while awaiting placement into a commitment program.
- Disposition Hearing- The court determines the sanctions, conditions, and services imposed on a youth who has committed a delinquent act.
- Diversion- A program designed to keep a youth from entering the juvenile justice system through the legal process.
- Intake-The screening or assessment of a youth who is alleged to have violated the law or a court order.
- Status Offenses- Things a youth may do that are not illegal for an adult, such as truancy, running away, or underage drinking.

Diversion

- After the youth has been charged with a law violation, he or she is then taken to the Juvenile Assessment Center (JAC) where it is determined whether or not he or she meets detention criteria and will be detained. If youth is not detained, he or she is released to a parent or guardian and assigned an intake Juvenile Probation Office (JPO).
- The JPO then makes a recommendation to the state attorney as to whether or not this youth should be placed in a diversion program.
- If a diversion program is recommended, the youth and parent/guardian must then sign a “waiver of speedy trial” agreement. By doing this, they are agreeing to waive their right to a speedy trial with the understanding that the youth will complete all of the requirements of the diversion program.

Sanctions

- When a youth is placed on probation, he or she must complete court-ordered sanctions and services. The youth will need to comply with all special conditions and mandatory sanctions imposed by the court.
- Examples of juvenile sanctions include but are not limited to: performing community service hours, paying money to the victim (restitution), attending counseling, following a curfew, attending a probation day treatment program, attending anger management, and attending substance abuse education classes.
- Numerous violations of a youth's court-ordered sanctions could result in new charges and possible commitment with placement into a residential program. With certain felony offenses and based on the youth's age at the time of the offense, it is possible that a youth will be sent straight to adult court without first going through the juvenile system. Youths can be sentenced to adult court by Direct File, Waiver, or Indictment.
- In some cases, a juvenile may be found guilty in adult court, but be "sentenced back" to the Department of Juvenile Justice for implementation of juvenile sanctions or programs.

Commitment Facilities

- Primary consideration for a commitment recommendation is public safety and meeting the individual treatment needs of the offender and to ensure that no other options are viable at a less restrictive level to reduce or eliminate the youth's threat to public safety.
- There are numerous residential commitment programs located throughout the state and they differ in restrictiveness level and in services provided, based on the youth they're designed to serve.
- Commitment facilities are categorized by their level of restrictiveness. These 5 levels are:
    - Minimal risk Nonresidential
        - Youth remain at home and attend 5 days a week treatment programs
        - Youth placed in this commitment level are a minimal risk to themselves and the community
        - These youth are able to live in the community
        - These youth's crimes cannot include firearms, sexual offenses or would be first degree felonies if committed by an adult
    - Low-risk Residential
        - Youth placed in this level are assessed as low risk to public safety, yet require 24 hour supervision

        - These youth have usually been unsuccessful in prevention and diversion programs
        - These youth's crimes cannot include firearms, sexual offenses or would be first degree felonies if committed by an adult
        - Examples of low-risk residential facilities include:
            - group treatment homes
            - short-term outdoor expedition programs
- Moderate-risk Residential
    - Youth placed in this level have been assessed as moderate risks to public safety and require 24-hour awake supervision
    - These facilities are environmentally secure, staff secure, or hardware-secure with fencing, walls, or locking doors
    - These youth's crimes are generally serious property offenses and they are typically frequent offenders
    - Program models include:
        - halfway houses
        - wilderness camps
        - youth academies
- High-risk Residential
    - Youth placed in this level have been assessed as posing high risk to public safety and require close supervision in a structured residential setting that provides 24-hour secure custody and care
    - High risk facilities are hardware-secure with perimeter fencing and locking doors
    - Community access for youths in a high risk facility is limited to court appearances and health-related events
    - Examples of high risk programs include:
        - Intensive halfway house
        - Sex offender programs
        - Youth development centers
- Maximum-risk Residential
    - Youth classified for placement in this restrictiveness level have been assessed as posing serious risk to public safety and require 24-hour custody, care, and close supervision in a maximum-security setting
    - These youth are chronic offenders who commit offenses consisting of violent and other serious felonies.
    - Youth are prohibited from having access to the community, besides court dates and health-related events

- Program models include:
    - Long term maximum-security programs
    - Juvenile offenders corrections centers
- These facilities are :
    - Hardware-secure with fencing and locking doors
    - Comprised of single cells

Parent/Guardian Responsibility

- It is expected that the parent/guardian assist and encourage the youth to fulfill the sanctions of Probation, this can be achieved by:
    - Maintaining regular contact with the youth's JPO
    - Cooperating with school officials to help the youth stay on task academically
    - Attending all court proceedings
    - Ensuring the youth attends all required counseling or therapy sessions
    - Arranging transportation for the youth to complete required sanctions
    - Providing a home that is safe, nurturing, and recognizes the youth's strengths and successes
- If the youth is placed in a facility, visitation is an important component of a youth's stay and is encouraged and supported by staff.

Impact on the Family

- Having a child who ends up in the Juvenile Justice System is certainly stressful on a family system. Ways to deal with this stress are:
    - Participation in family counseling
    - Participation in individual counseling
    - Having an accurate understanding of the court system will also help to reduce stress through the process.

Case Scenario:

Mary Townsend visits with her nine and 12 year old daughters at the Sunshine Family Program. Mary's 15 year old son, Antonio, has just been placed in a juvenile commitment program for a crime he was found guilty of committing. Mary's daughters are distressed to hear this news and ask the monitor to explain what is going to happen to Antonio.

Questions to Consider:

1. What can the director of the program do to assist this family?

   Answer: The director can call the case manager of the dependency case and find out the Department of Juvenile Justice Juvenile Probation Officer's name. The officer can provide the name and phone number of the commitment program where Antonio has been placed. The director can then explain how to or help the mother to make a call to the commitment program. Together they can speak with the commitment program's case manager and discuss Antonio's status, provide information for Antonio's performance plan and hear about visitation and how to write to Antonio. They can also learn how long he will be in the program and what he must do to earn his release and return home. The program's case manager can also agree to allow periodic phone calls through his office for the two daughters to talk with their brother and advise the mother that he will also be in regular contact with her as well. After the call, the daughters can be encouraged to write to their brother at the address provided. Mary can visit her son as often as possible once he is eligible for those visits.

Prevention is Key

- Delinquency prevention programs are designed to address specific problems and provide interventions for at-risk youth and their families in order to reduce juvenile crime and protect public safety.
- Prevention programs target at-risk juveniles and those who exhibit problem behaviors that might eventually place them in the juvenile justice system; such problem behaviors are: ungovernability, truancy, and running away from home. Examples of some of these programs are:
    - PACE Center for Girls
        - Gender-specific prevention program
        - PACE has 19 direct care and 2 outreach locations in Florida
        - Is a school-based program for at-risk girls.
    - Florida Youth Challenge Academy
        - A 17 ½ month voluntary program geared toward Florida's 16 to 18 year old at-risk youth.
        - Program promotes:
            - Structure
            - Academics
            - Life skills
            - Job skills
            - Physical Fitness and Health
            - Community Service and Citizenship
            - Leadership
    - The Florida Network of Youth and Family Services, Inc.
        - 30 year history of changing the outlook of Florida's at-risk youth population
        - A network of service providers, which includes local service providers and their neighborhood partners.
- The DJJ addresses these problems by contracting for delinquency prevention services and awarding grants to local providers throughout the state.
- Parent training is consistently highlighted as one of the most effective means of preventing delinquency and treating young children with conduct problems. Parent training has also proven to be one of the most cost-effective interventions for high-risk youth.
    - Prevention programs focusing on the youth alone may be successful while the youth is involved in the program, but there is no evidence supporting their long-term success.

- Parent training is based on the idea that youths who are attached to pro-social peers and parents are less likely to engage in delinquent acts. (Hawkins and Weiss 1985)
- Parent training consists of implementing four essential tasks (Patterson 1982):
  - Setting house rules
  - Enforcing behavior contingencies
  - Monitoring and supervising
  - Employing problem-solving strategies

- Parent training opportunities in Florida include the following:
  - The Parent Project
    - Located in West Palm Beach, Florida
    - Provides activity based instruction, support groups, and curriculum addressing the most destructive of adolescent behaviors.
    - A 10 to 16 week parent training program designed specifically for parents of strong-willed or out-of-control adolescent children.
    - The curriculum teaches concrete prevention, identification, and intervention strategies for the most destructive of adolescent behaviors.
  - Multi-Systemic Family Therapy (MST)
    - Reduced re-arrest rates of youth by 50% (http://www.cyc-net.org/).
    - Youths who received MST spent an average of 73 fewer days behind bars in the year following treatment than did youths in a control group (http://www.cyc-net.org).
    - MST is a pragmatic, goal-oriented and well-documented treatment approach that produces long-lasting outcomes in changing youths' social networks which contribute to their antisocial behavior (Eckerd.org).
  - Eckerd Youth Alternatives
    - Located in Clearwater, Florida
    - Offers intensive in-home MST treatment to youth and families referred by the Department of Juvenile Justice in three Florida counties:
      - Wakulla, Leon, and Gadsden

http://www.cyc-net.org/

http://www.djj.state.fl.us/Parents/DJJProcess.html

http://www.djj.state.fl.us/AboutDJJ/faq.html

www.eckerd.org

http://parentproject.com/

Hawkins, J. D., & Weis, J. G. (1985). The social development model: An integrated approach to delinquency prevention. Journal of Primary Prevention, 6, 73–97.

Patterson, G. R. (1982). Coercive family process. Eugene: Castalia Press.

Special thanks to Jacque Foster, who worked with the DJJ for several years, for her work on this unit. Jacque is well known to many Florida SV programs for her prior work at DCF.

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You asked, we answered:

When are Children Allowed to Testify in Family Court Cases?

A director asks: is there some consensus among the Florida District Courts of Appeal about a child's age in the admission of child testimony in proceedings in divorce court (under Florida Statutes Chapter 61)? The information provided here may be of help to your program's pro bono attorney.

Yes. There is a general consensus that children ten years of age and younger are presumed incompetent to give reliable testimony in a proceeding under Chapter

61. This does not mean, however, that courts necessarily prohibit children ten and younger from providing testimony. At least one court has stated that the testimony of younger children may prove valuable in custody determinations even when the children are not competent to provide reliable testimony.

Discussion

Florida Family Law Rules of Procedure 12.407 bars child testimony without a court order but places no age related prohibition on such testimony. The only statutory guidance as to limitations on the use of child testimony as it relates to age in proceedings under Chapter 61 is found in Section 61.13(3) which lists the factors for consideration in the determination of a child's best interests when developing a parenting plan. Listed among the statutory factors is the reasonable preference of the child (61.13(3)(i)). Courts will allow children to state their preferences for a custodial parent through testimony if the court deems the child to be of sufficient intelligence, understanding, and experience to express a preference.

The standard of sufficient intelligence, understanding, and experience to express a preference is analyzed in terms of a child's age. The clearest statement of how age relates to this standard was announced in the decision of *Holmes v. Green* where the First District Court of Appeals stated that "as a general rule, one would not expect a 10-year-old to possess the character traits necessary to make an intelligent decision regarding [custody]." 649 So.2d 302 (Fla. 1st DCA 1995).

In *Holmes*, the father of two ten year old children filed a petition to modify an award of primary custody to the former wife which alleged a substantial change in circumstances warranting modification. In support of his claim, the father alleged that his children desired to live with him rather than their mother. The trial court allowed the two children to testify as to their preferences and ultimately transferred custody to the father. However, on review, the First District Court of Appeals presumed that the children were lacking the character traits necessary to make an intelligent decision based on their young age and refused to consider the testimony in its eventual reversal of the trial court because there was no evidence in the record to the contrary.

The First District's *Holmes* decision relied heavily on a series of cases from the Third District which also gave no weight to the preferences of minor children who were found too young to possess sufficient intelligence, understanding, and experience to express a preference of custodial parent. In *Berlin v. Berlin*, the

Third District refused to give any consideration to the preferences of two eight and ten year old children after two psychiatrists testified that they lacked the maturity to make an intelligent decision regarding a custodial parent. 386 So.2d 577 (Fla. 3rd Dist. 1980). The fact that the children's preferences were announced in court by a guardian *ad litem* was insufficient to overcome the psychiatrists' testimony.

Berlin was later cited in the Third District's *Elkins v. Vanden Bosch* decision for the presumption that children younger than ten lacked the intelligence, understanding, and experience to express a preference of custodial parent. 433 So.2d 1251-53 (Fla. 3rd Dist. 1983). In *Elkins*, the Third District Court of Appeals reviewed a lower court's decision to change custody from the mother to the father based on the preferences of the former couple's four minor children. The four children, ages twelve to fifteen, were subjected to *in camera* interviews by a general master who found that the children possessed the maturity necessary to make an intelligent decision. The Court of Appeals rejected the general master's finding and cited *Berlin*, suggesting that even children of these ages were presumed to lack the sufficient intelligence, understanding, and experience to express a preference of custodial parent.

It is necessary to note that the Third District, like the First District, still allowed child testimony despite the district's presumption against younger children in the cases above. However, unlike the First District, the testimony of these younger children was taken in form of *in camera* interviews rather than directly in court. In addition to *Elkins*, a Third District trial court also held *in camera* interviews with minor children in *Perez v. Perez*. 767 So.2d 513 (Fla. 3rd Dist. 2000). On review in *Perez*, was a trial court's decision to modify custody based on the preferences of the former couple's three children, ranging from ages nine to fifteen. A guardian *ad litem* testified that the children should reside with their father but the trial court decided to reject the recommendation, and instead performed separate *in camera* interviews with each of the children to determine their preferences and whether they were of sufficient intelligence to make a decision regarding custody. From the interviews, the trial court found that the children possessed the intelligence necessary to articulate a preference and decided to change custody. (Note: The appellate court reversed the trial court's decision because a child's preference alone is not sufficient to modify custody. The appellate court's decision has also received negative treatment, but not as to the issues dealing with child preference or their *in camera* interviews).

The Second District also dealt with the issue of child testimony in these child preference cases in *Heatherington v. Heatherington*. 677 So.2d 1312 (Fla. 2nd Dist. 1996). In *Heatherington*, the mother of a fifteen year old child requested the modification of custody after the child had resided with the father for fourteen years. In support of her position, the mother told the trial judge that her daughter was unhappy living with the former husband, and that she desired to live with her. The trial judge "conducted a very thorough and thoughtful examination of the child…" during which the child stated an intention to run away if custody was not transferred to her mother. The trial judge granted the petition for modification, but it was reversed on appeal because a child's preference alone is not sufficient to modify custody. There was no question raised at either the trial court or on appeal as to whether the fifteen year old child possessed the sufficient intelligence, understanding, and experience to express a preference.

Although they only involved the use of child testimony as it relates to child preference in a modification hearing, the implications of the cases detailed above may be relevant to child testimony in all Chapter 61 proceedings. These cases, like most proceedings under this chapter that make use of child testimony, involved a request for modification of custody. The limited number of cases using child testimony outside the context of §61.13(3)(i) also involve requests for modification of custody and might apply a similar presumption.

In *Pallay v. Pallay*, the Fourth District found the testimony of a six year old child to be unreliable due to coaching by the child's mother. 605 So.2d 582 (Fla. 4th Dist. 1992). At court it was found that the child's mother had repeatedly accused the former husband of sexually abusing his son, following a long pattern of attempts to frustrate the former husband's visitation rights. Although the child was allowed to testify in court, his statements were believed to be coached by the mother and were given no weight.

The Second District heard a similar issue in *Warner v. Walker* where the father of a five year old boy filed a petition to change custody based on a belief that the former wife's new husband was using illegal narcotics and was sexually abusive. 500 So.2d 645 (Fla. 2nd Dist. 1986). The trial court in *Warner* also allowed the testimony of a minor child via recorded interview; however, on review the Second District Court of Appeals reversed the decision and held that the testimony was inadmissible because it was not only admitted for purposes which made it inadmissible as hearsay, but also because the child was incompetent to testify.

The most interesting and perhaps significant portion of the *Warner* decision was found in dicta (the part of the ruling that does not contain the holding):

"If it is important that a trial judge charged with determining custody of a child understand a child as best he can, the incompetency of the child to testify should not prevent the trial judge from observing the child, either in person or by video tape, if that observation would help the judge make a proper determination of custody. In that instance, the evidence would be offered not to prove the truth of anything that was said , but to merely observe and consider the demeanor, understanding, maturity and hostility of the child and other factors relating to the personality of the child that may properly influence the judge in making a decision on custody."

Conclusion

The majority of the opinions involving child testimony all appear to support the proposition that there is a presumption that children ten years of age and younger are incompetent to give reliable testimony in a proceeding under Chapter 61. However, many of the appellate districts with decisions on the matter have allowed younger children to testify despite this observation. Dicta in the Second District's *Warner* decision provides some insight as to why by clarifying that such testimony may still help the trial judge make a proper determination of custody

Bullying: A New Perspective on an Old Problem

What is it?

- According to the U.S. Department of Eduction, bullying may be defined as "the physical, verbal, and psychological behaviors such as hitting, teasing, taunting, and manipulating social relationships."

- It generally involves a skewed power dynamic and occurs primarily among youth.
- Bullying can be both direct and indirect.
    - Direct bullying involves violence and other forms of physical aggression.
    - Indirect bullying involves social aggression; its perpetrators often attempt to demean their victim by demeaning, isolating, and gossiping about him/her.

Why is it a problem?

- Victims of bullying often face hefty psychological repercussions. Here is some information on the effects of bullying on children and teenagers:
    - Victims of bullying are more likely to experience a violent victimization at school.
    - Victims of bullying are also more likely to experience property theft.
    - 18% of victims report constant fear in the school setting.
    - Victims of bullying are more likely to bring a weapon to school and also more likely to engage in a physical fight.
    - Victims of bullying often report avoiding populated areas of the school.
    - They are also more likely to take back routes to school in order to avoid potential bullies.
    - Victims of bullying are more likely to suffer academically; their chances of receiving Ds and Fs are higher than their non-bullied counterparts.

How common is it? Whom does it affect?

- 14% of students ages 12 to 18 have experienced bullying.
- Males and females are bullied equally, though males are more likely to face direct bullying.
- White, non-Hispanic students are most at-risk for bullying.
- Younger students are more at-risk than older students.
- Bullying occurs at equal rates in public and private schools.
- Law enforcement and staff supervision reduces the reported rate of bullying.

Bullying, Self-Esteem, and Suicide

- Even infrequent bullying can wreak havoc on a child's self-esteem. A bullied children often feels:
  - Isolated
  - Depressed
  - Rejected
  - Persecuted
  - Angry
  - Hopeless
- These feelings can be exacerbated by long-term bullying, and eventually cause the child to adopt a so-called "victim mentality". The lack of friendship, love,

support, and approval in everyday life drains bullied children of confidence, further perpetuating the cycle of victimization.

- Although some bullied children eventually overcome their insecurity and lack of self-esteem once removed from the school setting, many do not escape unscathed.
- Many victims of bullying carry their scars into adulthood.
- Others, unable to face the pain of constant bullying, take their own lives.
- It is estimated that between 15-25 children in the UK commit suicide each year as a result of bullying. (No such statistics exist in the United States, although the number would almost certainly be higher.)

What Can Be Done?

- Children who may face bullying must be handled delicately; many will deny their problems so as to avoid the perceived shame of admitting victimization.
- Those in at-risk situations may be counseled in several ways:
  - The victim should be told that being bullied is not his/her fault.
  - The victim should know that s/he is not alone.

- Adults should discuss ways of responding to bullies; while victims should be assertive, they should also not react to dangerous situations and get help when necessary.
- Victims should also be encouraged to report their bullying to a trusted adult immediately. This may be a parent, a guardian, or a member of the school faculty.

- Under no circumstances should an adult attempt to *mediate a truce* between the bully and the victim, nor advise the child to resolve the problem his/herself. Adult intervention to stop the bully is the only remedy to bullying.
- According to the US Department of Health and Human Services, the best way to address a bullying situation is to report the problem to the school. However, there are several steps which parents and counselors can take to prevent the incidence of bullying. Adults should:
  - Instill self-confidence in children.
  - Aid children in establishing good social skills.
  - Education children to speak for themselves.
  - Remind children to seek help from adults if harassed.
- Also, remember at all times *never to blame the victim.* Although bullying may seem trivial from an adult standpoint, those who face it often feel powerless, isolated, and worthless. Adults should remember at all times never to trivialize or

belittle the victim's situation. Explain this to parents, who need to understand how to support, not criticize a child who is being bullied!

Sources:

http://mentalhealth.samhsa.gov/publications/allpubs/svp-0056/

http://www.aare.edu.au/01pap/bet01229.htm

http://nces.ed.gov/pubs2005/2005310.pdf

http://www.coastkid.org/si-sob.html

CALL OR WRITE THE CLEARINGHOUSE WITH YOUR SUGGESTIONS, QUESTIONS, AND TRICKY CASES.

fsuvisit@aol.com

850-644-6303

QUESTIONS OR COMMENTS ABOUT THE CLEARINGHOUSE'S WORK?

CONTACT INFORMATION FOR DCF REGARDING CLEARINGHOUSE DELIVERABLES:

ARLENE CAREY: 850-921-1928 OR Arlene_Carey @dcf.state.fl.us

AUGUST 2010 E PRESS

AUGUST PHONE CONFERENCE:

WEDNESDAY, AUGUST 11TH

*****12:00 NOON ET*****

DIAL 719-457-0816 TO PARTICIPATE, YOU WILL NEED TO ENTER A PASS CODE TO PARTICIPATE. THE PASS CODE IS 635786#

PLEASE RSVP WHEN THE REMINDER EMAIL COMES OUT IF YOU PLAN TO ATTEND!

PLAN AHEAD AND HAVE YOUR TEAM CALL IN…

SEPTEMBER PHONE CONFERENCE

WEDNESDAY, SEPTEMBER 15TH @ 12:00 NOON, ET

OCTOBER PHONE CONFERENCE

WEDNESDAY, OCTOBER 20TH @ 12:00 NOON, ET

did you know??

If you have an unusual or tricky case, questions about supervised visitation, or a suggestion that you can call or write the Clearinghouse.

fsuvisit@aol.com

850-644-6303

Keep us posted on what's happening in your program!

DCF's summer newsletter is attached to this E Press.

Below is a very sad story involving a DV murder-suicide of a very committed juvenile judge, a real advocate for children. (The newspaper is in the Dallas, TX area.) One of the lessons of this story is that domestic violence crosses socio-economic and occupational lines. http://therockwallnews.com/2010/0622/crime/judge-3

Police confirm Rowlett judge killed by husband

By J.J. Smith.

Rowlett police confirmed yesterday that Rowlett juvenile court judge and attorney Belinda Loveland was shot and killed Sunday evening by her husband, Richard, who then killed himself.

They were the third and fourth domestic violence deaths in Rowlett this year. There was also a murder-suicide in April across Lake Ray Hubbard in Fate, just east of Rockwall.

According to Rowlett Police public information director John Ellison, police received a call at 5:04 p.m. Sunday from the Loveland's married son, Dustin, who told them he had just received a text message from his father stating, "I just killed your mother."

Officers then responded to the scene in the 3200 block of Sunrise and attempted to make contact with the residents inside the lakeside home.

Ellison said after numerous attempts and receiving no answer, police entered the residence which was searched with the assistance of a robot provided by the Garland police department.

Inside the home police discovered the bodies of the 52-year-old judge in the master bedroom and her 59-year-old husband in the adjacent bathroom.

"It appears that Richard Loveland shot his wife and then turned the gun on himself," said Ellison.

A spokeswoman for Rowlett said the city brought in grief counselors Monday to help adults and children who had worked with Loveland.

The judge created an after-school mentoring program for at-risk children in Rowlett in 2003 called Camp ROCK, which helps 150 Rowlett students each year.

"Judge Belinda Loveland was not only a wonderful public servant but also a good friend of mine," said Rowlett Mayor Dr. John Harper.

"This tragic event has taken away a talented and caring leader who devoted her life to helping troubled kids. She will be greatly missed in so many ways. I ask for everyone to

pray for her son who now has to deal with a loss of both mother and father in such a horrendous act."

Richard Loveland was self-employed and owned several businesses.

Police are still investigating the case and do not yet know the motive for the shootings. More information will be forthcoming as it becomes available, said Ellison.

FALL TRAINING OFFER

No one volunteered to host a Clearinghouse training in South Florida in the Fall. However, The Family Nurturing Program (Stella Johnson, E.D.,) has generously offered to sponsor a one-day training in Jacksonville.

IF YOU ARE INTERESTED IN ATTENDING a free training on SV issues in the Fall in Jacksonville, FL, please call or email Karen by August 31st. If at least five programs send representatives, I will conduct a free Friday training – 10 am until 3 pm, to allow people to travel to Jacksonville. You only pay for your lunch.

You may have noticed the changes to our website! Be sure to hit "refresh" the next time you log on, so that you are not still running the old site on your computer. Also, if you have photographs of your program in jpeg format, send them our way, with a caption. We may post them. No photos of children or client parents, please!

Question of the Month

What is trauma-informed care? Should I apply it to my supervised visitation program? Will it change my practices if I do?

Trauma-informed care is a somewhat different way of looking at the families who are referred to your supervised visitation program. It's also a new catchword in social service delivery. However, the approach is completely consistent with a family-centered practice, the Principles as defined by the Best Practices, and the training that has been offered by the Clearinghouse.

The basic idea of trauma-informed care is fairly simple: clients who come to social services agencies often have a history of trauma; this trauma affects them profoundly; and agencies (and their staff) need to be aware of the effects of and triggers concerning the trauma to assist clients. Before I offer a detailed explanation of the concept, and an upcoming training on the issue, though, I want directors to remember that terminology comes and goes, but the four Principles of Supervised Visitation are always your refuge when dealing with new concepts.**

The American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM-IV) defines a "traumatic event" as one in which a person experiences, witnesses, or is confronted with actual or threatened death or serious injury, or threat to the physical integrity of oneself or others. A person's response to trauma often includes intense fear, helplessness, or horror. Trauma can result from experiences that are "private" (e.g. sexual

assault, domestic violence, child abuse/neglect, witnessing interpersonal violence) or more “public” (e.g. war, terrorism, natural disasters). Trauma is becoming increasingly recognized as a significant factor in a wide range of health, behavioral health, and social problems.

SV directors understand that many families at supervised visitation have experienced trauma, including abuse, neglect, and/or violence. The concept of trauma-informed care is a good reminder that --just as every new case you receive has the potential to include hidden abuse issues, hidden violence, and hidden grief that can affect the service of SV – every new family may have experienced profound trauma. What that means to your program is that your staff should be ready to understand the potential impact of trauma and find ways –within your mission and scope --to help your clients heal from it.

In all cases, SV staff must be respectful of clients. Understanding that they have experienced trauma can help us remain compassionate, even when clients seem uncooperative. Thus, respectful interaction is a core value of trauma-informed care, as well as longstanding SV practice. SV staff have already received training on issues such as domestic violence, which reveals that victims may seem paranoid, anxious, and angry. (This behavior makes it easier for perpetrators to label victims as “crazy” to discredit them.) Trauma-informed practice encourages social service providers to understand that what clients have suffered can affect their behavior, demeanor, and function. Trauma-informed practice in sexual abuse cases teaches us about the devastating effects of child sexual abuse. The dynamics of such abuse are described at length in SV curricula. Finally, trauma-informed practice emphasizes that victims of trauma need help and treatment. SV staff are charged with working with case workers and referrals to outside services to help clients as much as possible within the program’s ability.

I think the most helpful aspect of trauma-informed practice is the constant reminder that each family brings to an SV program a history of challenges. Over the coming months, we will talk more about trauma-informed practice and discuss more ways to apply it at your program.

Note: *If you have been an active part of our technical assistance, you know that you could use the word “informed” to describe much of supervised*

visitation practice in Florida: For example, SV provides "culturally-informed" services (clients come from backgrounds and cultures that deserve acknowledgement and respect); "safety-informed" services (the primary mission is safe contact); and "community-informed" services (SV programs operate within the web of existing social services). You could also use the term "centered" for a description of SV practices (e.g. safety-centered, community-centered, etc.) We will discuss this further in the phone conference this month, so please plan to be there!

Access and Visitation Reminders

1. Grandparents can only be counted as visitors if they are also legal custodians!
2. It will soon be time for the statewide roll up of annual data. Be sure your data input is current. If you have questions, call us!
3. Be sure to prepare and send us a short paragraph about your program's unique achievements. Highlight what is special about you and the wonderful work you do, and send it to us ASAP for the annual report. Don't wait. Fall will be hectic!

DIRECTORS: Below is the DRAFT of the Frequently Asked Questions Booklet we are preparing. We discussed it on the phone conference. Please provide us with any feedback and suggestions by August 15. We will have it formatted into a booklet, send it statewide, and put it on the website.

Developing a Supervised Visitation Program in Florida: Answers to Frequently Asked Questions from the Clearinghouse on Supervised Visitation

Developing a Supervised Visitation Program in Florida: Answers to Frequently Asked Questions from the Clearinghouse on Supervised Visitation

Many people contact the Clearinghouse and ask about starting new supervised visitation programs. This information is offered to those who want more facts and data on the subject.

I would like to know about supervised visitation. What is it?

Supervised visitation is contact between a parent and a child which is overseen by a trained third party. The supervision is in a controlled environment, which enhances the safety of all vulnerable parties. The contact between the parent and the child is structured so that program personnel may actively encourage the parent-child relationship by providing age-appropriate activities, helping parents develop or enhance parenting skills when necessary, modeling appropriate interactions with the child, and discouraging inappropriate parental conduct.

What is a supervised visitation *program*?

A supervised visitation program is an entity that has as its core function the provision of supervised visitation services in a family-centered manner. Programs enter into an agreement with the Department of Children and Families and the Chief Judge of the circuit in which the Program is located to provide services pursuant to the program agreement and court order. A Program may operate under the auspices of the court, or be a not-for-profit corporation or association, or be a component of a larger not-for-profit corporation or association. Private entities may also operate supervised visitation programs, but there is no local, state, or federal funding available to such entities.

What does Family-Centered Mean?

The Department of Children and Families has a strategic mission of ensuring that all assistance to families in Florida is consistent with Family-Centered Practice. The purpose of such a practice includes ensuring that families have an active, leading role in reaching resolution to their problems. Those who use a Family-Centered approach are respectful of the family's ethnic and family

background, always focus on working with a family's strengths to help it meet its goals, and take time to understand what the family needs to help it reach those goals.

Is there a need for more supervised visitation programs?

Currently over 60 supervised visitation programs exist in Florida. There is at least one program in each of Florida's 20 judicial circuits, but not every one of Florida's 67 counties is home to a program. There is a need for more programs, especially for cases that involve parents whose child has been removed from the home by child protective services such as the Department of Children and Families. However, funding for more programs is scarce.

Who funds supervised visitation programs?

Currently programs in Florida are funded by several sources, including federal Access and Visitation grants which (partially) fund 23+ programs, federal Safe Havens grants, which have funded (at different times) six programs in the state, and a variety of municipal, state, and private funding sources. Programs are constantly seeking new sources of funding, and overall funding for programs is considered unstable. Many programs have suffered cutbacks during the economic downturn.

How do supervised visitation programs obtain clients?

In most cases, the courts and child protective services agencies refer families to supervised visitation programs. Sometimes programs accept self-referred families, but only under certain circumstances and after a thorough safety review. Parents in divorce/custody cases also often pay a sliding fee for services. Visits in family court cases, which typically originate from judicial referrals, are never paid for by the court. Visits in dependency cases, in which the child has been removed from the home by a child protective services agency, are usually paid for by the agency pursuant to an agency contract with the program.

How does a program obtain a contract from a Child Protective Services Agency?

The Florida Department of Children and Families (DCF) has outsourced and privatized the task of child protection to Community-Based Care organizations across the state. Sometimes the CBC will decide to keep the supervised visits "in house" and will use money from DCF to dedicate staff to supervise visits. However, when the CBC seeks to contract with a supervised

visitation provider, it will issue a request for proposals (RFP). Programs that apply for state dollars under such an RFP engage in a competitive grant process which ultimately determines who will receive the contract. RFPs are usually on a state fiscal year calendar, from July 1 until June 30, and can be awarded for annual or multi-year terms.

Can SV programs use volunteers?

Yes, but no program staffed by volunteers alone has survived more than a year. Volunteers, although crucial to many programs, should only supplement the staff at programs. They do play an important role in an otherwise stable program, though, and the Clearinghouse encourages programs to find ways to maximize their use.

How much does it cost to operate a supervised visitation program?

That depends on many factors, including hours of operation, rent and operating costs, number of staff, staff-to-client ratio during visits, salary of staff, etc. Budgets at Florida programs have ranged from $80,000 per year for a small program with weekend-only hours, to $750,000+ per year for programs operating five to seven days a week. Other typical expenses include criminal history checks on volunteers and staff, salaries and benefits for employees, insurance costs, utilities, office equipment and supplies, furniture, toys, pest control, security, and site maintenance.

Are there any rules or regulations I should know about?

Yes. There is a set of standards created by the Florida Supreme Court in 1999 that are still in effect. Also, there are Best Practices created by a legislatively-mandated Supervised Visitation Standards Committee in 2008 that are used throughout the state. All programs that receive referrals from the court aspire to meet the best practices. In addition, programs are required to conduct criminal background checks on all staff and volunteers. The extensive best practices can be found online at http://familyvio.csw.fsu.edu/messageboard/wordpress/wp-content/uploads/2010/03/Final_Report_to_Legislature.pdf. We recommend that anyone interested in supervised visitation read the Report to the Florida Legislature thoroughly.

Is there any certification for Programs or Providers?

No, the Florida Legislature has not yet mandated a certification process for programs or providers. DCF does not certify programs, but it does require that

all programs receiving state funds enter into an agreement with the court in the jurisdiction of the program and DCF. The agreement must state that the Program will abide by the Supreme Court Standards. The Clearinghouse supports a certification process, but does not currently have the authority or capacity to certify programs.

Is there any specific training or knowledge necessary for supervised visitation staff?

Yes, program directors and staff are required to have extensive training. Training requirements are detailed in the Best Practices in the Report to the Florida Legislature, found online at http://familyvio.csw.fsu.edu/messageboard/wordpress/wp-content/uploads/2010/03/Final_Report_to_Legislature.pdf.

Program directors should also have college degrees and experience in working with families in crisis. A lack of proper training can result in the revictimization of children and vulnerable parents on-site.

What kinds of problems do these families have?

The families referred to supervised visitation may have a variety of problems, including allegations of parental substance abuse, domestic violence, parental mental illness, parental kidnapping, child abuse and neglect, parental criminal activity, and/or other potentially detrimental parental behavior. Thus, working with these families requires a great deal of training, skill, patience, respect, and attention on behalf of staff.

Are there any risks associated with supervised visitation?

Yes. Although the majority of cases proceed with supervised visitation without incident, every program has experienced a variety of safety issues. These range from parents who arrive under the influence of drugs and alcohol to parental revictimization of children on-site, parental attempts at kidnapping, one parents' stalking of the other parent, and physical assaults on staff. Because the dynamics of supervised visitation are unique, intensive training is necessary for all staff. The Clearinghouse publishes training material that describes the risks in the service, and all prospective providers must be aware of the potential risks involved in supervised visitation. All cases must be screened by staff for safety issues, and programs are encouraged to have a working relationship with the local law enforcement agency so that the agency understands the program's mission, goals, and

structure. In addition, law enforcement agencies can advise programs about safety issues such as site safety and emergency response protocols.

What kinds of safety measures are used at supervised visitation programs?

Programs must be designed, developed, and administered with safety in mind. All cases must be thoroughly assessed for risks, and programs must only accept cases in which they have considered and can reasonably address the safety needs of vulnerable parents and children. In addition, programs are required to have safety measures and protocols in place because of the high level of family violence that often exists in supervised visitation referrals. (Referring judges typically do not screen for such risks before making referrals.) All cases must be screened by trained program staff using a danger assessment, and many programs use security personnel to enhance safety. Special and distinct protections exist for cases involving child sexual abuse.

I think I can help! How do I get started?

First, don't open a program until you are sure that the community can support it. (Information about forming a non-profit organization is on the internet.) Far too many well-intentioned people have started the service of supervised visitation before developing a strong foundation for it. Thus, many programs have failed shortly after opening because of poor preparation. Traditionally, successful programs get their start after a community collaborative has ensured that the service is needed, and has created the framework for a safe program with stakeholder buy-in.

What is a community collaborative?

A community collaborative is a core group of community members who have a stake in the availability, competency, and outcomes of a successful supervised visitation program providing quality services. This group may eventually form the program's community advisory board, or may only be brought together to help initially form the program. Judges are typically consulted to ensure that they believe that there may be cases to refer to a new program. (Even if judges agree in principle that a program is needed in a community, this does not create an obligation on the part of the judges to send cases to the program.) If the program intends to accept dependency cases that originate from child protective services agencies (Florida Statutes, Chapter 39), it is essential for representatives from the child protective services agency to communicate and correspond with the program.

Other members of the core community collaborative include the following:

- A member of the mental health community who specializes in child or family counseling and can help the program enhance the program environment for children;
- A family law attorney who can help advise the program about court orders;
- A representative from a local law enforcement agency, so that the agency understands the mission and goals of a program and can advise the program as to safety risks, issues, and potential security measures;
- A representative of the Guardian Ad Litem office, especially if the program plans to take dependency cases;
- A representative of the local domestic violence victim advocacy community to assist with cross training and informing about domestic violence dynamics and victim services.

These people can help determine whether or not the community can support a supervised visitation program. They may also be able to assist you with conducting a community Needs Assessment. Contact the Clearinghouse for a sample Needs Assessment.

What if I don't have a building for my program? Can I go into people's homes, or meet them in public places for visits?

Many entrepreneurs ask this question, and the Clearinghouse strongly cautions them to avoid off-site visits because of safety risks involved. We reiterate here what the Best Practices say about off-site visits:

Any Off-Site Visitation is subject to increased safety measures and training.

A. Off-Site Visitation: In non-dependency cases, courts sometimes ask Programs to provide supervision of parent-child contact in a setting such as a mall, restaurant, park, or any other location not on the Program's physical site. These visits are called "off-site" visits because, by definition, they are not conducted in a Program site/location. They have the disadvantage of less control, fewer safety precautions, and increased risk of intervening persons and circumstances. For these reasons, most programs do not offer "off-site" visits.

B. General Considerations for Off-Site Decisions

The following considerations apply to off-site decisions:

1. Programs may not be compelled to conduct off-site visits by any referring source, including the courts.
2. Program directors retain the discretion to reject any off-site referral for safety reasons. This includes a history of parental threats of abduction, and risk of flight. It also includes parental history of or threats of violence.
3. Cases where there is currently entered a temporary or final order of injunction for protection against domestic violence or where there has been a criminal no-contact order or criminal conviction for domestic violence are not appropriate for off-site visits.
4. Cases in which there are allegations of sexual abuse are not appropriate for off-site visits.
5. Programs must demonstrate that they have considered the risks involved before agreeing to supervise off-site visits.
6. Referring judges must issue written orders for off-site visits and must consider any potential safety risks, including allegations of domestic violence. The order must contain specific findings that off-site visitation is safe for the parties and the child and is in the child's best interest.

C. Risks Involved

The following is a partial list of risks inherent in off-site visits. The Clearinghouse training materials address these risks more thoroughly.

- Risks of child abduction. An unsecured location with many entrances/exits, open spaces, public access, and /or crowds increases the ability of a parent or his/her cohorts to abduct the child.
- Risks of child abuse. The ability to be vigilant – hear and see everything going on in a visit - is an essential component of supervised visitation, but is severely reduced in off-site visits.
- Slow responses in emergency. Programs have on-site security plans and work closely with local law enforcement to augment safety. The ability to get help quickly off-site may be reduced by the very nature of off-site visits. Staff simply have less control over the setting, intervening factors, and surrounding circumstances.
- Multiple child complications. Having more than one child present increases the possibility that the children will not be appropriately

monitored off-site; that if something such as an illness affect one child, all of the staff's attention must go to that child; that children can distract the monitor's attention easily, and that there is no backup to assist the monitor as there is on-site.

- Transportation risks. Visit monitors are not permitted to transfer children in their own cars unless the Program provides adequate and specific liability insurance for such transportation. This makes off-site visitation much more likely to involve the transporting parents (who are involved in the dispute) to have an opportunity to negatively interact in the presence of the children. It also increases the risks to non-offending victim parents.
- Concealed weapons risk. On-site, programs choose between prohibiting visitors from bringing packages or parcels to visits, or searching any such parcels brought on-site. This helps avoid the presence and dangers of concealed weapons. Off-site visits offer no such control, as there is no way to secure a public park, mall, or other similar location.
- Intervening emergencies and circumstances. Power outages, storms, intervening adults who show up unannounced (parent's friends, family, etc), all decrease the monitor's ability to control the visit.

D. **Off-Site Prerequisites**

For those communities and Programs that have considered the risks yet have decided to offer off-site visits, the following apply:

1. Off-site visitation can only conducted by staff who have at least three years of experience working with families at an on-site Program.
2. Each off-site referral must be pursuant to a court order which specifically states that off-site visitation is in the child's best interest.
3. Any Program offering off-site visits must have liability insurance that specifically includes coverage of off-site visits.
4. Separate policies and procedures dealing with off-site security issues must be developed by the Program.
5. The Program's Agreement with the court and DCF must include references to all of the above prerequisites (numbers 1-5 of this section).

6. Programs may not circumvent these requirements by referring off-site cases to current volunteers or staff acting as "independent contractors." All current volunteers and staff must agree not to take cases independently. This must be part of the Code of Conduct. (The Code of Conduct is part of Principle Two: Training.)

The essay below was submitted by a new director, Brenda Green. It expresses views consistent with the Best Practices, and sheds light on how a novice views the risks associated with SV.

Karen Oehme

Perspectives from a New Director: The Value and Importance of Law Enforcement to Supervised Visitation Programs

By Brenda K. Green

Supervised Visitation Coordinator: Family Resources, Bradenton, Fl.

If you've ever flown a commercial jetliner you know the drill, "In the event the cabin loses pressure, oxygen masks will release from the overhead compartment. Please put the mask over your face and breathe normally. If you are traveling with small children, please put your mask on first and THEN assist your child."

This precaution is a good reminder about the policies we have in place for our supervised visitation programs. If we do not have proper security measures in place for ourselves, how can we assure the safety of the clients that we serve? I am new to supervised visitation. However, during my eight month experience in this field, I have witnessed the critical necessity of hiring law enforcement during the visits. I do not believe any program should be without law enforcement. In fact, it is money well spent and is a win-win for everyone.

As professional as we are with the clients we serve, we must be reminded of one crucial factor: there's a reason that the visits are supervised. Of course we would like to believe that ultimately people are good, but there is nothing wrong with erring on the side of caution, especially for the very unique service that we provide to families.

In my program I hire law enforcement for each and every visit. A visitor cannot enter our building until a law enforcement officer is inside, and on duty. In some cases, I even make the officer aware of any special circumstances regarding the cases that will be happening that day or special things to look for or be aware of, such as prior rule violations.

Our program has a good rapport with the officers who serve our county. They have often accommodated me on a moment's notice if necessary. On one occasion, a phone conversation I had with a visitor to schedule an intake was not sitting well with me. Fortunately, I received a copy of the court order before the intake. From the court order I learned that this visitor had been removed from the courtroom by two bailiffs. With this in mind, I arranged for an officer to be present during the intake; not a normal procedure. The following day the visitor was jailed for a previous arrest. This brings to mind a very good point that was made during one of our FSU conferences a few months ago. *Do not assume the risk is low because the court has ordered supervised visitation. Judges typically do not conduct risk assessments.* Remember, we offer a service. It is ultimately our responsibility to have safeguards in place, perhaps even for that **one** time that we may need it. We are working with families that are often very volatile. Some of them have lost their parental rights. Many may think "What do I have to lose?"

I had one instance in which I had spoken to the visitor (father) about bringing unauthorized people into our building. (In this instance his fiancées teenage daughter.) I reminded him about our rules

in a polite and clear manner. After the children were returned to their mother, he asked to use the bathroom. Upon his return, this very large man stopped, stood in my office doorway, and proceeded to insist that he was vice president of a major corporation and didn't need to be spoken to like a child. Clearly, he was trying to intimidate me. To me it was obvious he did not like abiding by the rules that are meant for everyone. I had not spoken to this man in any unprofessional or degrading way. He saw an opportunity and he tried to take advantage of it. (The officer was a few feet away watching the fiancée and her daughter.) This instance provided me with a good learning opportunity. First, it reinforced the reasons that we have certain rules. In this case, there were too many people present which may have led to any number of risks. (Also known as the "what ifs") Secondly, it was an opportunity to review the procedures I have with law enforcement. But most of all, this occurrence actually scared me. This is not a usual trait for me. If this visitor had taken two steps inside my office there could easily have been an altercation. We know about domestic violence, but can never imagine the ideas being created in the minds of others. I could very easily have been a target. In this particular case, the custodial party had alleged domestic violence against the father and she was scared. I vividly recall her petite frame upon intake and how she pleaded to have monitored exchange at our office. Why? Because, according to the mother, the exchanges had been happening at the police station (!!) and they hadn't worked out. The exchange with the children would be made inside the police station then both parties would inevitably end up in the parking lot at the same time and the fiancée would throw verbal insults at the mother. So, you see, nothing is foolproof.

In another case, the visitor turned to me during the visit (and in front of his son) and asked, "Has anyone ever tried to steal their kid during a visit?" What I knew upon intake with the caregiver was that there was a concern about this father trying to kidnap the son from a previous supervised visitation program in our state (Florida) where there was **no** law enforcement and visits were allowed to be held

outside. I spoke with the visitor in front of the officer after the visit, informing him of the inappropriateness of his line of questioning. When he left, I spoke with the police officer. We were both struck that the father would even ask such a question.

Law enforcement officials also have a street sense. They've been around the block. They have seen a lot of things. They may have seen your client around town. The old saying that "two heads are better than one" may come in handy during your visits, and having an officer on hand can be helpful. Collaboration is a useful tool in our field. It may be helpful to run things by an officer on duty. I had a case where the visiting mother had a history of substance abuse. One of our rules state that if the visitation supervisor even suspects that a client may be under the influence, the visit is terminated. (We do not offer drug or alcohol screening at our program.) When the visitor arrived for the visit, her eyes were droopy and her speech was slurred. I asked the officer to casually observe her and give me his opinion. We both agreed that we suspected the visitor had been using drugs prior to entering our facility. I did not hold the visit due to our collaborative suspicions.

For purposes of this article, I asked a couple of officers for their contributions. They both said the same thing: essentially that having law enforcement present is for the general safety and comfort of the children. One officer even mentioned that it puts the visitor on a level playing field. I have one sergeant who goes above and beyond the call of duty and in a very respectful way reminds first time visitors that any past problems between adults should be left at the door- that this is the time for them to be here for their child and have a nice visit.

For the record I must state that it is not always the visitor who is inappropriate. I have also asked officers to escort me to speak with the caregivers for any number of reasons. Finally, I suggest you train your officers well because the unexpected is always an opportunity for people to try to get away with

things that may violate your program's rules, make someone uncomfortable, or create risk factors regarding safety. Of course, the officers won't know the case inside and out like you do, so just a quick rundown for them helps maintain a positive setting.

As we have seen in recent news from the "bullying suicide" to the recent oil spill in the Gulf, we should not wait until something happens before we make changes to our policies and procedures. Also one point which cannot be stressed enough. Remember to be as comprehensive in your documentation process as possible. Even Hansel and Gretel knew to leave a trail.

Practice Reminders from the Clearinghouse

1. **When you encounter parents in public, always record that interaction in the case file, in case what you said becomes an issue later.**
2. **When a client calls about a case on the telephone, be sure to note the phone call and a summary of the conversation in the case file.**
3. **Put some thought into how you will avoid being fooled into thinking that you are speaking to a client or lawyer when you really are not. People sometimes misrepresent who they are in order to gain or distort information. We'll talk more about this in the next phone conference!**

4. **When a parent does not show up for the visit, be sure to indicate whether the other parent/children/party shows up, and what their reaction to the no-show was. If you have conversations with the no-show parent, be sure that conversation is noted in the case file.**

5. **Staff is not obligated to answer questions from clients about the number of children they have, their marital status, or any other personal questions.**

Training Resources

Be sure to check out the resources available at Florida's Center for the Advancement of Child Welfare, at www.centerforchildwelfare.org.

The Center supports Florida's child welfare professionals in achieving practice excellence and helping keep kids safe. It is funded by the Department of Children and Families for the distribution of relevant, accurate and consistent information that is easily accessible and readily available to you 24 hours a day, 7 days a week.

September 2010 E-Press

SEPTEMBER PHONE CONFERENCE:

WEDNESDAY, SEPTEMBER 15TH

*****12:00 NOON ET*****

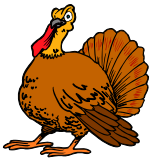
DIAL 719-457-0816 TO PARTICIPATE, YOU WILL NEED TO ENTER A PASS CODE TO PARTICIPATE. THE PASS CODE IS 635786#

PLEASE RSVP WHEN THE REMINDER EMAIL COMES OUT IF YOU PLAN TO ATTEND!

PLAN AHEAD AND HAVE YOUR TEAM CALL IN…

OCTOBER PHONE CONFERENCE

WEDNESDAY, OCTOBER 20TH @ 12:00 NOON, ET



NOVEMBER PHONE CONFERENCE

WEDNESDAY, NOVEMBER 17TH @ 12:00 NOON, ET

CLEARINGHOUSE Technical Assistance:

DOMESTIC VIOLENCE 101 Training

- **Do you have staff who have not been trained on domestic violence?**
- **Need a refresher on the dynamics of the crime?**
- **Does your entire team know about power and control, batterers as parents, why victims stay, and how perpetrators use supervised visitation to re-victimize non-offending parents and children?**

RSVP if you plan to attend (fsuvisit@aol.com)

Then CALL IN TO THE PHONE TRAINING

FRIDAY, SEPT 24th at Noon Eastern Time

Dial 1-719-457-0816, then enter the passcode 635786#

Free Training:

In-service Training for Resource Families, a Trainer's Guide & Tools

Connect is a three hour curriculum, Power Point presentation and related tools intended for use in child welfare settings with foster parents, kin caregivers, and adoptive parents with all levels of experience in caring for children who have been exposed to domestic violence, or who may have cause to care for these children in the future. With generous support from the Annie E. Casey Foundation, Connect is designed as a basic training session on the dynamics of domestic violence, the impact of exposure to domestic violence on children, and strategies for supporting children who have been exposed to violence.

Curriculum & Tools

http://endabuse.org/content/features/detail/1314/

Question of the Month:

I learned at intake that an eight year old child who will be visiting his mother this weekend is a diabetic. I know he is insulin dependent, because the foster mother told me. Is there anything else I should know to prepare for this visit?

Learn the basics about diabetes (read our summary, below) and be sure that the staff know that the child has this condition, so that they can look out for warning signs of problems associated with it.

What SV Programs Should Know about Children with Type 1 Diabetes

What is Type 1 Diabetes?

- It is the result of the body's inability to produce insulin, which is vital to convert food into energy.

How is it treated?

- Type 1 diabetes is known as "the juvenile disease" as it is often diagnosed early in life and has no cure.
- To maintain proper insulin levels, the individual uses multiple daily insulin injections or insulin pumps coupled with blood tests that monitor sugar levels (blood glucose).
- Diet and exercise can also be employed to minimize the effects of type 1 diabetes.
- While regular insulin supplementation helps, individuals are still at greater risk for kidney failure, blindness, nerve damage, amputations, heart attack, stroke, and pregnancy complications.

Who does it affect?

- About one in every 400-600 children and adolescents have type 1 diabetes and about 2 million adolescents aged 12-19 have pre-diabetes.
- Each year roughly 15,000 children are diagnosed with this disease, and experts suspect that many more go undiagnosed and untreated.
- The average age of onset has dropped in the past decade; today more children under the age of ten are receiving the diagnosis.
- It affects non-Hispanic blacks at nearly twice the rate (11.8 %) that it affects non-Hispanic whites (6.6%).
- Diabetes accounts for 32 % of all Medicare Expenditures.
- In 2007, medical expenses for those with diabetes were roughly 2.3 times higher than the amount of those without the disease.
- Diabetes was the seventh leading cause of death in the United States in 2006.
- Both genetic and environmental factors contribute to the disease.

The dos and don'ts for those supervising children with type 1 diabetes

- The chief danger for a child during visitation is low blood sugar (hypoglycemia or low blood glucose).
- The visitation supervisor should be made aware that they need to monitor for the following:

    - Shakiness
    - Dizziness
    - Sweating
    - Hunger
    - Headache
    - Pale skin color
    - Sudden moodiness or behavior changes, such as crying for no apparent reason
    - Clumsy or jerky movements
    - Seizure
    - Difficulty paying attention, or confusion
    - Tingling sensations around the mouth

- If low blood sugar does occur there are ways to treat it. Simply eating something with approximately 15-20 grams of carbohydrates works, such as the following:

    - 4 oz (1/2 cup) of juice or regular soda
    - 2 tablespoons of raisins
    - 4 or 5 saltine crackers
    - 4 teaspoons of sugar
    - 1 tablespoon of honey or corn syrup

- If hypoglycemia is not caught in time the child can pass out. If the child passes out, then the ADA recommends the following:
    - DO NOT inject insulin
    - DO NOT provide food or fluids
    - DO NOT put hands in their mouth
    - DO inject glucagon
    - **DO call for emergency help**

Tips for Caregivers of children with type 1 diabetes

- Stress, hormonal changes, growth periods, illness and other factors can lead to complications with this disease
- Caregivers of children with diabetes should be hyper-vigilant in monitoring and minimizing stress where possible
- Every child needs to replenish his or her store of glucose with either a healthy snack or a meal after physical activity
- Encourage the child to take an increasingly active role in diabetes management
- Stress the importance of lifelong diabetes care
- Teach your child how to test his or her blood sugar and inject insulin
- Help your child make wise food choices
- Encourage your child to remain physically active
- Foster a relationship between your child and his or her diabetes treatment team
- Make sure your child wears a medical ID tag

What should children with type 1 diabetes eat to maintain correct blood sugar levels?

- Grains, beans and starchy vegetables (6 or more servings daily)
- Vegetables (3-5 servings daily)
- Fruits (2-4 servings daily)
- Milk (2-3 servings daily)
- Meat and fish (2-3 servings daily)
- When possible, it is advisable that these foods be fresh or frozen
- It is advised to AVOID eating high fat foods (like bacon, butter or hamburgers) or sweets on a regular basis
- However, sweets can be enjoyed as long as they are part of a balanced meal plan that is not overly high in sugar or fat
- Children with diabetes CAN eat cake and ice cream as long as portion control is exercised and is coupled with the proper administration of insulin

Additional Resources:

- Diabetes Fact Sheet, the Center for Disease Control and Prevention

  http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2007.pdf

- Type 1 Diabetes, the Journal of the American Medical Association

  http://jama.ama-assn.org/cgi/reprint/298/12/1472.pdf

- Diabetes Care in the School and Daycare Setting, American Diabetes Association

  http://www.diabetes.org/assets/pdfs/schools/ps-diabetes-care-in-the-school-and-daycare-setting.pdf

- Children with Diabetes, American Diabetes Association

  http://www.diabetes.org/assets/pdfs/schools/chren-wdiabetes-brochure-caregivers.pdf

- Tips for Eating, Juvenile Diabetes Research Foundation International

  http://kids.jdrf.org/index.cfm?fuseaction=home.viewPage&page_id=268DBC44-5004-D739-A5306B265CF37C74

Sources:

http://www.diabetes.org/living-with-diabetes/treatment-and-care/blood-glucose-control/hypoglycemia-low-blood.html

http://www.jdrf.org/index.cfm?page_id=102585

http://jama.ama-assn.org/cgi/reprint/298/12/1472.pdf

JAMA Vol. 290 No. 16, October 22, 2003

http://care.diabetesjournals.org/content/28/1/186.full

Diabetes Care January 2005 vol. 28 *no. 1 186-212* Silverstein et al

http://www.mayoclinic.com/health/type-1-diabetes-in-children/DS00931/DSECTION=lifestyle-and-home-remedies

statistics:
http://www.diabetes.org/diabetes-basics/diabetes-statistics/

diet:
http://www.nlm.nih.gov/medlineplus/ency/article/002440.htm

Characteristics of Adults Who Physically Abuse Children

Things you should know:

1. Although child maltreatment occurs in ALL socio-economic groups, child physical abuse occurs disproportionately in economically and socially disadvantaged families.

2. Physically abused children are 12 times more likely to come from families with an annual income of less than $15,000.

3. Half of all families reported for child physical abuse receive public assistance (food stamps- Medicaid).

4. Low income also is related to the severity of abuse, with serious or fatal injuries more likely to occur among families below poverty level.

5. Birth parents are the abusers in the majority of reported abuse cases.

6. Although we can't establish whether parental characteristics cause a parent to physically abuse a child, research on characteristics can be helpful in *guiding the treatment and intervention efforts.*

<u>Adults who abuse children report more of the following:</u>

Emotional and behavioral difficulties (individual pathologies)

- ☐ Self-expressed anger
- ☐ Depression
- ☐ Low frustration tolerance
- ☐ Low self esteem
- ☐ Rigidity
- ☐ Anger control problems
- ☐ Deficits in empathy
- ☐ Anxiety
- ☐ Perceived life stress and personal distress
- ☐ Substance abuse/dependence

Family and interpersonal difficulties

- ☐ Spousal conflict
- ☐ History of abuse in childhood
- ☐ Deficits in positive interactions with child and other family members
- ☐ Isolated from friends and the community

Parenting difficulties

- ☐ Unrealistic expectations of children *(example of toileting)*
- ☐ Disregard for the child's needs/abilities
- ☐ Deficits in parenting skills (*no information from others*)
- ☐ Viewing parenting role as extremely stressful
- ☐ Negative bias/perceptions regarding the child *(child is "bad" "slow" "difficult to discipline" "annoying to parent")*
- ☐ Poor problem-solving ability with regard to child rearing

- Intrusive/inconsistent parenting
- Less communication, interaction, stimulation
- Lack of child development knowledge

Biological factors

- Reports of physical health problems (abusive parents report more health problems about themselves)
- Physiological over-reactivity
- Neuropsychological deficits (neurological function lower than that of parents who have not abused their children)

Child Factors

- Young age (most younger than 7; this may be because of extent of injuries)
- Physical and/or mental disabilities
- Characteristics of "difficult child"

Exercise: Based on the above, what interventions and assistance from supervised visitation staff might be helpful to parents?

_____

_____

_____

_____

Answers may include: staff may be able to teach parents about children's developmental phases, may be able to model appropriate interaction, may be able to provide referrals for assistance, and may be able to work with the case manager for additional intervention.

Call the Clearinghouse for advice on supportive measures for parents who have neglected or abused their children.

Trauma-Informed Care: The Basics

This is a continuing discussion by E press, phone conference, and trainings.

What is it?

- Trauma-informed care focuses on recognizing and accommodating for a victim's history of mental and/or physical trauma.
- In a trauma-informed system, every aspect of treatment has been re-evaluated to take into consideration the role that violence plays in the lives of people seeking mental health and addictions services.
- Such a system is designed to accommodate the special vulnerabilities of trauma survivors and to ease the threat of future traumatization.

What is trauma? What are its effects?

- A traumatic event occurs when an individual is faced with extreme emotional and/or physical distress which s/he is overwhelmed by and unable to cope with.
- Many sufferers of trauma are haunted by their experiences throughout their lives.

- Traumatic experiences have the capacity to alter the chemistry of the brain, resulting in a number of possible symptoms, including:
  - panic attacks
  - flashbacks to trauma
  - nightmares
  - insomnia
  - hypersensitivity
- The resulting mental disturbances of trauma have also been known to foster extreme irritability, low self-esteem, denial of trauma, and depression. Other common responses to trauma include:
  - Eating disorders
  - Smoking
  - Substance abuse
  - Self-harm
  - Sexual promiscuity
  - Severe medical conditions including heart disease, pulmonary disease, liver disease, and gynecologic cancer.
  - Many of these maladies can lead to an early death for victims of trauma.

What are some specific causes of trauma?

- There are no specific guidelines for what might qualify as trauma, and every individual experiences trauma differently. However, there are a number of common causes known to lead to psychological trauma, including:
  - Sexual abuse
  - Physical violence
  - Emotional abuse
  - Severe neglect
  - Domestic violence
  - Poverty
  - Exposure to substance abuse

Whom does it affect?

- Trauma is present across every race, ethnicity, gender, class, and orientation.
- However, trauma appears to be more prevalent among certain populations.
  - Veterans are at particularly high risk of experiencing trauma, which is closely linked with PTSD.
  - Homeless people also often have a history of trauma.
    - One study found that 97% homeless women with mental illnesses suffered trauma in either childhood, adulthood, or both.
- Substance abusers have a notably higher chance of having been exposed to trauma, as many trauma victims use drugs to cope with mental disturbances.

- 50% of women in substance abuse treatment programs have a history of rape or incest, two common causes of trauma.
- Up to 77% of male veterans in substance abuse programs were exposed to childhood trauma, and 58% also suffered post-traumatic stress disorder.

- The effect of such experiences is particularly devastating for children.
  - Between 84-93% of adolescents within the mental health population had experienced trauma at some point.
  - Among them, 32-42% also suffer from post-traumatic stress disorder.
  - Suffering trauma as a child raises an individual's likelihood of juvenile criminality by 59%.
  - 70-92% of girls in juvenile detention reported childhood trauma.
- Prison populations are also more likely to have experienced trauma.
  - At the Correctional Institute for Women in Massachusetts, 90% of prisoners receiving mental health services or substance abuse services were found to have histories of trauma.
  - Between 34-63% of women at the Correctional Institute for Women in Rhode Island were found to have faced some kind of trauma, often repeatedly, throughout their lives.

How is trauma treated?

- Trauma is often treated as part of a treatment for another mental health issue, often one stemming from exposure to trauma.
- Intensive counseling, one-on-one talk therapy, and group therapy are often helpful in the treatment of trauma.
- Certain prescription drugs may also be useful in treating the symptoms of mental disturbances resulting from exposure to trauma.
- A number of new treatments are currently being developed for trauma and post-traumatic stress disorder, including modified forms of psychotherapy and Eye Movement Desensitization and Reprocessing.

How does knowledge of a history of trauma affect the service provision?

- Service providers should always bear in mind that those seeking to escape physical, emotional, and/or sexual violence are often victims of trauma, and that they may exhibit some of common effects of such experiences, including mental illness and substance abuse.
- Its objectives are to further implementation of trauma-informed service systems, to enhance trauma-specific service delivery to trauma survivors, and to improve all staff interactions with consumers, including the most difficult-to-treat, suicidal, and self-injuring consumers. This curriculum model was developed by the Sidran Institute and authored by trauma specialists at the Trauma Research, Education, and Training Institute, Inc. (TREATI) with

input from helping professionals and trauma survivors with extensive experience in state mental health systems, clinical treatments of traumatic stress conditions, curriculum design, and the law. Risking Connection provides a basic ("Trauma 101") framework for understanding and responding to trauma survivors. It is used with all levels of public mental health, health, and substance abuse staff—from inexperienced non-degreed front-line workers to highly trained personnel, mental health, and medical professionals—to create a trauma-informed environment and to empower both client and helper to work more effectively together.

- In adjusting to trauma-informed care, service providers should:
  - Understand the common causes of trauma.
  - Be able to identify specific groups who are at-risk for exposure to trauma.
  - Be able to recognize the common disorders which spring from traumatic experiences.
  - Be aware of the effects of such disorders on sufferers' behavior and personality.
- Once trauma has been identified as a component of an individual's history, the service provider should cater its services toward trauma-specific treatments, which are modified to address the impact of trauma on the victim's life and the victim's resulting disturbances, disorders, and vulnerabilities.

Sources:

http://www.annafoundation.org/MDT.pdf

http://mentalhealth.samhsa.gov/nctic/trauma.asp

http://knowledgex.camh.net/amhspecialists/specialized_treatment/trauma_treatment/Pages/trauma_informed_model.aspx

http://download.ncadi.samhsa.gov/ken/pdf/NCTIC/NCTIC_Brochure.pdf

http://www.nasmhpd.org/general_files/publications/ntac_pubs/Responding%20to%20Childhood%20Trauma%20-%20Hodas.pdf

Special thanks to Jerry Childress in Hernando County for sharing his Cancellation Form (attached in pdf) with directors statewide.

Kinship Care Handbook

What are the challenges of kinship care giving for the adults and for the children involved?

Caregivers have reported that they experienced the following challenges:
• Struggles with finances;
• Emotional ups and downs;
• Need for supportive services and financial assistance, such as child care, help with school issues, mental health services, Medicaid, food stamps, transportation, housing assistance, sick child care and respite care;

• Understanding and appropriately interacting with the court system;
• Need for more and better information, including legal information;
• Need for support groups for both caregivers and children offering an opportunity to get together and share experiences; and
• Interactions with service providers.

This list resulted in the creation of a valuable handbook attached in pdf.

Reminder!!!! Reminder!!!! Reminder!!!! Reminder!!!!

FREE FALL SV TRAINING

What: Free, one day training for all Florida SV staff, NOV. 4th

Who: Karen Oehme, Institute Director, will conduct the training

Where: The Family Nurturing Center, Jacksonville, FL

How do I sign up? Contact Karen at fsuvisit@aol.com by Sept.30

Attachment to E Press:

DCF's

Florida's Family Centered Practice Framework

Overview

The purpose of this paper is to provide a Practice Framework that is family centered for Florida's child welfare system. This overview provides the basic components of the Family Centered Practice Framework. The overview is followed by a more detailed description of values, principles and practice expectations while also offering considerations for implementation.

Florida's Family Centered Practice Framework contains a common set of core values and principles that provide guidance to how child welfare services are to be delivered. These core beliefs, values and principles are inherent in the expectations defined in Florida Statute, have been articulated in the Department's Mission Statement to *Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families and to Advance Personal and Family Recovery and Resiliency,* and are consistent with the spirit and philosophy of community-based care.

Recommendations from the most recent Federal Child and Family Services Review (CFSR) identified a need for a more clearly articulated practice model. In response to these findings, the Department, in partnership with its community-based care stakeholders, has developed a Quality Improvement Plan (QIP) to improve the quality and consistency of child welfare practice across the state. A unifying theme of the QIP is the development and implementation of a family centered model of practice. This federal recommendation was also consistent with work being done in a number of other states to develop practice models. Accordingly, models from Alabama, Utah, Iowa, New Jersey, Washington and Washington, D.C. were reviewed for the early development of Florida's Family Centered Practice Framework.

Family Centered Practice – Defined

Family centered practice is a way of working with families to enhance their capacity to care for and protect their children. It focuses on the needs and welfare of children within the context of their families and home communities. Family centered practice recognizes the strengths of family relationships and builds on these strengths to achieve

optimal results for children and families. Family centered practice has a set of core beliefs, including:

- Family centered practice focuses on the family as a whole, and not just the individual child, and sees the family in the context of their own culture, networks and community.

- Families are seen as partners in the change process, helping to define problems and identifying solutions through the strengths in their own stories. They are engaged in trust-based relationships reflected genuineness, respect and empathy by child protective investigators and child welfare case managers and other human services professionals.

- A child and his/her family are meaningfully engaged and involved in the assessment, planning, decision-making, delivery and coordination of services when it is safe and in the best interest of the child for his/her family to do so.

These core beliefs are informed by a set of underlying values and are implemented in the day-to-day lives of a child and his/her family by following a set of basic practice principles. Taken together, these beliefs, values and practice principles act as an overarching framework for how child welfare services are to be delivered with each and every child and family served.

Core Values of a Family Centered Child Welfare System

- A child should be safe and protected.

- There is an intrinsic value and human worth in every child and family.

- A child's home should be safe, stable and permanent.

- A child should live with their families/relatives or in their communities with a focus on timely permanency.

- A child should achieve success in school and their medical, emotional, behavioral, developmental and educational needs must be met.

- Families are engaged, involved and are partners in the development of family solutions.

- The first and greatest investment of public resources should be made in the care and treatment of a child in his/her own home and community.

Guiding Principles of Family Centered Child Welfare Practice

- Every child deserves to live in a family which provides basic safety, nurturing and a commitment to permanent caretaking.

- A child's need for safe and permanent family caretaking can be met by providing appropriate and adequate resources in a timely and effective manner.

- If removal of a child from his/her family is necessary, the child should be placed in a family based setting, with the first priority given to the family of origin and kin, or people with whom the child has a connection.

- The cultural and ethnic roots of the child/family are a valuable part of their identity. In order to understand and communicate with the child/family, cultural sensitivity must be a primary feature of service delivery.

- Our approach to working with a child and his/her family should be family focused, with the needs of the child and family dictating the types and mix of services and supports.

- Services to a child and his/her family shall be individualized based on their unique strengths and needs and should be delivered pursuant to an individualized plan, constructed with the family and their team.

- An array of individualized services is needed to meet a child and his/her family's unique needs.

- Practice is always local: our work with a child and his/her family should be community based with management, services and decision-making responsibility, at the community level.

- Intervention into the life of a child and his/her family should ideally offer as much service as necessary to achieve intended goals, and no more.

- The rights to privacy and confidentiality must be treated with respect.

Practice Framework

A Practice Framework encompasses the range of the major activities of child welfare practice and service delivery at the level of the child and family. The Practice Framework is informed by a family centered set of values and practice principles and includes core practice functions. These core practice functions encompass the major activities of frontline child welfare professionals working with individual children and their

family, and include: Family Engagement; Child and Family Assessment; Team-Based Planning and Decision-Making and Individualized Planning; Case Tracking and Adjustment. Ultimately, these core practice functions, and the many initiatives, strategies, steps, interventions, approaches and activities within them, are intended to drive the service delivery process to achieve behavioral change that will reduce future risks and mitigate safety concerns while achieving child and family specific outcomes, such as, safety, stability, permanency, strengthened family functioning, and meeting the child and family's well-being needs.

It is important to differentiate between a Practice Framework and how a local system of care may have been designed. A system of care is the collection of local resources and alignment of processes to manage how a service delivery system operates to meet the need of a child and his/her family within their home environment and communities. The Practice Framework guides how investigations, case management and the provision of services are to be delivered to meet the individual needs of a child and his/her family within a system of care, such as how a protective investigator or case manager may work with a family, facilitate a team meeting, craft a case plan or access local resources.

Summary

The Family Centered Practice Framework is a collection of beliefs, values and basic practice principles about how child welfare services are to be delivered. The expectation to provide child welfare services in a family centered approach has been established in statute, and the development and implementation of a practice model is a requirement of Florida's QIP. Family Centered Practice is consistent with the philosophy of community-based care and the Practice Framework should provide guidance as to how child welfare services are delivered within local systems of care. Florida's Family Centered Practice Framework is described in more detail in the following paper.

Florida's Family Centered Practice Framework

I. Introduction

Florida has as its mission a commitment to *Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families and to Advance Personal and Family Recovery and Resiliency.* This mission statement was informed in part by the purpose assigned by the Florida legislature related to child protection, permanency and well-being in Chapter 39, Florida Statutes. It binds the Courts and Department to the following principles:

(a) To provide for the care, safety, and protection of children in an environment that fosters healthy social, emotional, intellectual, and physical development; to ensure secure and safe custody; to promote the health and well-being of all children under the state's care; and to prevent the occurrence of child abuse, neglect, and abandonment.

(b) To recognize that most families desire to be competent caregivers and providers and children achieve their greatest potential when families are able to support and nurture the growth and development of their children. Therefore, the Legislature finds that policies and procedures that provide for prevention and intervention through the department's child protection system should be based on the following principles:

1. The health and safety of the children served shall be of paramount concern.

2. The prevention and intervention should engage families in constructive, supportive, and non-adversarial relationships.

3. The prevention and intervention should intrude as little as possible into the life of the family, be focused on family strengths and clearly defined objectives, and take the most parsimonious path to remedy a family's problems.

4. The prevention and intervention should be based upon outcome evaluation results that demonstrate success in protecting children and supporting families.

(c) To provide a child protection system that reflects a partnership between the department, other agencies, and local communities.

(d) To provide a child protection system that is sensitive to the social, cultural and economic diversity of the state.

(e) To provide procedures which allow the department to respond to reports of child abuse, abandonment, or neglect in the most efficient and effective manner that ensures the health and safety of children and the integrity of families.

(f) To preserve and strengthen a child's family ties whenever possible, removing the child from parental custody only when his/her welfare cannot be adequately safeguarded without such removal.

(g) To ensure that the parent or legal custodian from whose custody the child has been taken assists the department to the fullest extent possible in locating relatives suitable to serve as caregivers for the child.

(h) To ensure that permanent placement with the biological or adoptive family is achieved as soon as possible for every child in foster care and that no child remains in foster care longer than 1 year.

(i) To secure for the child, when removal of the child from his or her own family is necessary, custody, care, and discipline as nearly as possible equivalent to that which should have been given by the parents; and to ensure, in all cases in which a child must be removed from parental custody, that the child is placed in an approved relative home, licensed foster home, adoptive home, or independent living program that provides the most stable and potentially permanent living arrangement for the child, as determined by the court. All placements shall be in a safe environment where drugs and alcohol are not abused.

(j) To ensure that, when reunification or adoption is not possible, the child will be prepared for alternative permanency goals or placements, to include, but not be limited to, another planned permanent living arrangement, independent living, custody to a relative on a permanent basis with or without legal guardianship, or custody to a foster parent or legal custodian on a permanent basis with or without legal guardianship.

(k) To make every possible effort, when two or more children who are in the care or under the supervision of the department are siblings, to place the siblings in the same home; and in the event of permanent placement of the siblings, to place them in the same adoptive home or, if the siblings are separated, to keep them in contact with each other.

(l) To provide judicial and other procedures to assure due process through which children, parents, and guardians and other interested parties are assured fair hearings by a respectful and respected court or other tribunal and the recognition, protection, and enforcement of their constitutional and other legal rights, while ensuring that public safety interests and the authority and dignity of the courts are adequately protected.

(m) To ensure that children under the jurisdiction of the courts are provided equal treatment with respect to goals, objectives, services, and case plans, without regard to the location of their placement. It is the further intent of the Legislature that, when children are removed from their homes, disruption to their education be minimized to the extent possible.

(n) To create and maintain an integrated prevention framework that enables local communities, state agencies, and organizations to collaborate to implement efficient and properly applied evidence-based child abuse prevention practices.

(o) To ensure that the physical, emotional, behavioral and educational needs of the child are met.

Florida has employed these principles in establishing the following Child Welfare Family Centered Practice Framework, which provides further guidance to the field in translating best practice principles into operational practice with each child and family.

II. What is a Practice Framework?

A Practice Framework (sometimes called a practice model) may be defined as:

Practice – the values, principles, relationships, approaches and techniques used at the system and casework practitioner level to a child and his/her family to achieve the goals of safety, stability, permanency and well-being.

Framework – a structure to hold together or support something; an underlying set of ideas: a set of ideas, principles, agreements or rules that provides the basis or outline for something intended to be more fully developed at a later stage.

Ideally, the Practice Framework provides a unified approach that guides policies, training, composition of the service array, accountability, evaluation and most important, frontline practice. Among the increasing number of states where practice models are in place and improving outcomes are Maine, Utah, Iowa, Indiana, Idaho, Tennessee, Georgia, New Jersey, Alabama and Washington, D.C..

To illustrate the relationship between Practice Framework principles and family centered approaches, a simple matrix is provided at the conclusion of this document, reflecting some of the ways in which family centered practice would support or implement the basic values and principles.

III. Florida's Family Centered Practice Framework

The underlying principles of the Practice Framework are the core of its direction to the field and reflect legislative mandates, evidence-based approaches and promising practices demonstrating results in local and national use. Influencing those principles is a set of practice values, based on successful practice experience in child welfare settings throughout the country. As an approach to practice, those values and assumptions are reflected in the following description of what we believe about children and families and their response to child welfare interventions.

Children and families are more likely to enter into a helping relationship when the worker or supporter has developed a trusting relationship with them. The quality of this relationship is the single most important foundation for engaging the child and family in a process of change. As part of that relationship, children and families are more likely to pursue a plan or course of action that they have a key role in designing. When children and families see that their strengths are recognized, respected and affirmed, they are more likely to rely on them as a foundation for taking the risks of change.

Decisions about child and family interventions are more relevant, comprehensive and informed when the family's team makes them. Children and families should always be core members of the team, "nothing about me without me!" A family team is a gathering of family members, friends, child welfare workers, other professionals and other interested people who join together to strengthen a family and provide ongoing support for the achievement of safety, permanency and well-being for the family's children. The family team conference is often the forum in which the child and family team come together to help the family craft, implement or change the individualized child and family plan. These same principles and values apply to older and transitional youth in foster care, who should also be seen as equal members in the planning and decision-making processes.

Children and families should always be core members of the team. Their informal helping system and natural allies are also central to supporting capacity for behavioral change. Their involvement in the team planning process promotes sustaining supports over time. Team planning and decision-making should be based on assessment that focuses on underlying needs, as opposed to symptoms alone, to provide the best guide to effective intervention and lasting change. Child and family plans should be based on the unique child and family needs identified rather than a fixed set of services in order to achieve lasting safety, permanency and well-being. Coordination of the activities of

case contributors is essential and works most effectively and efficiently when it occurs in regular face-to-face meetings of the family team.

Children experience trauma when they are separated from their families. When children must be removed to be protected, their trauma is lessened when they can remain in their own neighborhoods and maintain existing connections with families, schools, friends and other informal supports. Reunification occurs more rapidly and permanently when visiting between parents and children in custody is frequent and in the most normalized (homelike or in the parent's home) environment possible. Office based visits and supervised visits are the least normalized environment.

Success in school is a reliable predictor of child well-being. When the direction of planning for safety, stability and permanency is fully integrated with school needs and plans, children are more likely to make progress in all of these areas.
Children in foster care who are transitioning to adulthood are most successful in achieving independence when they have established relationships with caring adults who will support them over time. Older children in foster care and transitional youth should also be provided opportunities for normalcy and be partners with the child welfare system.

The service array should be sufficiently flexible to be adapted to the unique needs of each child and family. Services and supports best meet child and family needs when they are provided in the family's natural setting or for children in custody, the child's current placement. If services are limited to delivery in a particular place, children often have to move to receive them. Services for children should be flexible enough to be delivered in the setting where the parent and/or child currently reside (parent's home or foster caregiver's, for example). Many of the services and resources that children and families find most accessible and responsive are those established in their own community, provided within their own neighborhoods and culture. Services should also be planned in such a way that relapse is considered and strategies for its prevention are utilized.

These values and assumptions differ considerably from the application of conventional deficit focused practice, as illustrated by the following matrix.

Conventional Deficit Focused Practice	**Family Centered Practice**
Deficits are the focus	Strengths are recognized and employed in

	planning
Case manager operates separately from other partners	A child and family team guides planning and decision-making
Assessment focuses on symptoms/incidents and primarily on risk and safety within family functioning	Assessment looks at all aspects of child and family functioning and needs
Case plans are prepared largely by the case manager	Case plans are developed by the child and family team with strong participation by all
Most families get a similar array of services based on what's available	Plans and services are individualized and crafted to match unique needs
Case plans are fixed documents renewed at set intervals	Plans are regularly adapted to meet changing child and family circumstances
Outcomes are poor	Outcomes are improved

Comparing deficit focused practice with family centered practice in this manner illustrates the dimensions of practice change needed to move to family centered practice by all involved in the service delivery process.

Practice Framework Principles

The foundational principles of the Practice Framework are important not just because they identify effective relationships and approaches, they also provide a moral and ethical authority underpinning practice with children and families. For example the principle, "Children belong with their families" is more than an agency rule; it is an important professional value that staff should internalize.

The core principles of the Practice Framework are found below. These principles lead the Practice Framework description as they reflect the outcomes which family centered practice is intended to achieve.

- Every child deserves to live in a family which provides basic safety, nurturing and a commitment to permanent caretaking.
- A child's need for safe and permanent caretaking can be met by providing

appropriate and adequate resources in a timely and effective manner.

- If removal of a child from his/her family is necessary, the child should be placed in a family based setting, with the first priority given to their family of origin and kin, or people with whom the child has a connection.

- The cultural and ethnic roots of the child/family are a valuable part of their identity. In order to understand and communicate with the child/family, cultural sensitivity must be a primary feature of service delivery.

- Our approach to working with a child and his/her family should be family focused, with the needs of the child and family dictating the types and mix of services and supports.

- Services to a child and his/her family shall be individualized based on their unique strengths and needs and should be delivered pursuant to an individualized plan, constructed with the family and their team.

- Practice is always local: our work with a child and his/her family should be community-based with management, services and decision-making responsibility, at the community level.

- Intervention into the life of a child and his/her family should ideally offer as much service as necessary to achieve intended goals, and no more.

- A child should be supported in achieving success in school and in the transition to adulthood.

- A child who reaches adolescence without achieving permanency should be connected to caring adults who can support them over time. Older or transitional youth in care should be meaningfully involved in their planning and decision-making processes.

- The rights to privacy and confidentiality must be treated with respect.

How are Results for Children and Families Achieved?

Through Frontline Practice

- The response to reports of alleged abuse and neglect should be timely and thorough, attentive to the strengths and challenges of families throughout their history, not limited to the current incidence of abuse and neglect.

- A child and his/her family should be engaged in trust-based relationships reflecting genuineness, respect and empathy by the child protective investigator and case manager. Child and family strengths should be recognized and serve as a foundation of system interventions and supports. Where child protective investigations are concerned, respect and empathy for family circumstances should not obscure responsibility for safety as a primary goal.

- A child and his/her family should be meaningfully involved in case planning and decision-making. They should be encouraged to identify their own goals and the strategies which lead to their achievement.

- Planning and decision-making should occur with the input of the family's team. Teams are composed of the family, its informal supports, professionals, substitute caregivers, attorneys and others with a role in assisting the family to achieve its goals. The family should be enlisted in identifying its own team members.

- Assessment should be based on child and family strengths and needs. Need describes the condition or state causing the behaviors (or symptoms) to occur. Needs statements reframe the problem statements we often use to define the underlying need or condition. Assessment is a process that is continuous, not static, necessitating a constant readiness to adjust supports and interventions as child and family circumstances change.

- Planning should be individualized based on the unique strengths and needs of each child and family. Plans should be constructed to permit early success and reflect an understanding of the many competing demands on family schedules. Plans should be adjusted to respond to emerging child and family needs.

- Services and interventions should be coordinated within the team to permit regular exchange of information about issues and progress and assure that supports are effective in addressing child and family goals.

- Engagement, assessment, planning and coordination occur most effectively when they occur within a child and family team that meets regularly face-to-face. Using the team as the locus for these functions not only contributes to success, but also enhances efficiency in performance.

- Where a child is considered for placement, priority should be given to placement with kin, who should receive the same attention and support that non-related caregivers are provided.

- A child in out-of-home care should be provided the opportunity for frequent normalized visits with family members. Supervised visiting plans are appropriate only when safety risks are present.

- Siblings should be placed in the same setting.

- An array of individualized services is needed to meet a child and his/her family's unique needs.

- A child should be free of excessive or inappropriate psychotropic medication, restraints, seclusion or time out.

Through Community-Based Resources

- Services should be flexible and adaptable to individual child and family needs. If needed services do not exist, the agency should commit to developing them. Flexible services should be available not only to the child and family, but substitute caregivers as well. These services include those provided in the home.

- Placement should be in close proximity to the family and neighborhood from which the child was placed. A child should be placed in settings that permit continued attendance at the school attended at time of placement.

- A child should be placed in family-based settings with the first priority given to families of origin and kin, or people with whom the child has a connection. A

child should be placed in congregate settings only when needs cannot be met through the provision of flexible, individualized services in family-based settings.

Through Organizational Action

- The system response to a child and his/her family should be culturally responsive to the ethnicity, religion and heritage of those served.

- Service delivery should be through adequately trained staff whose practice is consistent with the Practice Framework.

- Agency policy should be guided by the Practice Framework and foster practice consistent with the principles within it.

- Accountability mechanisms should include approaches that assess the degree to which local practice is faithful to the Practice Framework.

Through Organizational Culture

The final Practice Framework principle described reflects not just an action on the part of staff in the child welfare system; it reflects a personal commitment and a different way of thinking about achieving the goals for the child and family. Underlying the important principles listed previously is a commitment to pursue "Whatever It Takes" to achieve safety, stability, permanency and well-being. This philosophy shifts the perception of services to families from an agency or systems response to a personal commitment. Through this approach, for example, instability for challenging children is not seen as inevitable, nor is lack of permanency for a youth with prior failed adoptions. The obligation of Practice Framework implementation is to make it possible for staff to do "Whatever It Takes", by strengthening engagement, assessment and planning skills, ensuring that needed services can be individualized and strengthening community-based resources essential to better outcomes.

IV. Implications for Practice

The adoption of a Practice Framework is a critical step in beginning and sustaining family centered practice. The most challenging task is implementing it. There must be commitment to translating Practice Framework principles into action. The following section identifies key areas of organizational performance that will require examination

and in many cases change to faithfully implement the Family Centered Framework of Practice.

Key Practice Functions

Family Engagement – Family engagement, or creating trust-based relationships, is more than developing a friendly relationship with parents. In implementing family centered practice, particular attention is needed in strengthening the practice of case management and protective investigative staff. Trust-based relationships require genuine respect for families, even while focusing on parenting practices that can be harmful. Trust-based relationships also require honesty, especially when truths are painful to confront. And trust-based relationships require empathy, which many child welfare professionals struggle to experience when children have been harmed by parents. When engagement roles begin in child protection investigations, treating families respectfully and understanding the dynamics of family functioning still should not compromise the honest language needed in determining child safety and risk.

Within a trust-based relationship, there is no better evidence of the strength of that relationship than a high level of family involvement in case planning and decision-making. When fully engaged, the family helps set case goals, identifies its own natural supports as part of their team, contributes to selection of the strategies for achievement of the goal and helps select the service providers needed to implement the family's plan.

Assessment - The assessment of needs in family centered practice is a continuous process throughout the life of each case, starting with the protective investigation. A complete understanding of the family is dependent upon multiple sources, especially the family's communication about its own strengths, challenges and history. Enabling families to honestly discuss their strengths and needs is dependent on the level of engagement and trust reached between the team and family, a key reason why family engagement is so important. Assessment should consider all of the areas of child and family functioning, safety and permanency foremost, but also family and social relationships, culture, health and mental health, economic self-sufficiency and education. Because of the prominence of substance abuse, domestic violence and

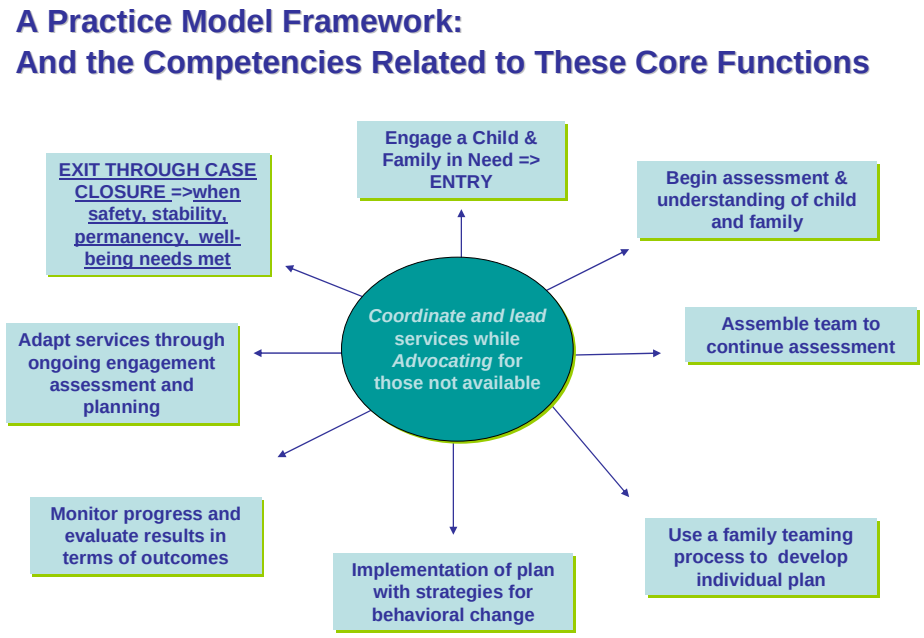
mental illness among families served by child welfare, particular attention is needed to the presence and causes of these conditions.

Assessment should identify strengths and underlying needs of the family. Underlying needs are the conditions that cause behaviors that bring families to the attention of child-serving systems. Traditionally, child welfare systems are focused on symptoms rather than needs and for that reason, interventions frequently fail to produce lasting results. When the team is contributing actively to identifying child and family needs, more expertise is available to produce the understanding needed to craft an effective and sustainable plan.

Team-Based Planning and Decision-Making - Child welfare systems face significant challenges in meaningfully involving families in planning, using their informal helping system strategically, integrating assessment information from multiple sources and coordinating service delivery. In many systems, case managers tend to coordinate activities with providers and other partners much as a switchboard operator would, one partner at a time. This leads to fragmentation of the system response and often uncoordinated, misinformed interventions. Face-to-face team meetings are a very effective way to address the barriers referenced above. Team meetings, when they are experienced by families at their meeting, provide an effective and efficient forum for involvement of the family's informal supports and complement collaboration across all professional areas of expertise. Adding the family's knowledge of its own strengths and needs to the expertise of professionals present leads to much better informed assessment of needs and permits direct coordination of the work of multiple participants. An effectively facilitated team meeting saves time and provides the family a partnership role not often present in more conventional practice.

Individualized Planning – A central feature of family centered practice is individualized case planning. When services and supports are matched to needs, plans take a very different form than the "one size fits all" combination of required services common in many child welfare system plans. Individualized planning produces unique child and family plans that demand flexibility and creativity from the service array. Like assessment, planning is a continuous process, with plans routinely being tracked for progress and interventions adapted to respond to changes in the family's status and functioning.

The Practice Wheel – The following Practice Wheel represents one way of looking at the elements of family centered practice.



The Practice Wheel demonstrates the continuous nature of engagement, assessment, reaming, planning and tracking as well as the relationship of these elements to each other.

Community-Based Resources

A family centered framework of practice requires a diverse array of community-based service resources, with a strong focus on accessible home-based supports and family based placement resources. Rather than requiring children to change placements to access a more intensive, structured or specialized set of supports, family centered practice anticipates those services being flexible enough to serve children where they currently live. Providers should be flexible in their service delivery and have the capacity to tailor their resources to fit the needs identified in an individualized plan. For example, rather than attending a parenting class, parents might improve their parenting skills most effectively through in-home parent coaching involving practice with their own

child. For many children with emotional or behavioral needs, mentoring and behavioral coaching might be more effective than office-based therapy.

In a family centered practice environment, many providers may need to offer an array of services and supports, not a single service. So, a provider of residential services might diversify to provide intensive in-home mental health services as well as therapeutic foster care.

Flexible dollars accessible to the family team are a necessity in family centered practice. Many child and family needs are not easily met with categorical services, necessitating the availability of local funds for use by the family team in creating an individualized service. For example, in the absence of existing capacity, one system used flexible funds to contract with a retired special education teacher as a behavioral coach for a student with disruptive behaviors in the classroom and in his foster home. Prior to adopting family centered services, the system would have looked to a group home placement to address behavioral issues. Not only was this service more effective, it has the potential to be eligible for Medicaid reimbursement and a substantial cost savings in state funds.

Organizational Action

The implementation of family centered services has significant implications for policy, training and accountability. Family centered practice policy should set clear expectations for practice and provide the guidance and structure that facilitates rather than restrains good practice. Systems should be alert for areas of policy that are artifacts of child centered, deficit-focused practice at odds with the principles and values of family centered practice. Examples of such discontinuity might be a risk assessment tool that ignores family strengths, a template permanency planning form that impedes individualized planning, planning driven by attorneys rather than the family team or rigid contracting rules that make effective use of flexible funds difficult.

No system has implemented family centered services with fidelity to the Practice Framework without development of its new staff and existing workforce through training

and practice coaching. Much in conventional child welfare training is process and information based, rather than also teaching specific practice skills. As a result participants may know what is to be performed, but not how. Attention will be needed to ensure that staff have the opportunity to see good family centered practice modeled in the classroom and field, can practice it, receive coaching and feedback related to their skills and in the case of supervisors, coach family centered practice at the frontline.

Attorneys representing the child welfare system play a crucial role in the delivery of family centered practice and achievement of better outcomes. Their traditional role in areas such as analyzing case statutory authority, legal precedents, preponderance of evidence and advising on judicial rulings, for example, would not change within a Family Centered Practice Framework. Neither would judges, parent attorneys or attorneys for children experience a change in their primary legal role and obligations. The recognition that the child's best interest is the primary focus of practice and decision-making remains primary in a family centered approach. The greatest additional contribution legal partners can make is to within their ethical obligations, be open to a greater degree of family and youth participation in decision making, a less adversarial relationship between families and agency staff, the regular use of family teams to assess, plan and coordinate case activity and highly individualized plans and services different than the "one size fits all" planning approach too common in the field. These approaches are compatible with the mission of the Department as assigned by the Florida Legislature and are increasingly recognized nationally as important contributors to achieving safety, permanency and well-being.

Accountability measures also are likely to need refinement. Many accountability approaches are process oriented and while useful, cannot accurately judge the degree of meaningful family involvement in planning, whether assessment of family functioning is accurate or if services are actually being effective. A combination of process measures, qualitative measures based on interviews with families and other team members and outcome tracking most effectively evaluates practice and system performance.

Similarly, performance expectations of staff should mirror family centered practice principles. For example, while it is important to hold staff accountable for meeting expected time frames for action, it is also important to expect staff to engage families and work within a team.

V. Getting Started

Following the creation of a Practice Framework, there is a variety of entry points available to begin implementation of family centered practice. Prior to actual implementation of new practice approaches, some appraisal of the current practice environment is desirable.

Appraisal of Current Practice – Through key informant interviews of agency staff, parents, foster teens and foster parents, gather information about your own culture of practice. Are trust-based relationships with families evident and common? Are families involved in decision-making? Are plans individualized and routinely monitored and adapted? Is team-based planning and decision-making occurring and if so, do families perceive the team meetings as their meeting or an agency meeting? How much does practice need to change?

Identification of Internal Practice Champions – Some staff are already practicing family centered practice based on past training and experience or a natural affinity for family engagement. They can be engaged as practice champions, potential mentors and coaches and work group leaders charged with helping lead implementation of family centered practice.

Assessment of Practice Supports – Assess the congruity of policy, training, service availability and flexibility, supervisory and accountability processes with the family centered practice approach. Where does policy need to change to support the practice change? What is needed in the way of training, both in content and availability? Are providers willing to try adapting services to individualized plans? Are new tools needed to assess the quality of practice and its consistency with family centered practice principles? How can front line supervisors be developed and employed as practice coaches?

Feedback from Community Partners – Engage community partners in assessing current practice and implementation planning. Providers, youth, family members, foster parents, advocates, educational and legal partners all have important perspectives that need to be considered.

Selection of First Steps – Nationally, systems have chosen different paths to initial implementation. A common first step has been strengthening family engagement expectations and skills, since engagement is so fundamental to the Practice Framework. Many systems began implementation with the use of family teams, an approach already in place in some Florida jurisdictions. Others have begun by focusing on strength and needs-based assessment. Skill-based training and coaching have been used to support these strategies.

Other systems have begun implementation by conducting a practice review, most using a version of the Qualitative Service Review (QSR), a tool and approach already familiar to some Florida child welfare professionals. The Child and Family Services Review (CFSR) case review tool, with modifications, is also an option chosen by states. The reviews have helped identify vulnerabilities in practice quality and pointed to a logical entry point for quality improvement.

Development of an Implementation Plan – To effectively implement family centered practice, an implementation plan is important in assuring that strategies are appropriately sequenced and that responsibilities and timelines are clear.

The Role of Leadership – No single family centered practice initiative can change a child centered, deficit focused practice culture to a strengths-based family centered culture. Different expectations, policy, training, practice coaching, resource availability, quality improvement and accountability all contribute to creation of a new organizational culture. There is a single intangible that is the most essential in changing the culture of practice – system leadership. For family centered practice to be internalized and followed by the work force, its importance has to be a central and lasting focus of both state and local level leadership. Evaluation of the variability of performance among states and counties involved in implementing family centered practice suggests that the most important variable in regard to improved outcomes is the commitment and capacity of system leadership. Florida is fortunate in having leadership positioned to guide this change process. Adoption of the D.C.F Family Centered Practice Framework provides the foundation from which to begin.

Appendix

The following matrix demonstrates the relationship between core Family Centered Practice Framework principles and applicable family centered practices and supports to illustrate the relationship between the two.

Summary of Core Practice Framework Principles	**Applicable Family Centered Practices and Supports**
A child should be protected from abuse and neglect	Family engagement Intensive home-based services Family involvement in decision making Family team involvement in safety and risk management Thorough strengths & needs based assessment
A child should have timely permanency	Family engagement Intensive home-based services Family involvement in decision making Team involvement Using foster parents as parent mentors Attention to permanency urgency by court and other legal partners
A child should live with family where safety can be provided (including kin)	Family engagement Intensive home-based services Family involvement in decision-making Family team involvement
Families should be engaged in trust-based relationships	Skill-based engagement training and supervision Qualitative assessment of practice

Families should have a meaningful role in planning and decision-making	Family team conferences Participation of informal family supports on family team Qualitative assessment of practice
Case assessment, planning, coordination and intervention should occur through an ongoing family team	Training and coaching in team facilitation, attention to fidelity Appropriate meeting space Flexible hours for evening meetings Child care, where needed Qualitative assessment of practice
Assessment should be strength based and focused on underlying needs	Functional assessment training and supervision Parent and youth involvement in assessment Input from expert team members - case assessment formed by the team, not solely an outside provider Qualitative assessment of practice
Plans should be individualized	Training and supervision in strength & needs based individualized planning Responsive case plan and court order formats Qualitative assessment of practice
Services should be flexible and adaptable	Flexible local funds Diversified contract provider service array Simple individualized service contracting process Qualitative assessment of practice
A child should experience success in school	Training of staff in educational rights and advocacy Family teams involving classroom teachers Flexible school supports (mentoring, tutoring, behavioral coaching)

	Qualitative assessment of practice
A child in out-of-home care should live in close proximity to their family, placed in family settings	Child specific placement recruitment Neighborhood based foster home recruitment Intensive in-home supportive services for kinship placements Intensive in-home behavioral support capacity to avoid distant residential placements
A child should have stability in his/her life	Timely permanency Thorough strengths & needs based assessment Appropriate needs based placement matching Flexible funds and services permitting in-home supports to prevent disruptions
A child should live in the least restrictive settings appropriate to their needs	Thorough strengths & needs based assessment Flexible funds and services permitting supports to address challenges in current placement
A child in out-of home care should have frequent contact with family in the most normalized setting appropriate to their needs	Court openness to review supervised visiting orders Family foster homes as a normalized visiting location In-home supports to supervise visits in-home
Siblings should be placed together	Child specific placement recruitment Neighborhood based foster home recruitment Flexible funds to address foster parent housing constraints
A child should be free from inappropriate psychotropic medication, seclusion, restraints and time-out	Appropriate professional standards and oversight Training of youth and families in informed consent (psychotropic medication) Qualitative assessment of practice
Transitional age youth should be connected to caring adults before independence	Family team meetings offering significant youth opportunities for input/choice

	Reconnecting youth with family Using family team meetings to involve informal supports

October 2010 E-Press

OCTOBER PHONE CONFERENCE:

WEDNESDAY, OCTOBER 20TH

*****12:00 NOON ET*****

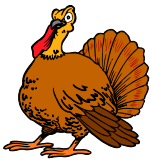
DIAL 719-457-0816 TO PARTICIPATE, YOU WILL NEED TO ENTER A PASS CODE TO PARTICIPATE. THE PASS CODE IS 635786#

YOU MUST RSVP WHEN THE REMINDER EMAIL COMES OUT IF YOU PLAN TO ATTEND!

PLAN AHEAD AND HAVE YOUR TEAM CALL IN…

NOVEMBER PHONE CONFERENCE

WEDNESDAY, NOVEMBER 17TH @ 12:00 NOON, ET



DECEMBER PHONE CONFERENCE

WEDNESDAY, DECEMBER 15TH @ 12:00 NOON, ET

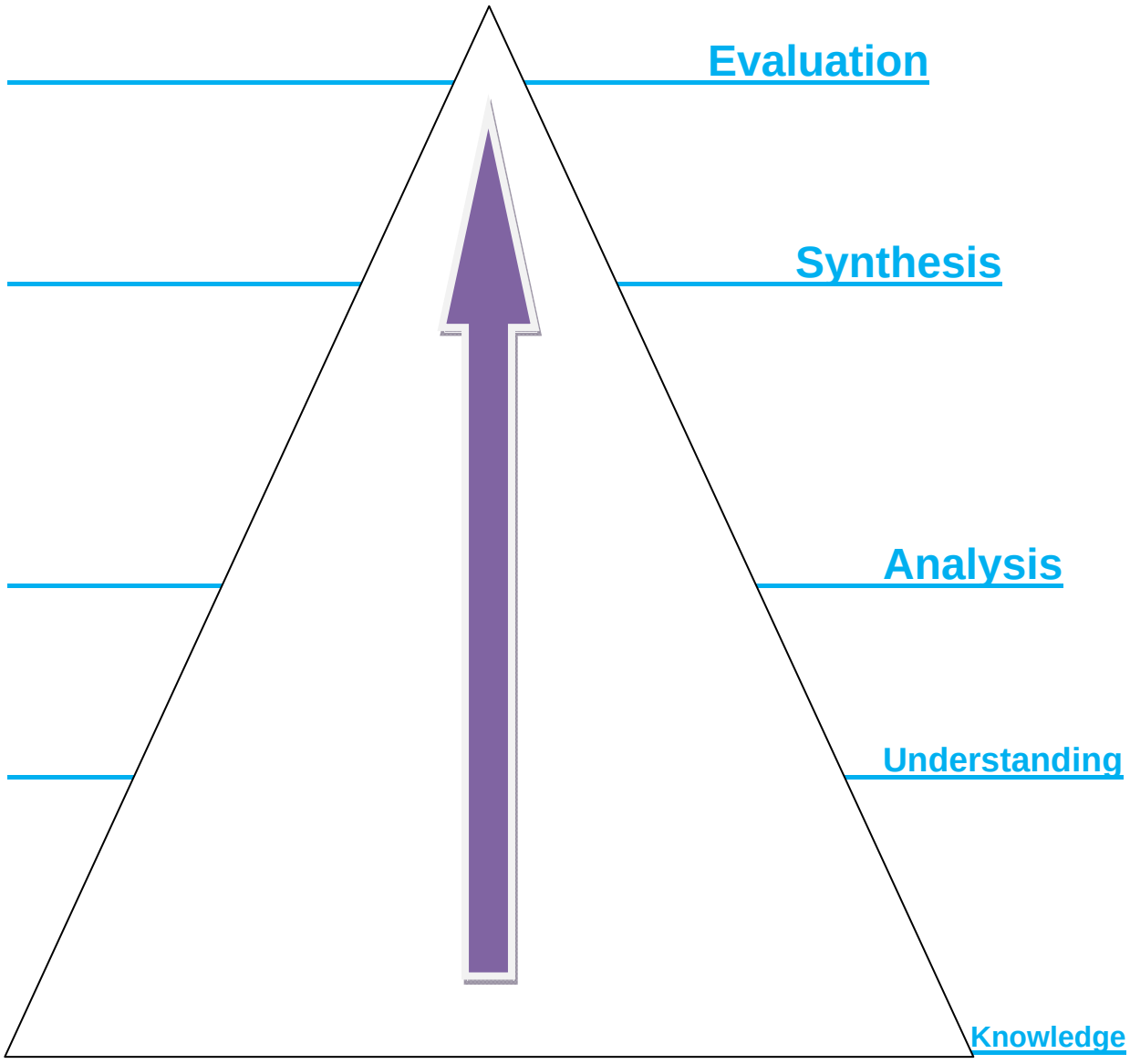
FUNDING ALERT

DID YOUR PROGRAM APPLY FOR SAFE HAVENS/OVW funding?

Did you get the funding? Please let us know immediately by hitting REPLY! (fsuvisit@aol.com)

Practice Tips - The Difference Between Basic Practice and Comprehensive Practice

Comprehensive practice



Basic practice

There is a difference between comprehensive practice and basic practice. As you know, unique situations occur in supervised visitation often. Existing rules and polices may not always address these situations. However, a simple process of critical thinking can help providers navigate almost any new issue.

Look at the pyramid and think about moving your program UP into comprehensive practice!

1. **Knowledge means knowing the principles, rules, and policies of supervised visitation.**

2. **Understanding means comprehending the reasons for the principles and rules.**

3. **Application means applying knowledge and understanding to interaction with clients.**

4. **Analysis means analyzing facts, policies, and ethical considerations to determine your responses.**

5. **Synthesis means creating new responses to unfamiliar situations within ethical boundaries.**

6. **Evaluation means assessing the effectiveness of your responses and planning future improvements.**

We will talk about this issue in the next phone conference. Considering these issues, answer the following:

- **Why might simply copying some else's forms be a mistake at your program?**
- **What are the implications of each program being unique?**

It's that time again: A and V Reports are DUE!

Supervised Visitation Program

Guide for Developing Social Media Policy

Social media is an undeniable force in our new, global, and connected society. For those in the social services, social media both presents incredible opportunities and poses great risks. Supervised visitation programs are encouraged to develop a social media policy in order to maintain client confidence and confidentiality, guard the program's reputation, protect

staff/volunteers, and maintain high standards of ethical practice. Such a policy should be updated at least annually, because of the speed at which the technology is changing.

I. What is social media?

A. Definition

- Social media is any online mode of communication used by individuals for the purpose of social interaction and networking.

B. Examples of social media include:

- Facebook, MySpace, Wikipedia, You Tube, Twitter, Yelp, Flickr, Second Life, Yahoo groups, Wordpress, Blogspot, etc.

II. Why should supervised visitation programs develop a social media policy?

A. Protection

- Protecting clients' personal information

1. Scenario:

   Thomas just started a blog, which he writes late at night. He has a username and feels almost anonymous, except to his family and close friends. He thinks that finally he has a safe place to vent about all the families he sees at the supervised visitation program, how he feels about his coworkers and how his job affects him on a daily basis. He gets lost in the relief of sharing all of his pent up feelings and frustrations. Over time, he starts using first names, giving details, revealing his inner thoughts and intentions. Then, one day, a client stumbles upon his blog.
2. Consider how a client might feel seeing his/her confidential information on the internet. Consider how the judge would feel about Thomas's actions. This scenario illustrates how one individual can threaten the integrity of the entire program.

3. The internet can sometimes feel like a safe haven for venting and sharing about one's experiences, but when supervised visitation staff/volunteers share ("chat" or "post") about their day on the internet, they are violating clients' rights to confidentiality, putting themselves at risk of disciplinary action, endangering the integrity

of the program, possibly exposing the program to a libel suit, and perhaps influencing the litigation.

- Staff/volunteer safety

    1. Scenario:

        Sharon is an employee at a supervised visitation program. She proudly advertises the name of her agency and is constantly updating her Facebook status with things like "Wow, today was a hard day. Seeing so many screwed up families is really tough. This one little boy and girl I saw today have a real loser for a dad. Poor kids." The "loser" happens to be a friend of a friend on Facebook, unbeknownst to Sharon, and was snooping around on her site. He is infuriated by this post, which he assumes refers to him, and decides to do something about it. He notices Sharon often has her daily routine on Facebook, including when and where she takes her kids to school…
    2. Possible repercussions of Sharon's actions?

        a. Threats to her/her family

        b. Physical violence or stalking

        c. Legal repercussions against both her and the program for which she works

        d. Loss of employment

    3. Social media policy is essential for protecting staff/volunteers from putting themselves at risk by provoking clients and divulging too much personal information.

- Protecting the program

    1. Misrepresentation

        a. Staff who use social media and discuss work are representing their agency, often poorly and unprofessionally. This can lead to misunderstandings and even legal repercussions.

    2. Losing respect and credibility

a. Unprofessional behavior by staff/volunteers on social media sites can give the agency a bad reputation and endanger credibility.

b. The funders of the program might decide not to renew the program's contract if they believe that standards of confidentiality and professionalism are not maintained.

c. Scenario:

> *Julie is a recent college graduate. She loves working in the child welfare field and enjoys getting to know families who come into the program. Two of the teenage girls who visit their father at the visitation program find Julie on MySpace. They ask to be friends. Julie she thinks this will be a good way to get to know them better and develop a good relationship with them. She fails to remember all the pictures on her MySpace from her crazy college days- at the beach on Spring Break and at various frat parties. She also is very open about her night life, and one of the girls has asked her about "clubbing" at the visitation program. Now Julie is being treated differently by the family. They have mentioned Julie's postings to the program director.*

d. As illustrated above, mixing personal and professional lives can invalidate staff/volunteers' credibility and undermine the agency's reputation.

3. Lawsuits and other forms of legal retribution

a. Agencies could be held accountable for staff/volunteers' behavior on social media sites, even legally, especially if clients' confidentiality is violated. The program can be held in contempt of court for confidentiality violations.

b. The vast majority of cases are referred to supervised visitation through the child protection and/or court system. This means that the cases sent to the program are part of ongoing litigation. Case-specific postings on social media sites might become part of the parents' complaints against each other and/or the program.

B. Professionalism

- Program staff/volunteers are not only bound to the law, but to professional ethics. These include-
    1. Treating clients with dignity and respect.
    2. Honoring clients' rights to confidentiality.
    3. Maintaining appropriate boundaries with clients.
- Representing oneself online (in the public sphere) should be done with the same level of professionalism displayed in any public arena.
    1. If you would not walk around the office in a bikini, tell everyone around the office exactly what you think of them, or air your dirty laundry publicly- you should ***not*** do it online!

III. Who decides what each program's social media policy should be?

- Each organization must follow its own protocols for developing new policies.
- If the program is under the umbrella of a larger agency, the program director should identify what the corporate policies are regarding social media.
- If no corporate policy can be found within the larger organization, the program director should find out whose approval is needed to create a new policy at the local level.
- If the program director is the head of the 501(C)(3) agency, it is his or her responsibility to evaluate alternatives and make choices regarding the program's social media policy with the Board of Directors.

IV. What are the possible components of a social media policy?

A. Affirmation of social media's potential for good

- Affirmation is important, as the agency does not want to seem disconnected and out-of-touch with technological advancement or opposed to change.

- Social media should be affirmed as an exciting new part of our world and an opportunity to better serve the community, if care is used.

B. Advising staff/volunteers of general web safety precautions, such as:

- Take advantage of opportunities social networking sites offer to protect personal privacy and information.
- Remember that the information posted online, even when privacy settings are utilized, is potentially available to anyone with access to the internet. It is public information (comparable to writing your personal information on a billboard on I-75).
- Take precautions to assure that potentially dangerous information is not displayed on your social media sites (i.e., personal activities, schedule and whereabouts, address, telephone number). The list might also include email, children's names or activities, etc.).

C. Addressing basic ethical considerations, such as:

- Staff/volunteers are expected to abide by social media site's policies and terms of service.
- Staff/volunteers are expected to comply with the law, as with copyrights and plagiarism.
- Staff/volunteers are expected to behave professionally and ethically (i.e. not making defamatory comments, racial slurs, offensive language etc).

D. Issues specific to supervised visitation staff/volunteers, such as:

- Staff/volunteers should be advised whether or not they are permitted to use the agency's name and/or their job title on social media sites.
- Staff/volunteers should be reminded of their commitment to confidentiality and instructed that they are prohibited from disclosing clients' names, personal information and/or discussing client situations on social media sites, just as they would be in any other social context.
- Staff/volunteers should be instructed that in order to avoid conflict of interest situations, they should refrain from interacting with clients and/or anyone related to clients on social media sites (this includes being friends on Facebook, sharing blog posts, etc.).

- Staff/volunteers should be advised to refrain from discussing their workwith people on social media sites, especially with friends with whom there could be a potential conflict of interest.

- Staff/volunteers should be encouraged not to "vent" about work on social media sites, but to find other, more private and professional ways of processing their work experiences, such as with a trusted colleague or the program director.

E. **Clarifying information *if* programs allow employees to use the agency name/job title in social media:**

If agencies decide to allow staff/volunteers to post their information on a social networking site, agency decision makers and policy makers need to decide what information is acceptable and unacceptable for those staff/volunteers to broadcast.

- A list of acceptable and unacceptable examples may be helpful for staff to understand the boundaries of permissible online activity.

- The consequences of mixing personal and professional lives should be described.

- Conflict of Interest should be discussed.

    1. Inadvertently creating a conflict of interest is a huge risk when using social media

        a. Scenario: *Jim is talking wall-to-wall on Facebook with a friend going through a messy divorce. In the course of comforting her, he confides that he works for a supervised visitation program and he can help her through the process if the judge refers her family to the program.*

        b. In the above scenario, Jim may be perceived by his friend's ex-spouse as offering a special, biased relationship to a potential client.

        c. This kind of situation can easily happen when personal and professional lives become too mixed on social media sites.

- Other risk factors:

a. Potential endangerment of their safety and/or their families' safety.

b. Heightened caution and restriction regarding the content of their social media site.

c. Heightened risk of employment loss and other work-related consequences.

V. <u>When should a social media policy be updated?</u>

As technology changes, social media policies should be updated to reflect those changes.

VI. <u>What are the consequences of failing to adhere to the program's social media policy</u>?

- Specific consequences actions for violation of the policy should be clearly communicated to staff/volunteers and executed consistently.
- If your agency develops a social media policy, have all staff/volunteers review and sign upon hiring.
- Add your policy and reminders about social media policy to the program's Code of Ethics.

VII. <u>Who is responsible for handling questions, concerns and case-by-case ethical dilemmas</u>?

- It is important to designate someone to whom staff/volunteers can be referred if they need additional information.
- The name of this designated person and their contact information should be included in the social media policy.

SAMPLE TEMPLATE

<u>Sunshine Visitation Program's Social Media Policy</u>

An Introductory Statement should spell out the tension between the benefits and risks of social media.

I. **General web safety precautions:**

This is a list of general safety precautions that you want your staff/volunteers to understand.

II. **Ethical considerations:**

This is a list of ethical considerations concerning social media, program policies, and general ethical conduct.

III. **Issues specific to supervised visitation staff/volunteers:**

This is a list of issues that deal specifically with the mission and goals of supervised visitation and with your program's business ethics.

IV. **Acceptable vs. unacceptable use**:

This section determines whether staff/volunteers are able to identify their agency name and job title in a social media site. It describes what kinds of information can be communicated on social media by staff/volunteers. It also lists prohibited communication.

V. **Consequences of failing to adhere to the programs' social media policy:**

The consequences of failing to adhere to the program policy, and the authority and discretion of the program director to take action when staff/volunteers commit breaches of the policy, should be outlined. The program contact for questions relating to the social media policy should be identified.

Questions from Directors #1:

My staff suspects that a teenager at our program might have an eating disorder. Can you help us?

We talked about this issue in a phone conference a few months ago. Here are the basics of the issue. Call the Clearinghouse for details specific to a case.

Eating disorders – a refresher

Anorexia Nervosa: What is it?

- According to the DSM-IV-TR this condition is characterized by a refusal to maintain a minimally normal body weight which is clinically defined as less than 85% what is considered normal for that person's age and weight (criterion A)
- These individuals have an intense fear of gaining weight or becoming fat (criterion B) that is not alleviated when weight loss actually occurs
- Self perceived body weight and shape is distorted in these individuals (criterion C). Many often become obsessed with either total weight and shape or concerned with specific parts of their bodies
- Absence of at least three menstrual cycles (amenorrhea) in postmenarcheal females, due to low levels of estrogen secretion, is an indicator of physiological dysfunction (criterion D)
- Subtypes:
    - Restricting type – achieves weight loss by dieting, fasting, or excessive exercise
    - Binge-eating/purging type – achieves weight loss through a combination of eating and vomiting

How common is it? Whom does it affect?

- This condition rarely manifests before puberty and effects females ten times more than males
- Females age 14-18 are most at risk for engaging in this behavior
- The average length of time people engage in anorexic behaviors is 1.7 years
- The average age of onset is 18.9 years

Related issues

- Depressive symptoms like depressed mood, social withdrawal, irritability, insomnia, and diminished interest in sex can be the result when individuals are extremely underweight (less than 85% of their normal weight, BMI equal to or lower than 17.5kg/m)

- They often engage in obsessive-compulsive behaviors and/or thinking concerning food and other nonfood related domains
- Other features include concerns about eating in public, feelings of ineffectiveness, a strong need to control one's environment, inflexible thinking, limited social spontaneity, perfectionism, and overly restrained initiative and emotional expression
- 25% of those with Anorexia Nervosa also suffer from either social phobia or a specific phobia
- 47.9% of those with Anorexia Nervosa also suffer from other anxiety disorders
- 42.1% of those with Anorexia Nervosa also suffer form other mood disorders
- 30.8% of those with Anorexia Nervosa also suffer from impulse control disorders
- 27% of those with Anorexia Nervosa also suffer from substance abuse

Bulimia Nervosa, What is it?

- According to the DSM-IV-TR, it is characterized by repeated episodes (at least twice a week for three weeks) of binge eating followed by inappropriate compensatory behaviors such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise (criterion C)
- Binge is defined as eating larger amounts of food than other individuals eat under similar circumstances in about two hours time (criterion A1); these individuals are often ashamed of their eating and tend to do so in private
- Binge episodes are accompanied by a sense of lack of control (criterion A2)
- An essential component of Bulimia Nervosa is the use of inappropriate compensatory behaviors to prevent weight gain (criterion B). Purging is the most common (used by 80-90%), another third will use laxatives, and some use diuretics
- Individuals are overly concerned with body shape and weight which is the primary way they derive their self esteem (criterion D)

- Subtypes:
    - Purging type – regularly engages in purging behavior to compensate for binges
    - Nonpurging type – uses fasting or excessive exercise to compensate for binges

How common is it? Whom does it affect?

- 90% of those engaging in bulimic behaviors are female
- Between 5% and 18% of adolescents engage in Bulimic behaviors
- The lifetime prevalence of Bulimia Nervosa is 1% to 3%
- The average length of time people engage in bulimic behaviors is 8.3 years
- The average age of onset is 19.7 years

Related issues

- There is an increase frequency of depressive symptoms (low self-esteem) or mood disorders (particularly dysthymic disorder and major depressive disorder)
- 41% of those with Bulimia Nervosa also report social phobia and 50% report other specific phobias
- 80.6% of those with Bulimia Nervosa also suffer from other anxiety disorders
- 70.7% of those with Bulimia Nervosa also suffer from other mood disorders
- 63.8% of those with Bulimia Nervosa also suffer from impulse control disorders
- 36.8% of those with Bulimia Nervosa also suffer from substance abuse

Why are eating disorders a problem?

- Anorexia, if extreme starvation is used, can lead to death
- These behaviors are self-perpetuating, individuals that engage in weight reducing behaviors (a socially desirable outcome) are positively reinforced when they are successful and tend to continue the behavior

- Extreme changes in diet during developmental stages can have severe impact on normal growth patterns of adolescents
- Eating disorders can be a compound problem for those experiencing family turmoil and can be an impediment to successful therapy
- Often those with eating disorders have difficulty expressing and/or accepting their emotions
- They show less expressivity, greater timidity, and more submissiveness

What Can Be Done?

- One study of 48 women ranging in age from 20-38 years of age identified seven aspects that they considered would be part of their own successful recovery:
    - To accept myself and my body (76%)
    - Not to use food to resolve problems and not to let food dominate life (76%)
    - To feel that life has a purpose to oneself and to others (38%)
    - To have contact with emotions and the courage to express them (33%)
    - To have less anxiety and depression (29%)
    - To fulfill own potential and not just to conform to expectations from others (20%)
    - To have a good social functioning (13%)

Tips for Talking about an Eating Disorder

Below are basic tips for discussing an eating disorder. In most cases, supervised visitation staff will be relaying their concerns to custodians and the case manager. Remember, simply discussing this problem with a child client will not make the problem go away. Making referrals to professionals who have experience with the issue is the best approach.

- **Communicate your concerns.** Share your memories of specific times when you felt concerned about the person's eating or exercise behaviors. Explain that you think these things may indicate that there could be a problem that needs professional attention.

- **Avoid conflicts or a battle of the wills.** If the person refuses to acknowledge that there is a problem or any reason for you to be concerned, restate your feelings and the reasons for them and leave yourself open and available as a supportive listener.
- **Avoid placing shame, blame, or guilt** on the person regarding their actions or attitudes. Do not use accusatory "you" statements like, "You just need to eat." Or, "You are acting irresponsibly." Instead, use "I" statements. For example: "I'm concerned about you because you refuse to eat breakfast or lunch." Or, "It makes me afraid to hear you vomiting."
- **Avoid giving simple solutions.** For example, "If you'd just stop, then everything would be fine!"

Additional Resources:

Maudsley Parents, A site for parents of eating disordered children

http://www.maudsleyparents.org/welcome.html

Eating Disorder Survival Guide for Family and Friends

http://www.edsurvivalguide.com/eatingdisorder-opheliatips.htm

Eating Disorder Hope

http://www.eatingdisorderhope.com/treatment-parents.html

Tips for Parents

http://www.empoweredparents.com/1tips/tip_05.htm

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Questions from Directors, #2

I've been hearing a lot about the new health care reform. Will any of it help our SV clients?

Below is a synopsis of the changes coming in the near future.

Effects and implications of the Affordable Care Act, 2010

Changes already in place

- January 1st: small businesses begin receiving tax credits to help more businesses be able to provide insurance to their employees.
- June 1st: individuals between age 55-65 who are retiring early and are not eligible for insurance through Medicare yet may be eligible for early retiree insurance.

Pre-Existing Condition Insurance Plan

- Created to ensure coverage for those that have been denied coverage by private insurances due to pre-existing conditions.
- How it works:
  -There are monthly premiums, determined by age, ranging from $363 (for age 0-34) to $773 (for ages 55 and up).

  -There is a $2,500 deductable before the plan will start to pay, as well as co-pays, and co-insurance (a percentage of the cost of services), not to total more than 5,950 a year.

  -Starting July 1st, 2010, Florida residents can apply if they meet 3 conditions:

  1. Being a citizen, national, or legal resident of the U.S.

  2. Being uninsured for a minimum of 6 months prior to application.

  3. Having had a problem obtaining insurance due to their pre-existing condition.

Changes in the near future

Can older children stay on their parent's plans?

- Yes. For health plan years starting on or after September 23, 2010, a person can stay on their parent's plan until the age of 26 (unless in the case of a group plan where the child has insurance through his/her job). This has already begun early with certain insurers.

What about preventative services?

- All plans starting after September 23rd will have to provide free preventative services such as mammograms and pap smears for women (or other screenings/exams/immunizations for women, men and children).

Are limits and doctors going to change?

- Plans will no longer be allowed to place a "lifetime dollar limit" on vital benefits such as an impatient hospitalization.
- For existing group plans and plans starting after September 23rd, insurers will not be able to refuse coverage to a child under 19 because of a pre-existing medical condition.
- In an effort to increase available providers, there will be incentives such as scholarships, loan repayment and tax cuts for doctors and nurses to work in underserved areas.

Effects for 2011

Changes for seniors

- As of January 1st, 2011, eligible seniors will get a 50% discount for seniors getting Medicare D brand name prescriptions.
- Seniors on Medicare will receive special preventative care, including annual check-ups and "personalized prevention plans."
- If you have questions, visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

Changes that affect everyone

- A Center for Medicare and Medicaid Innovation will be established to create a "national strategy for quality improvement in health care" by January 1st, 2011.
- Also starting January 1st, a new law requires that 85% of all premiums paid to plans must be spent on health care and/or quality improvement

- If plans' profits are found to be exceeding the limit, they will have to give members rebates.

Sources:

http://www.healthcare.gov

www.medicare.gov

Questions from Directors #3

We have now had three clients with severe allergies at our SV program. New programs should know about this! We ask at intake about allergies, and now we even ask about the custodian's allergies! Please spread the word!

Gladly.

Important Information Regarding Allergies

The Science of Allergies

An allergy is an aversive immune response to a food or plant protein, which is influenced by ones' heredity. A type of protein, immunoglobulin E (IgE), and a mast cell interact to yield a reaction.

When someone is first exposed to an allergen their lymphocytes produce the specific IgE for that allergen. The IgE then adjoin to mast cells in certain parts of the body, which release chemicals, like histamines. Symptoms will then follow.

Symptoms commonly affect the gastrointestinal area (abdominal pain, nausea, vomiting, and diarrhea), the eye (itching, watering, and swelling), the skin (hives, swelling, and eczema), the respiratory area (wheezing, coughing, swelling of lips and throat, and runny nose), or they may be generalized (anaphylaxis).

Anaphylaxis

Can include many of the symptoms above and may also be characterized by incapacitating symptoms, such as: difficulty breathing, a decrease in blood pressure, or a loss of consciousness.

The Most Common Allergies

4% of the population or 12 million Americans have a food allergy. 90% of food allergies are triggered by milk, eggs, peanuts, tree nuts, fish, shellfish, soy, and wheat. Other allergies include: medication, latex, foliage, and insect stings.

Milk

- 2.5% of children under 3 have this allergy, however many of them outgrow the allergy within a few years.
- The reaction is triggered by either the casein or whey proteins.
- It is characterized by allergic reactions from the skin, the gastrointestinal tract, and the respiratory tract. Alternatives - extensively hydrolyzed, casein-based formulas or soy formulas

Eggs

- 1.5% of young children experience this allergy.
- The proteins in egg whites bring on this reaction.
- Symptoms are manifested through the skin, gastrointestinal tract, respiratory tract, and anaphylaxis can occur.

Peanuts

- 1.3% of the general population is affected by this allergy.
- There are 19 proteins in peanuts that can cause a reaction, many of which can trigger a deadly form of anaphylaxis.
- The skin and respiratory tract are commonly affected.

- Alternatives: soy nuts or sunflower seeds (contact the manufacturer before eating, they may have been produced in a factory with peanuts)

Tree Nuts

- 1.1% of the population has a tree nut allergy
- Seed storage proteins cause this allergy
- This allergy can affect the skin, respiratory tract, gastrointestinal tract, or the heart. A severe anaphylactic reaction can also take place.

Fish and Shellfish

- 2.3% of Americans have this allergy
- Homologues of Gad c1 from cod (protein M) cause the reaction
- Commonly affects the skin, respiratory tract, and the digestive system. An anaphylactic reaction may occur

Soy

- 1% of Americans are affected
- Range from mild symptoms to anaphylactic reactions

Wheat

- Less than ½ % of the population is allergic to wheat
- Reaction is triggered by seed storage proteins
- Symptoms are usually related to the respiratory or gastrointestinal tract
- Alternatives: amaranth, barley, corn, oat, quinoa, rice, rye, and tapioca

Medication

- 1% of the population has a drug allergy
- Penicillin is the main trigger
- Commonly affect the skin, respiratory tract, and can lead to anaphylaxis

Latex

- Less than 1% of the population are affected
- The reaction can affect the skin or respiratory tract. Anaphylaxis scan occur.

Insect Stings

- 3% of Americans are highly allergic to insect stings
- Reaction from venom of stinging insects
- Affect the skin and can cause nausea or a low-grade fever

Preventative Measures in a Social Services Setting

Make sure the allergy is noted on the child's initial intake. Find out and document what symptoms typically accompany the child's allergic reaction, and what steps need to be taken to assist the child in the event an "attack" occurs.

- Strictly avoid foods that cause the allergic reaction (read ingredient labels for all foods). Have approved alternatives available.
- Be conscious of the early signs of an allergic reaction
- Have on hand medical documentation, instructions, and medication for the child as recommended by their physician using the Food Allergy Action Plan (http://www.foodallergy.org/files/FAAP.pdf) as a template.
- Have updated emergency contact information for the child.
- Choose a core team of professionals to define, understand, and use this prevention plan (all professionals in the work place should be educated about all children's allergies and what to do in an emergency)
- A supply of epinephrine auto-injectors (most people with diagnosed severe allergies keep these on them at all times) should be easily accessible in the case of an emergency and staff should know how to operate them

If a Severe Allergic Reaction Occurs

If it is recommended for the child (as noted on their Food Allergy Action Plan) inject them with Epinephrine to control their severe reaction. During this process alert someone to call 911 and continue to monitor the child's symptoms.

- Epinephrine it is available as the prescription EpiPen® or Twinject®, which are self-injectable.

Consult These Websites for More Information Regarding Allergies:

http://www.foodallergy.org

http://kidshealth.org

http://www.aaaai.org

http://medicineworld.org/medicine/allergy/allergy-statistics.html

LAST CHANCE TO REGISTER FOR THE FREE NOVEMBER 4th Jacksonville Training

Contact Karen for details

Terrific Manual on Community Partnerships

Community Partnerships: Improving the Response to Child Maltreatment

This manual, offers guidance on how diverse community agencies, organizations, and individuals can work together to form a web of support for families and create safe, healthy environments where children can thrive. The manual describes the benefits of community partnerships, outlines the steps for establishing and sustaining partnerships, and demonstrates how to measure results. In the appendices are valuable resources such as checklists, sample forms, and success stories.

We at the Clearinghouse have reviewed this new manual, and we encourage all program directors to take a look at it ASAP! It is terrific!
www.childwelfare.gov/pubs/usermanuals/partners

A Discussion of the term "Parental Alienation" is attached to this E press as a reminder of the dangers in assuming that it exists in your custody cases.

November 2010 E-Press

NOVEMBER PHONE CONFERENCE:

WEDNESDAY, NOVEMBER 17TH

12:00 NOON ET

DIAL THE NEW NUMBER 770-659-9299 TO PARTICIPATE. YOU WILL NEED TO ENTER A CONFERENCE CODE TO PARTICIPATE. THE CONFERENCE CODE IS 3103468751

YOU MUST RSVP WHEN THE REMINDER EMAIL COMES OUT IF YOU PLAN TO ATTEND!

PLAN AHEAD AND HAVE YOUR TEAM CALL IN…

DECEMBER PHONE CONFERENCE

WEDNESDAY, DECEMBER 15TH @ 12:00 NOON, ET

(THIS IS OUR BI-ANNUAL SURVEY CALL)

JANUARY PHONE CONFERENCE

WEDNESDAY, JANUARY 19TH @ 12:00 NOON, ET

(THE WEDNESDAY AFTER THE MARTIN LUTHER KING JR HOLIDAY)

Understanding Clients and Poverty:

A tutorial for supervised visitation providers who work with low-income clients

Overview

Poverty is a large and difficult concept to define. Everyone worries about having enough money to pay the bills, raise children, and invest in the future. People who must live on insufficient funds to feed their families, maintain transportation, cool and heat their homes, and receive medical attention, survive a difficult and stressful subsistence. Their daily trials are different from our own.

For people living in poverty, relying on erratic and unpredictable social services is a way of life. Simply trying to get to the next step in the bureaucratic process can be problematic. Clients want to make peace and stability out of the chaos in their lives, but often they get overwhelmed when the systems break down. As professionals, we can try to offer solace and direction in the chaos of the lives of our clients.

Objectives

This training is designed to last approximately 1 hour. Extended discussion and an extra scenario could lengthen the time.

By reading and thinking about clients who experience poverty, participants will be able to:

- Understand clients' personal situations better
- Understand ways to offer help to poor clients
- Create ways to better assist clients in the supervised visitation process

Contents	Time	Cumulative time
Mind Map	10 min. + 5 min. recap	0:15
Scenarios	20 min.	0:35

Brainstorming Forward	5 min.	0:40
Identifying Steps Forward	10 min.	0:50

Mind Map

(10 minutes)

A “Mind Map” is an activity like brainstorming, which is designed to anchor the group on the topic at hand and explore the full ‘territory’ of the topic. Like brainstorming, some answers may not seem to have a place, but no answer is ‘wrong’. Place unrelated ideas off to the side and perhaps they will get worked into the greater map as the activity progresses. Try to put related ideas in relative proximity, but there is no ‘proper’ way to organize this organic activity.

Get a large piece of paper, or a whiteboard, and write the word ‘POVERTY’ in large letters in the center. Then ask the group to provide words or short phrases that come to mind when they hear the word poverty. The answers can be **causes, effects, synonyms, common victims, government policies**, or anything else related. This is not a time to discuss the words and phrases, but just try to get as many on the ‘map’ in a short time, in order to see how people think. Keep encouraging more answers both from talkative people and quiet participants. There is no need to draw lines between words; a chaotic order will develop.

If the group has trouble coming up with ideas, try stimulating participation with questions related to the bolded words above, or offering some of the following words: *income, wages, jobs, employment, minimum wage, age, children, parents, inter-generational, transportation, car, sick, healthcare, nutrition, hunger, children, single parents, disabilities, homeless, substance abuse, education, literacy, immigrant, culture, rights, policies, welfare programs, public assistance, etc.*

SNAPSHOTS

(5 minutes)

Read through the following list of facts by passing the list around and having each person read one, or copy this page and cut each statistic into a slip that the participants draw from a pile. Then, ask the group if they would like to add anything to their mind map.

- 17.8 % of rural populations and 13 % of urban populations in Florida live in poverty.
- Poverty rates in the suburbs of Florida are increasing.
- 10.5% of residents in Florida are unemployed. (2009)
- 48.8% of all people in Florida have only a high school diploma or less.
- In a study of mothers receiving welfare, each additional year of schooling led to approximately a 7% wage increase.

US Poverty guideline by persons in family (2009)	
$10,830	**1**
14,570	**2**
18,310	**3**
22,050	**4**
25,790	**5**
29,530	**6**

- About 40% of homeless people in the US are children.
- Every $1 invested in quality early childhood education saves as much as $7 by increasing the likelihood that children will be literate, employed and less likely to be school dropouts, dependent on welfare or arrested.
- Every year a child spends growing up in poverty will cost an estimated $11,800 in lost future productivity over his or her working life.
- Almost 44% of Florida's students in public school were eligible for free or reduced price meals in the 1998-1999 school year. That represents 1,025,470 students.
- 41% of children in Florida (1,627,259 children) are in low-income families, defined as income below 200% of the federal poverty level. (2003)
- 9.15% of people 65 and older were living below the poverty level in Florida in 1999.
- As much as 90 % of some populations who are eligible for welfare benefits do not claim them, particularly, immigrants living in a household with a member that would not qualify.
- 18.1% of Americans are uninsured.

- About 31 % of American women become pregnant before the age of 20. Nearly 13 % of the sexually active American men between the ages of 15–19 report that they have fathered a pregnancy (Suellentrop & Flanigan, 2006).

- In 2007, Latino children and black children were most likely to be born into low income families (61%). There are 8.8 million Black children and 6.5 million Latino children. There are 0.8million Asian children (28%) of the population living in a low income family. The rate for white children was 26%. They make up the largest number of children living in low income with 11.1 million. 57% of the children of immigrants are likely to be born into poverty (7.0 million) as opposed to 36% native-born children (20.4).

Case Studies

(20 minutes)

In each of the following examples, a fictional client-specific scenario is presented. Have participants envision themselves as the main character in the case. Break the group into discussion size segments, and have them discuss the difficulties of each situation. Give about 10 minutes before reading the next scenario. Have the participants discuss what else might break down, and hinder advancement toward the character's goals. Discourage the participants from trying to think up solutions as if they were presented with the problems to solve, but to experience these circumstances as if they had weighed on them for weeks, months, or years.

None of these, stories is unique, and yet each person that comes through your doors is an individual. Each has faced challenges and overcome many of them to be standing in front of you. Each is faced with difficulties

"Close your eyes, and imagine:

- feeling the exhaustion at the end of a day after working two jobs, and knowing that you still must cook dinner and bathe your kids - alone;
- smelling a neighbor's cooking, when your stomach groans;
- hearing the noises of crying children and a loud television through thin walls late at night;
- feeling the perspiration and heat of summer on the back of your legs, as you try to fall asleep - knowing it will be 4 more weeks before you have enough money saved to fix the air conditioning;
- trying to sleep as the lights come on late at night, then early in the morning, as the people with whom you share close quarters get ready for work;
- tasting the bland food, that is acceptable to all palettes, at the shelter where you get a more substantial dinner on Friday nights."

Case study 1 – Tanya

Tanya is a single mother of two. She has a stable clerical job, but her employer will not let her advance unless she gets her GED. She lost the means to pay for a home when her husband disappeared a few years ago, but she was able to keep their car. Tanya's sister lets the children share a room with her own child. Tanya sleeps on the couch. Her sister watches the children and helps them with school work, but expects Tanya to do most of the house work for them all.

Discussion points

- Would you be productive in GED classes at night, after working all day?
- What if your work had a significant physical strain as well, such as construction?
    - Additional study may be exhausting, but you know your body will not hold up to your physical labor forever.
- What if you needed to drive a half hour each way to get to your classes and your car had no air conditioning?
- What if you had no family members that were willing to help with support?
- When you don't know the address or phone number of something, where do you look it up?
- What if you had no cell phone or computer, how would you find a physical address, or call a repair man?
- If your car broke down and you had no cell phone, what would you do?
- How do you feel, when you are so tired from work that you never get to spend play time with your kids?
- What if you do not agree with your sister's style of discipline?
- What if, in addition, you had an elderly parent to also take care of?
- How do you coordinate child care, cleaning, education, health care, and work?

Case Study 2 – Douglas

Douglas has been looking for a job for 6 months. He has an old construction injury that makes it a bit difficult for him to lift heavy objects. He has moved between several construction companies in the last few years in order to keep his family from relocating. They have no private vehicle. His wife dropped out of high school when she became pregnant with their first child. Douglas began working to support them. They now have 3 children. The second child has Down's Syndrome. Douglas' wife is also looking for a job to help pay for the family's need, but that would require costly day care if both jobs were on the same shift. In addition, if the parents have different shifts, they wouldn't see each other, causing more stress on the relationship.

Discussion points

- How do you juggle the children's schedule, household choirs, and the job search?
- What if you do not have a private vehicle to help in these duties?
- How effective would you be if you were forced to use the bus to run all your errands? Are the routes intuitive?
- What if bus and street signs were not in your native language?
- What if you are carrying grocery bags, a toddler, and it starts to rain while trying to get off a crowded city bus?
- What if your child's disability required expensive medication, or regular care, like diabetes?
- What if Douglas had a mental disability?
- Where would you find health insurance for your children?
- Did you have support for your education – financially or emotionally? What if your friends, co-workers and parents had said not to waste your time, because you wouldn't finish, and there was no money to afford it?
- Have you ever skipped a meal to make sure that your child had enough to eat?

The Foreign National

If time allows, have the groups discuss Anna below. If not, after discussing Douglas and his wife for a few minutes, interrupt the discussion to pose the question, "What if Douglas and his wife were recent immigrants from a Spanish speaking country and their English was limited?" You can further prompt discussion with the first few discussion points for Anna.

Extra Case Study – Anna

(additional 10 minutes)

Anna came to the United States as a young adult looking for more opportunity. She came from a rural poor background, and her family had grown most of their own food. She lives in a trailer, and does most of her shopping at a large convenience store. She has never been taught proper nutrition and cannot find many of the native ingredients she knows. She has a toddler. She does house cleaning for an agency and has not learned much English. She has a pay-as-you-go cell phone, and only has enough credit about half the time.

Discussion points

- What would you do if your child was injured and you had no credit on your cell phone?
- What if you couldn't communicate in the native language of a repair man or baby sitter?
- Would you like your children playing around and under mobile homes?
- Have you ever been to a market abroad, or even an ethnic market? Would you know what to buy to stock your pantry?
- Are the cheapest foods of the best nutritional value? What if you don't have a proper stove to cook on?
- What do you do for child care when you have to work?
- What if you, or your child, broke an expensive vase in the home of a client?
- Do you save money every month? How would you approach savings, if your monthly expenses left only $20?

Brainstorming Forward

(5 minutes)

Now bring the group back together. Using their newfound knowledge and understanding, lead a brainstorming session on how the process of supervised visitation might be different or difficult for poor clients. It might be helpful to write the main topic of ideas on the board, or you might want to save writing for the next task. Remember there are no bad or crazy ideas in brainstorming. When conversation has been exhausted, move on to the evaluation stage in the next activity.

Some possible questions that could be answered are as follows:

- Do our clients have effective communication skills to use with our staff, or their partner?
- Are our clients typically not on time because of some factor that is out of their control?
- Do our clients have proper parenting skills?
- Is the client eating and sleeping well? Do our clients have manageable stress levels?
- Do our clients have different cultural norms?
- Do our clients feel intimidated by the situation, or the power status of our staff's positions?
- Is it hot outside and the clients have no air-conditioning? Is it raining and they have no private transportation?
- Do qualities that you find inappropriate or offensive about our clients, such as appearance, negatively affect the child-parent relationship? Do those qualities negatively impact the way you view or treat the client?

Identifying Steps Forward

(10 minutes)

Now is the time to look at detailed and concrete implications for the staff and facility. We have been discussing mostly hypothetical situations, but how can we convert these activities into practical strategies. Go back through the ideas that were generated in the brainstorming session and look at how they can be applied to your particular institution. The main focus of this discussion is: 'Are policies generally set up to give the child-parent interaction the most richness and value in the greatest amount of time possible?'

A few things to keep in mind are:

- What are the specific cultural and demographic elements that would affect policies in our organization?
- Who is the population served by our organization?
- How does this population's background differ or compare to that of our staff?
- Do I have bias about this population in general, or their reasons for being here?
- How can we, the staff and directors, make the process of supervised visitation easier for poor clients?
- Are there referrals that we can make to help our clients?

Then evaluate ideas for possible solutions and policy changes, such as:

- ❖ Is the policy on timeliness, and tardiness, reasonable?
- ❖ Is there a reasonable rain-check policy, if the client has an issue and has no way to call in?
- ❖ Are the clients aware of what social services are available to them in the community, such as health care options, food assistance, etc?
- ❖ Do the clients know their rights?
- ❖ Are all necessary signs, information, and handouts available in our clients' native language?
- ❖ Have we ever asked our clients what they like/dislike/would change about our policies and processes?

LOW INCOME ASSISTANCE

Many directors have questioned how to better serve low income clients, who have even fewer resources in the current economic climate. You should know about the following services and assistance. Be ready to make referrals as needed.

Florida Medicaid

What type of Medicaid could a person be eligible for?

- Medicaid can be granted through the Social Security Administration or the Department of Children and Families.

- A person may be eligible for Medicaid through the Department of Children and Families (DCF) if they meet fall into one of these categories:
  -Low income families with children

  -Children only

  -Pregnant women

  -Non-citizens with medical emergencies

  -Aged and/or disabled individuals **not** currently receiving Supplemental Security Income (SSI)

  -Persons receiving Temporary Cash Assistance (TCA)

- A person may be eligible for Medicaid through the Social Security Administration (SSA) if they fall into one of these categories:
  -Individuals with low income that are either over the age of 65 or are disabled.

  -Persons receiving Supplemental Security Income (SSI) are automatically eligible and do not need to fill out a separate application (unless nursing home services are needed.)

Where does a person go to apply for Medicaid?

- Families or individuals seeking coverage can apply online at http://www.myflorida.com/accessflorida.
  -Only one application needs to be done for the whole household (or an individual). The application will automatically apply for food stamps as well.

  -Questions will be asked about income, family size, expenses, assets, disabilities, etc…

  -The form can be submitted online, printed and faxed in or printed and mailed in.

- For questions about eligibility or other help, call the Department of Children and Families directly at 1-866-762-2237 or the Social Security Administration at 1-800-772-1213.

- Some may find it easier to go to a local Medicaid area office in person. A directory is available online to find addresses to the nearest office at: http://ahca.myflorida.com/Medicaid/Areas/index.shtml
- (See below for every Florida county's area office phone number and address.)

Is Medicaid the same in all of Florida?

- Medicaid eligibility is the same for the whole state.

- The way the programs work is different in reform counties vs. non-reform counties.

Reform counties:

- Medicaid reform started in 2006 in an effort to increase preventative care, coordination of care and quality of care, as well as to increase fiscal efficiency.
- So far it only applies in **Baker, Clay, Nassau, Broward and Duval** counties but is expected to expand in the coming years.
- In these 5 counties most members are now required to enroll in one of the available Medicaid health plans in their county. (Those members that must enroll will be placed in a plan if they do not choose one in the allotted time.)

Who has to enroll in a health plan?

- Some members, like persons with developmental disabilities, certain pregnant women and adopted or foster children, will not have to enroll in a reform plan and will have the option to keep "regular Medicaid" or to be in a plan.
- Members with 3rd party insurances will not be able to enroll in a health plan and will keep straight/regular Medicaid.
- To find out more or to enroll in a plan, recipients in one of these counties should contact the Medicaid Choice Counseling Helpline at 1-866-454-3959 or visit their website at www.flmedicaidreform.com.
- Recipients will be notified by mail if they are required or have the option of enrolling in a plan, so it is vital to have a current address on file with DCF or SSA.

Will doctors take these plans?

- The helpline assists recipients in finding providers and, once in a plan, members will also get a complete list of providers under that plan.
- Not all providers that take regular Medicaid will take every health plan (or they can choose not to take any of the plans and still take only the gold card.)

Non-reform counties:

- In all other Florida counties, Medicaid is continuing to cover members as it has been before Medicaid reform.
- This means members may be given a gold card when they receive Medicaid benefits, and this card will be presented to any Medicaid provider (primary care doctors, specialists, and pharmacies) to bill Medicaid for covered services.
- This will be used until the member gets into a non-reform plan available in their county (if they are required or have the option to be in one.)
- To get information about the options available in non-reform counties, members that have Medicaid can call Medicaid Options at 1-888-367-6554 or the local Medicaid office for additional questions. (The addresses and numbers are listed below.)

Sources:

http://www.dcf.state.fl.us/ess/

www.flmedicaidreform.com

http://www.myflorida.com/accessflorida

Florida Medicaid Area office addresses and phone numbers

Escambia, Okaloosa, Santa Rosa, and Walton Counties

160 Governmental Center, Room 510
Pensacola, Florida 32502

Main Line: (850) 595-2300
Fax: (850) 595-5718
Toll Free: 1 (800) 303-2422

Bay County

651 West 14th Street, Suite K
Panama City, Florida 32401
Main Line: (850) 767-3400
Fax: (850) 747-5456

Franklin, Gulf, Holmes, Jackson, and Washington Counties

2727 Mahan Drive, MS #42
Building 2, 3rd Floor
Tallahassee, FL 32308
Toll Free: 1 (800) 226-7690
Fax: (850) 747-5456

Calhoun, Gadsden, Jefferson, Leon, Madison, and Wakulla Counties

2727 Mahan Drive, MS #42
Building 2, 3rd Floor
Tallahassee, FL 32308

Main Line: (850) 412-4002
Fax: (850) 921-0394

Taylor and Liberty Counties

2727 Mahan Drive, MS #42
Building 2, 3rd Floor
Tallahassee, FL 32308
Toll Free: 1 (800) 248-2243
Fax: (850) 921-0394

Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union Counties

14101 N.W. Highway 441, Suite 600
Alachua, Florida 32615-5669

Main Line: (386) 462-6200
Fax: (386) 418-5370
Toll Free: 1 (800) 803-3245

Citrus, Hernando, Lake, Marion, and Sumter Counties

2441 West Silver Springs Boulevard
Ocala, Florida 34475

Main Line: (352) 840-5720
Fax: (352) 620-3076
Toll Free: 1 (877) 724-2358

Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia Counties

Duval Regional Service Center
921 North Davis Street
Building A, Suite 160
Jacksonville, Florida 32209-6806

Main Line: (904) 798-4200
Fax: (904) 353-2198
Toll Free: 1 (800) 273-5880

Pasco and Pinellas Counties

525 Mirror Lake Drive North., Suite 510
St. Petersburg, Florida 33701

Main Line: (727) 552-1900
Fax: (727) 552-1216
Toll Free: 1 (800) 299-4844

Hardee, Highlands, Hillsborough, Manatee, and Polk Counties

6800 North Dale Mabry Highway, Suite 220
Tampa, Florida 33614

Main Line: (813) 350-4800
Fax: (813) 673-4592
Toll Free: 1 (800) 226-2316

Brevard, Orange, Osceola, and Seminole Counties

400 W. Robinson Street
Hurston South Tower, Suite S309
Orlando, Florida 32801

Main Line: (407) 420-2500
Fax: (407) 245-0847
Toll Free: 1 (877) 254-1055

Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota Counties

2295 Victoria Avenue, Room 309
Ft. Myers, Florida 33901

Main Line: (239) 335-1300
Fax: (239) 338-2642
Toll Free: 1 (800) 226-6735

Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie Counties

1655 Palm Beach Lakes Boulevard
Suite 300
West Palm Beach, FL 33401

Main Line: (561) 712-4400
Fax: (561) 616-1545
Toll Free: 1 (800) 226-5082

Broward County
1400 W. Commercial Boulevard, Suite 110
Ft. Lauderdale, Florida 33309
Main Line: (954) 958-6500
Fax: (954) 202-3220
Toll Free: 1 (866) 875-9131

Dade and Monroe Counties
8355 N.W. 53rd Street
Doral Center
Manchester Building, 2nd Floor
Miami, Florida 33166
Main Number: (305) 593-3000
Fax: (305) 499-2022
Toll Free: 1 (800) 953-0555

Source:

http://ahca.myflorida.com/Medicaid/Areas/index.shtml

Florida Food Stamps

General Eligibility requirements:

- **Living in Florida**
- **Having proof of identity**
- **Being a US citizen or having a "qualified noncitizen status"**
- **Being able to show a social security number or proof of application for one**

Exclusions:

- To receive food stamps for more than 3 months in a 3-year time frame, individuals that are healthy, between the age of 18 to 50 (without dependent children and who are not pregnant) must work or participate in a "workfare program."
- Some people may have to prove the identity/relationship of their child and have the court mandate child support payments and/or be in compliance with child support mandates already in place.
- A household's assets must not exceed $2,000, or $3,000 for a household including a disabled individual or person over the age of 60.
- A person must not have been convicted of drug trafficking or have a warrant for a felony against them.
- Persons who have knowingly broken the rules of the food stamp program are not eligible.
- Certain college students may not be eligible for food stamps.

Income requirements:

- Total monthly gross income must be equal to or no more than 130% of the federal poverty level.
- Net income must be equal to or no more than 100% of the federal poverty level.
- Individuals over 60 (or families with an individual over 60) only have to meet the net monthly income limit.

Income Chart **(from DCF webpage)**

People in Household	200% Gross Monthly Income Limits	130% Gross Monthly Income Limits 10/09	100% Net Monthly Income Limits 10/09	Maximum Benefit Amount 04/09
1	$1,805	$1,174	$ 903	$200
2	$2,429	$1,579	$1,215	$367
3	$3,052	$1,984	$1,526	$526
4	$3,675	$2,389	$1,838	$668
5	$4,299	$2,794	$2,150	$793
6	$4,922	$3,200	$2,461	$952
7	$5,545	$3,605	$2,773	$1,052
8	$6,169	$4,010	$3,085	$1,202
For Each Additional Person Add	+$624	+$406	+$312	$150

(http://www.dcf.state.fl.us/programs/access/docs/fafactsheet.pdf)

How to apply online:

- **Those wishing to apply online may go to http://www.myflorida.com/accessflorida/ to complete an application (and there is also a pre-screening questionnaire if a person wants to first see if they are likely to be eligible for benefits.)**
- **On this site there is an icon that states "Apply for Benefits"**
- **The first bullet point under the icon is the link for the application for food stamps, Medicaid and cash assistance.**

Other ways to apply:

- By calling Department of Children and Families at 1-866-762-2237, a person can find out the address of the **nearest field office to apply in person.**
- Addresses of field offices can also be found online at http://www.dcf.state.fl.us/programs/access/circuit03.shtml (by selecting the county from the drop box on the left side of the web page).
- After locating the field office, persons interested in applying by mail can call the office to have an application sent to them or can go directly to the office.

WHAT TO BRING INTO THE OFFICE OR HAVE READY WHEN APPLYING:

1. **Government picture ID**
2. **Social Security card (for everyone applying to receive benefits)**
3. **Information about income, family size, assets, who is working or disabled and information about child support (whether receiving and/or paying.)**

THE STATE WILL FACT CHECK THE INFORMATION IN THESE APPLICATIONS AND TAKE LEGAL ACTION IN CASES OF ATTEMPTED FRAUD.

How much can an individual get per month?

The amount a person or family will get is determined by how many family members are in the household and how much income would be left over after certain necessary expenses.

What foods can be purchased with food stamps?

All the major food groups (breads, fruits, vegetables, meat, dairy, and poultry) can be purchased. Things that are not approved include household items, hygiene products, or hot food.

Source:

http://www.dcf.state.fl.us/programs/access/foodstamps.shtml

TANF and TCA

What is the TANF program?

Temporary Aid for Needy Families is a program that began in 1996 as part of the welfare reform. It provides financial assistance to families with dependent children with four major goals:

1. **Helping families maintain resources to be able to stay together, with the children in the home.**
2. **Helping the families gain autonomy to no longer have to rely on government benefits, by gaining employment, getting job preparation and promoting marriage.**
3. **Lowering the rates of pregnancies that take place out of wedlock.**
4. **Encouraging the development of two-parent families.**

Who is eligible?

Low income families with dependent children may be eligible if they:

1. **Are US citizens or "qualified non-citizens."**
2. **Are legal residents of Florida.**
3. **Meet specific income requirements to be considered "needy."**
4. **Are a pregnant woman.**

What is TCA?

Temporary Cash Assistance is available to needy families if they:

1. **Are US citizens or "qualified non-citizens."**
2. **Are legal residents of Florida.**
3. **Have a minor living in the household (and they have custody.)**
4. **Meet income and resource requirements.**
5. **Register for work program if not exempt.**
6. **Are in compliance with child support.**
7. **If a parent is a minor, they must live with adults who provide supervision and have an adult as the payee.**

8. **If no minors in the home, women must be in 9th month of pregnancy (or sometimes in the last trimester based on ability to work.)**

Where and how does a person apply?

- **Apply online at http://www.myflorida.com/accessflorida/ by clicking on the same application link as for Medicaid and food stamps. (It is all one application.**
- **Applications can also be done in person at local Department of Human Services office.**

How much does a person receive if approved for TANF?

Family Size	Family has no shelter obligation (lives rent free)	Monthly shelter obligation is $50 or less	Monthly shelter obligation is more than $50
1	$95	$153	$180
2	$158	$205	$241
3	$198	$258	$303
4	$254	$309	$364
5	$289	$362	$426

http://www.dcf.state.fl.us/programs/access/docs/TANF%20101%20final.pdf

http://www.dcf.state.fl.us/programs/access/docs/TANF-Plan.pdf

What is Florida Kid Care?

Florida Kid Care is includes Medicaid for Children and Children's Health Insurance Program or **CHIP**. It is funded in part by Title XIX and XXI of the Social Security Act. It is split into four types of coverage:

- Medicaid for Children
- MediKids (CHIP)
- Healthy Kids (CHIP)
- Children's Medical Services (CMS)

Applications are completed in the same way as for adult Medicaid.

Medicaid for Children

- Children who may be eligible must be no older than 20.
- Income requirements depend on the child's age, with younger children having higher income limits.
- There may be small co-pays for services.
- No premiums.
- Funded by state and federal funds as well as some contributions by the county.

Healthy Kids and MediKids

- Both are programs to insure children whose families exceed income requirements for Medicaid and both are part of CHIP.

- ❖ MediKids is for children age 0 to 4.
- ❖ Healthy Kids is for children age 4 to 18.
- ❖ There are monthly premiums for both programs.

Children's Medical Services

- ❖ Funded by the Department of Health.
- ❖ Program for children up to the age of 21 with special medical needs.
- ❖ Both Medicaid-eligible and non-eligible children can receive CMS.
- ❖ There is a premium if the child is ***not*** eligible for Medicaid (but only one per family.)

Sources:

http://ahca.myflorida.com

http://www.floridakidcare.org

Food, Religion, and Culture

A director recently called to ask what she needed to know about food issues at supervised visitation. As you know, we covered food allergies last month. This month, we will talk about foods prohibited by certain religious groups. I recall a few years ago around Christmas a friend served rum cake at an event. A Persian woman, who fled Iran in the 1980's, asked my friend if there was really rum in the cake. My friend assured her that "all the alcohol burned off in the cooking," but the woman still refused to eat the cake. It turns out that people of the Baha'i faith do not eat anything with alcohol in it.

This list is not exhaustive. It does remind us that people of different faiths have different sensibilities, and they deserve respect. The best way to find out is to ask: Is there anything that we should know about your eating or dietary practices that will help us accommodate your family?

Eating considerations for Muslims[1]

[1] More information can be found at http://www.infoplease.com/spot/ramadan1.html#axzz0y5uhpox2

- Eating pork is not permitted.
- During the month of Ramadan, Muslims do not consume food or drink from sun up to sun down.
- Ramadan corresponds to the lunar calendar and begins with the new moon. So, for example, Ramadan in 2010 began August 10.

Eating considerations for Judaism[2]

- Eating pork is not permitted.
- Some Jewish people will not eat food unless it is in accord with the laws that make the food Kosher.

Eating considerations for the Bahá'í faith[3]

- Alcohol is not permitted to drink unless for medicinal purposes. People of the Bahá'í faith also prefer not to eat food containing alcohol.
- People of the Bahá'í faith fast from sun up to sun down from March 2 to March 20th.

Eating considerations for the Hindu Faith[4]

- Eating the meat of cows is not permitted.
- Eating pork is not permitted.
- Some Hindus follow a vegetarian diet.

Eating considerations for Buddists[5]

- In some schools of Buddhism, meat and fish are not eaten.
- In some schools of Buddhism, onion, leek and garlic are not eaten.

Vegan Dietary Habits[6]

- Vegans abstain from eating meat, fish and poultry.
- Vegans do not consume eggs, dairy products or honey.

[2] More information can be found at http://www.jewfaq.org/kashrut.htm
[3] More information can be found at http://www.faithandfood.com/Bahai.php
[4] More information can be found at http://www.faithandfood.com/Bahai.php
[5] More information can be found at http://www.faithandfood.com/Buddhism.php
[6] More information can be found at http://www.vrg.org/nutshell/vegan.htm

December 2010 E-Press

DECEMBER PHONE CONFERENCE:

WEDNESDAY, DECEMBER 15TH

12:00 NOON ET

DIAL THE NUMBER 770-659-9299 TO PARTICIPATE. YOU WILL NEED TO ENTER THE CONFERENCE CODE TO 3103468751 PARTICIPATE.

YOU MUST RSVP WHEN THE REMINDER EMAIL COMES OUT IF YOU PLAN TO ATTEND!

PLAN AHEAD AND HAVE YOUR TEAM CALL IN…

JANUARY PHONE CONFERENCE

WEDNESDAY, JANUARY 19TH @ 12:00 NOON, ET

(THE WEDNESDAY AFTER THE MARTIN LUTHER KING JR HOLIDAY)

FEBRUARY PHONE CONFERENCE

WEDNESDAY, FEBRUARY 16TH @ 12:00 NOON, ET

Semi-Annual Performance Measures Survey

Takes one minute online!

It's that time of year, when we ask for your feedback through the Semi-Annual Performance Measures Survey. The simple and quick survey will take only a minute to complete and we have 2 ways to do it. You can print and fill out the survey (below) and fax it back to 850-644-8331, or mail to:

Clearinghouse on Supervised Visitation

Florida State University

University Center C, Room C2306

296 Champions Way

Tallahassee, FL 32306-2570

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You may also now complete this survey online at http://fsusocialwork.qualtrics.com/SE/?SID=SV_bvaEIA9PhzS8JLK

or you may print it and fax it, or scan it and email it using the information above. Beginning in 2011 all surveys will be in a web-based format only.

Clearinghouse Semi-Annual Performance Measures 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 satisfaction scale is indicated below for each project.

Instructions: Please circle your level of satisfaction as it relates to each of the items in question.

1. How satisfied are you with the information in the **Monthly EPress**?

Very Satisfied Satisfied Not Satisfied Not Applicable

2. How satisfied are you with the Monthly **Phone Conferences**?

Very Satisfied Satisfied Not Satisfied Not Applicable

3. How satisfied are you with the Institute's **Website** (with training materials, archives, and message board)?

Very Satisfied Satisfied Not Satisfied Not Applicable

4. How satisfied are you with the **trainings offered** in the past 6 months (including the Miami training on July 12, the special phone training on DV101, and/or the Jacksonville training on Nov 4)?

Very Satisfied Satisfied Not Satisfied Not Applicable

5. How satisfied are you with the Clearinghouse's **responsiveness (response, timeliness, appropriateness of response)** to your problems/calls/questions?

Very Satisfied Satisfied Not Satisfied Not Applicable

6. How satisfied are you with the **Database** (and data reports)?

Very Satisfied Satisfied Not Satisfied Not Applicable

7. How satisfied are you with the Responding to Unique Family Needs **posters**?

Very Satisfied Satisfied Not Satisfied Not Applicable

Thank you for completing the survey.

We would be happy to receive your comments and questions to improve our services at any time. You may include any comments or questions below, or send them to the Clearinghouse via email (clearinghouse@fsu.edu or fsuvisit@aol.com), fax (850-644-8331), or USPS at the address listed above.

Live Webinar Event Invitation

Hosted by: Florida's Center for the Advancement of Child Welfare Practice

The Department of Children and Families invites you to participate in *Accessing mental health services: An overview of Florida's mental health system for children and adults*

December 2nd, 2010

12:00pm – 1:30pm (Eastern)

This webinar will be an informational overview of Florida's children's mental health system, adult mental health system, mental health service for children involved in the child welfare system, available behavioral health services, and specialty services for children and youth with highly complex needs (e.g. - dual diagnosis, severe trauma history). Populations served, funding services, available programs and points of access will be included in the discussion. The format will include both presentation, and a closing group panel Q & A session with the following persons:

Laurie Blades, Chief of Children's Mental Health, Department of Children and Families

Jackie Beck, Chief of Adult Mental Health, Department of Children and Families

Matthew Claps, Chief of Practice for Family Safety, Department of Children and Families

Barbara Butler-Moore, Program Administrator, Medicaid Behavioral Health, Agency for Health Care Administration

Before the webinar:

First Time Users: you MUST install a small program in order to view the video portion of this webinar!
Before the meeting, check your system to make sure it is ready to use Microsoft Office Live Meeting. (Click on Accept, Install, and Join)

Pre-registration for the Webinar is required. Use the link below to register!

https://www.livemeeting.com/lrs/8000362188/Registration.aspx?pageName=7qk4g6c0h9lwktkt

If you have technical questions or concerns please contact Center Support staff at centersupport@fmhi.usf.edu

AUDIO ONLY Phone Number: 888-808-6959

Conference ID 6567215873#

THE IMPACT OF THE INTERSECTION OF DOMESTIC VIOLENCE AND SUBSTANCE ABUSE ON SUPERVISED VISITATION

BY JENNIFER LYNNE HOLMES

Introduction

Studies have estimated that the incidence of substance abuse and misuse in domestic violence cases by the perpetrator, the victim, or both may be as high as 40-80%. This chapter explores the complicated dynamics of cases when domestic violence intersects with substance abuse.

Overview

Although women are the petitioners for an Injunction for Protection Against Domestic Violence in nearly 80% of the domestic violence cases in Florida, women represent nearly 36% of the visitors in supervised visitation referrals from domestic violence cases. This means that the proportion of women as the visitor is 75% higher than might be anticipated. In many cases, this discrepancy occurs when the batterer is given primary custody of the children due to symptoms from the victim's (mother's) substance abuse or misuse, which can be misperceived and actually due to the effects of domestic violence. It is vital that the visitation monitor understand the complex forces at work in such a situation to best assist both the victim and the children during the visitation.

Objectives

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

1. Identify possible reasons for substance abuse and misuse among female survivors of domestic violence.
2. Explain why a perpetrator of domestic violence might obtain custody of the children, resulting in the assignment of the mother to supervised visitation.
3. Identify key considerations a program might need to assess when dealing with a custodial parent who is the batterer in cases of intersecting domestic violence and substance abuse.
4. Explain underlying challenges to the mother-child relationship when domestic violence and substance abuse intersect.
5. Discuss specific strategies your program might implement to support the mother-child relationship when the victim is the visitor.

Snapshots

- According to research, 66.4% of female battering victims are believed to abuse alcohol and/or drugs.
- In one study of court-referred batterers, researchers found that 53% had used marijuana and 24% had used cocaine.
- Untreated, the use of substances and/or use of violence become more frequent and more severe over time.
- Just as relapse is common in substance abuse, a return to an abusive relationship is also common in domestic violence. An abuse victim typically returns to the relationship 6 to 7 times before the final separation.

- Multiple studies have correlated a relapse to alcohol misuse with a return or escalation of the violence.
- Of the 22 child deaths reviewed by the NC Division of Social Services in 2000, 77% (17) of the families were impacted by both domestic violence and substance abuse.
- A case study in San Francisco found that all 20 domestic violence homicides researched included drug or alcohol involvement; 20% displayed both alcohol and cocaine use by the perpetrator.
- Another study of children referred into care found that parental capacity was severely affected in 71% of the cases where there was evidence of both domestic violence and parental substance misuse.
- Advocates must address the stigma, myths, and misinformation regarding both domestic violence and substance abuse, particularly when each intersects within an individual case.

The 'Race to the Courthouse'

The search for legal protection when terminating a violent domestic relationship often results in a 'race to the courthouse' in which partners (with potentially unequal resources) rush to file an Injunction for Protection Against Domestic Violence first. However, initial decisions regarding the assignment of child custody can be particularly complex when the victim displays co-occurring symptoms of substance abuse and domestic violence:

- The batter may appear calm, in control, employed, and have access to a wide range of monetary and social resources.
- The perpetrator may be able to produce multiple witnesses to testify that the victim:

- 'looks crazy' (including jumpy and skittish behaviors due to PTSD)
- is frequently intoxicated or drugged, and
- is neglectful or unable to care for the children.

- Judges may have a very tough call determining *which* parent will pose a lesser risk to the children.
- Given the co-occurring symptoms, the parental capacity of the mother may be judged as less than that of the abuser, overlooking the mother's potential to recover.
- *Domestic violence victims can be especially responsive to intervention and counseling following a separation.* While experience has proven that both mental health concerns and substance abuse issues are treatable, significant doubt remains as to the extent to which a perpetrator's battering behaviors can be remediated.

The Effects of Co-occurring Domestic Violence and Substance Abuse

Domestic violence and substance abuse can undermine parental capacity. Over a third of children from families with co-occurring domestic violence and substance misuse have severe unmet developmental needs. The parents in over half of the families face serious difficulties meeting their children's needs. Two-thirds of the children also experience negative impacts within the extended family and environment.

- Constant violence and the struggle against an addiction can compromise the mother's self-esteem and her confidence. The victim may experience significant feelings of guilt:
  - Over the impact of the domestic violence and substance abuse on the children
  - Over her failure to protect children from the effects

    - Because of the abuser's efforts to perpetuate the victim's feelings of blame and responsibility
    - Complicated by the stigma the victim may have already encountered in social service situations for not leaving the relationship or due to blame for her substance abuse
- Both mother and children may have experienced a lack of necessary human contact, support, and secure settings during the abuse:
    - Due to the efforts of the abuser to isolate the victim by restricting contact or driving her support system away.
    - Extended family and friends may express anger, frustration, negative judgments, and rejection towards the victim, her care of the children, and her relationship.
    - The separation could result in further isolation.
- Both domestic violence and substance abuse can result in a significant lack of stability for the victim and children involved:
    - The mother's attempts to free herself from the addiction may result in ongoing relapses where crises are followed by attempts to get free of the addiction, complicated by a repeat of self-medicating behaviors.
    - If the mother's substance abuse involves illegal drugs, the situation may be further complicated by imprisonment, hospitalization, loss of employment and/or housing, and schisms within the social and familial support system.

Why did Mom Become a Substance Abuser in the First Place?

Substance misuse and abuse in domestic violence relationships can include prescription medication, alcohol, and illegal drugs. The substance abuse on the part of the victim usually results from:

1. Destructive, self-medicating behaviors to cope with the emotional pain of living in a violent environment.
2. The abuser *forcing* the victim into substance use:
    a. by injecting or drugging the victim directly
    b. by using the threat of elevated violence
3. The abuser *forcing* the victim into an addiction.
4. Many batterers are also substance abusers and misuse occurred together as part of the relationship.

The Effects on Supervised Visitation

Visitation monitors will meet visiting mothers in any stage of substance abuse recovery who may still be exposed to highly variable levels of danger from the domestic violence.

- Visitation monitors may have natural innate negative reactions to the mother's condition if she comes into visitation jumpy, disheveled, or with what seems to be alcohol on her breath.
- The mother may appear uncooperative and defensive, display a hostile, distrustful attitude towards staff, and express a suspicion of offered services or 'help'.
- Visitation monitors must try to understand the mother's viewpoint:
    - she has already lost temporary custody trying to get help leaving the relationship
    - she may be very concerned about her chances of regaining custody of her children

- she could be worried about sharing any more information that might be damaging or could be used to cast her as an 'unfit' mother
- she may also be terrified of encountering her abuser or having her abuser discover her new living arrangements

What the Supervised Visitation Monitor Needs to Watch For

Supervised visitation monitors must realize that the power and control dynamics of domestic abuse, when combined with the shame associated with substance abuse (including blame for the current separation), can significantly impact the mother-child relationship expressed at supervised visitation. Breaking down the mother-child relationship may have been one of the abuser's methods of asserting power and control within the family. A few common tactics include:

Pre-Separation:

- Stressing that the mothers can't even protect themselves (much less the children).
- Portraying the mothers as 'bad' or 'naughty' and deserving of punishment (especially in light of mom's substance abuse).
- Belittling all women in general in front of the children.
- A constant pattern of verbal abuse intended to convince the mother that she is incompetent, including ridicule when she is unable to complete tasks in unreasonable time frames, without appropriate resources, or due to inebriation.
- Undermining respect for the mother and her authority over the children (needed for parenting), particularly by constantly pointing out her 'defects' to the children.
- Encouraging a child to insult or assault the mother.

- Highlighting the mother's substance misuse or addiction to persuade children to blame the victim for upheavals (including job loss, moves, and worsening abuse).
- Forcing the woman into a position of abusing the children herself to avert more severe abuse of the children by the perpetrator.
- Ensuring that depression robs the women of both the energy and self-esteem needed to be emotionally available to their children.
- Role reversal: placing the children in the role of protector and parent of the mother.

Post-separation:

- Exploiting supervised visitation contacts to ensure that the mother feels uncertain and unsafe, including attempts to use the children to find out current information regarding the mother.
- Deliberate attempts to further alienate the children in his custody from the victim in order to emotionally traumatize the visiting mother.

Mother-child relationships within cases of co-occurring domestic violence and substance abuse have often been defined by:

- An atmosphere of secrecy and fear
- Restrictions on mutual communication
- Protective behaviors that exclude the other
- The need to construct the relationship to safely respond to the demands of the abuser

Many mothers and children do provide a great deal of support for each other during an abusive relationship, often designing protective strategies together to best survive. However, mutual sharing

between mother and child may not be safe or possible at supervised visitation. The inability of visiting mothers to share basic information at the supervised visitation with their children (such as where they live or work) can continue to impede the rebuilding of closeness and trust within the damaged relationship now further complicated by the separation of mother and child.

Supervised Visitation and the Batterer

It is vital that visitation monitors recognize the *responsibility* of the batterer for his abusive behaviors, contrary to any attempts that might be made in front of staff or children to shift the blame onto the victim:

- Research has shown that alcohol use by the victim was twice as likely *after* an abusive attack, in an effort to cope. This can feed into a recurring cycle of abuse:
    - The abuser justifies and escalates further violence because the victim 'deserves' to be punished.
    - It is very likely that the batterer will try to use the victim's substance abuse to manipulate the system against her.
- Perpetrators who abuse substances can be *more* dangerous when they are sober (particularly in withdrawal).
- Incidents of abuse often stem directly from power and control dynamics rather than substance abuse.

Why is treating substance abuse not enough?

Many treatment programs focus exclusively on domestic violence *or* substance abuse, without taking into account that factors of one may be influencing the other:

- Protective behaviors developed to reduce the risk of abuse might be contradicted by the requirements of a substance treatment program.
- A victim of domestic violence may not be able to take complete responsibility for her use of the substance, as required in many treatment programs.
- Some programs for either domestic violence or substance abuse will require clients to resolve the other issue prior to admission to the program.

To avoid further harm to the victim, it is vital that a supervised visitation program:

- Refer individuals within co-occurring domestic violence and substance abuse cases *only* to those programs that
    - understand the intersections.
    - construct treatment plans to address each issue concurrently.
- Understand that the time frame immediately after a separation may be:
    - the most physically dangerous to a woman in terms of injury or death at the hands of the former partner/perpetrator.
    - an excellent opportunity for her to address her substance abuse.

Practical Strategies

Assisting the mother's recovery in cases of domestic violence and substance abuse can substantially help the children as well. When the abused mother's safety increased, so did the children's. Supervised visitation programs can play a vital role in this process, particularly when the mother is the visitor.

Steps to Take—Before your next client.

- Staff Training—Get together and discuss (role-play):
    - Up-to-date current topics within domestic violence and substance abuse (including the interactions, most prevalent drugs, and the effects)
    - Common symptoms you might see (and what those might indicate)
    - *Why* you shouldn't blame the victim
    - Why you can't solve every problem…but what you *can* do to help (make a plan)
- Review your safety procedures:
    - A feeling of safety within a program is essential for building the trust of the client (and vital to any efforts to support the mother-child relationship).
    - A program may have few options in the face of a dangerous domestic violence conflict other than calling police and following established safety plans, however:
        - it is important to keep in mind that the victim may be the visitor.
- Identify methods the abuser might use to manipulate and control the visits—make a plan for how the visitation monitor and program can best respond to situations such as:
    - using the children to obtain information about the mother
    - showing up early or late to overlap with the mother's arrival or departure

- detailing the mother's 'deficiencies' to the staff or the children
- undermining the mother-child relationship

Steps to Take—For your next client.

- Do not blame the victim:
  - Innate judgment calls and first impressions are natural, but understand that the displayed symptoms may have different causes than first assumed.
  - Know where the substance abuse came from and understand that recovery can be an on-going cyclical process.
  - The victim visitor (and her children) can benefit from the belief and emotional support of your program.
- Prioritize safety:
  - Be alert to danger (including the red flag warning signs from the abuser and the potential of stalking and/or weapons usage)
  - Be aware of the woman's established safety plan (usually developed by a certified program for Domestic Violence)
  - Be cautious of the information that is shared within the visit (it may not be safe for the children to learn certain details of the mother's current circumstances if it will get back to the abuser)
- During the visitation, focus on the needs of the children and support of the mother-child relationship:
  - Avoid making unsympathetic judgments of the visitor's interactions with children.

- Focus on encouraging and supporting mother-child interactions rather than blaming or 'punishing' the mother for the lack of interaction or unsuccessful attempts to connect with her children.
- It's better to focus on the children's needs for consistency, safety, secure boundaries, and stimulating interaction.
- Be alert to impediments to mutual sharing that may still exist in the relationship.
- Have a range of activities available for the mother and children to safely interact, potentially indirectly opening up routes to communication about the underlying issues that may be a concern of both.

[Exercise: Empathizing with the Intersections of Domestic Violence and Substance Abuse]

Instructions: As a whole group:

1. First briefly list a few of the symptoms you might see in visiting mothers in cases where domestic violence and substance abuse intersect.
2. Do some of these symptoms overlap?
3. Can you necessarily distinguish whether these symptoms are specifically caused by one concern or the other?
4. As practitioners, how challenging can it be to successfully interact with a visiting parent displaying these symptoms?

Now divide your staff participants into small discussion groups and explain that the individual groups will be considering symptoms displayed by clients in an attempt to:

I. understand and empathize with the motivations and actions of the client, and

II. consider strategies to assist the client.

Each group should select a secretary to record their ideas on a postable flip chart to share with the main group. Give each group about 15 minutes to brainstorm together:

- Think of a visiting parent from the past who displayed many of the symptoms mentioned.
- Was she officially identified as a domestic abuse survivor or a substance abuser?
- Consider specific details of the case in light of the intersections between substance abuse and domestic violence:
    - What factors do you think might have motivated her behaviors?
    - How would you have reacted in her situation?
    - Did her behaviors make sense as self-protective tactics?
    - What additional information did your program not know about the case that it might have been helpful to find out?
    - What strategies did your program try?
    - What worked? What didn't? Can you speculate as to why?

Conclusion: After each group presents their discussion highlights, take time as a staff to identify overarching themes that you see emerging and how these insights might help you better empathize with and assist your *future* clients experiencing co-occurring factors from domestic violence and substance abuse.

[Case Example (Discussion Questions/ Possible Answers)]

Carli is the mother of two young children ages 4 and 6. She has been assigned to your supervised visitation program as the visiting mother following her release from a short in-patient rehabilitation program for substance abuse. The children are currently in the custody of their father, who is always punctual in his scheduled drop-offs for the visits. Carli's attendance to scheduled visits has been sporadic. Her attitude toward the staff is frequently defensive or even aggressive.

Today she showed up nearly fifteen minutes late for the visit and claimed that she had trouble getting there because she missed her bus connection. The visit was allowed to proceed, but the visitation monitor is becoming concerned: Carli appears very jumpy and spends more time watching the doors and clock than interacting with the children. In fact, she's twice refused to answer the 6 year-old's questions about how she's been and what she's been doing since they last meet. The visitation monitor is beginning to wonder if the mother is high and whether the visitation should even continue.

1. What alternate explanations might apply to Carli's behavior? *(It is also possible that Carli has experienced co-occurring domestic violence and is increasingly worried about stalking behaviors by the children's father—this may be why she has missed previous visits. It is also possible that her perceived level of danger has increased in the last few weeks, leading to her jumpiness today and her refusal to talk to the 6 year-old [currently in the father's custody] about her recent activities.)*
2. What additional information does your program need to know? *(Is Carli currently associated with a domestic violence treatment program? Has there been an Injunction for Protection Against Domestic*

Violence filed? Why is Carli actually jumpy today and watching doors and clocks? What are Carli's underlying reasons for the lack of communication with the children?)

3. What might you do now to assist with the situation? *(Talk to Carli in a non-judgmental fashion and privately, away from the children, about her possible concerns. It may also help to have a staff person offer to accompany her to the bus stop in order to help assuage her fears. It may help to bring in a staff member that Carli has not previously reacted to defensively or aggressively. It may also help to go over agency safety procedures. Attempt to engage Carli and the children in a neutral activity in which the discussion can center on play.)*

[Quiz]

1. How might a perpetrator of domestic violence obtain custody of the children, resulting in the assignment of the mother to supervised visitation? *(Due to the visible symptoms the mother may display from the substance abuse and domestic violence, her parental capacity could be in doubt and the judge may conclude that the abuser's behavior poses less of a risk to the children.)*
2. Detail possible reasons for substance abuse and misuse among female survivors of domestic violence? *(As a self-medicating coping behavior, the abuser forces substance abuse upon the victim, substance abuse originally forced is now an addiction, substance misuse with the abuser in the context of the relationship)*
3. Explain a few of the underlying causes of challenges to the mother-child relationship in situations in which the victim is the visitor? *(Atmosphere of secrecy and fear, restrictions on mutual communication, protective behaviors that exclude the other, the need to construct the relationship to safely respond to the demands of the abuser, efforts of the abuser to undermine the mother-child relationship)*

4. In cases that indicate an intersection of domestic violence and substance abuse, what considerations should a program take into account when dealing with a custodial parent who is the batterer? (K*nowledge of safety plans, appropriate referrals to programs which understand the effects of the intersection of domestic violence and abuse, impact of batter's influence on mother-child relationship, understanding of the batterer's responsibility for his behavior*)
5. Describe particular strategies your program might employ to support the mother-child relationship in cases in which the victim is the visitor? *(Emphasize encouraging and supporting the victim rather than making judgments, focus on the needs of the children first, be alert to impediments to safety and open communication, have a range of activities to encourage interaction and communication)*

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Family Centered Practice

Relating to Clients with Difficult Demeanors

This supplemental material is to integrate the concepts that have been taught in other training segments. The examples of clients with difficult demeanors below are not intended to serve as "molds" or "boxes" in which to place clients, but as examples of how to apply what has been learned. We will look at examples of potential clients and then actual client files with the goal of understanding from where the individuals have come, what they are feeling, and where they want to go, striving to keep a practice family-centered and trauma-informed.

We will look at the presenting issues, what implications these have for supervised visitation staff, and what can be done to accomplish staff and client goals. Clients can be easily labeled as 'difficult' and written off a busy schedule, but these clients offer a great opportunity. By understanding why they are behaving in a difficult manner, staff can tailor activities and services that will meet the unmet needs of some individuals. It is our responsibility as professionals to reach these individuals on their own terms.

A Client who is disinterested

Clients can often appear disinterested in the activities or withdrawn from staff. A client may be a mandated client and have no motivation to participate, or he/she may have previously had unsuccessful helping relationships with other professionals. In order to facilitate a constructive current experience, the staff needs to validate the client's previous experiences and seek to empower the individual to set his or her own goals.

A Client who is frustrated

Some clients may not have a good understanding of cognitive processes or legal proceedings. They may not have much formal schooling. They may see your facility as an extension of the court system, a system they did not navigate or understand well. Not being able to coordinate what they think and what happened can lead to frustration. Staff may be seen as a representation of the state and a direction for their frustration. This client may become **aggressive** or **disinterested** and withdrawn depending on his or her coping mechanisms. In addition, or alternatively, the client may not be a native English speaker. All of these aspects can compound frustration if staff speaks quickly, using jargon and state agency acronyms, or if the spouse navigates the systems or speaks English better than the client.

A Client who is inconsolable

Clients may also feel defeated or helpless. This could be due to their **frustration** with the systems or because they do not feel that they can control their lives. The client may exhibit great signs of distress and be very upset when arriving, leaving, or during supervised visitation. Someone this emotional can prove difficult to work with toward specific goals or supervised visitation, but we can help minimize their impressions.

A Client who is aggressive

Clients who demonstrate aggressive behaviors for coping may be very difficult. In fact, previous similar behavior may be what resulted in them needing the services of a supervised visitation facility. Again, this reaction could stem from **frustration** but could result in violence if not contained or de-escalated. In this scenario, staff's first responsibility is not to the client, but to maintain the safety of other participants and staff. Staff should look at what led to this escalation, and if it can be mitigated in the future with this client and others.

Presenting issues and strengths	Implications	Practice Tips
History of abuse as victim	Not comfortable with authority figures	Be patient
Mandated client	May not want to attend	Establish rapport. Start with general open ended questions; validate; empathize
Distant and unresponsive	Poor past experiences with social systems; chemical dependency; English fluency	Establish rapport; validate; empathize. Check for chemical dependency signs. Check if language is a barrier
Wants to have a relationship with child(ren)	May not have best parenting/social skills	After rapport building and at intake, look for opportunities to teach or improve skills
Was willing to sacrifice his/her own well being to preserve the family	Child may not fully understand the situation	Offer to advise client on discussing violence issues with child
Does not acknowledge previous abuse	Child may also have not dealt with issues	Ask if goals for family unification are being met
Is not caring for her/himself	Are appropriate habits being taught to the child? The parent may not have learned self care from his or her own	Make sure she knows of available support services in the community

	parents.	
Exhibits consistent behavioral issues	Are appropriate habits being taught to the child?	Validate, but seek to empower families to set their own goals
Does not follow facility rules	Is parent encouraging child to not follow facility rules? Does the parent understand the rules?	Remind and encourage; stop activities when breaches are significant or repeated; discuss with client if he/she fully understands expectations and what obstacles he/she has to understanding
Acts aggressively or violently	Safety of all involved	Stabilize and de-escalate the situation; arrange for security for future visits, if necessary

Moving Beyond the Label

Here are a few other potential ideas to consider as we begin to apply these concepts to the actual clients of your facility. Get out a few files to peruse, as you read through the activities below.

Preparing for the next visit

For each family file:

- Who is the family?
- What are the client strengths?
- What are potential skill building areas?
- Have cultural differences been noted in files?
- How is the safety of family members addressed?
- Are there examples of disrespect or harmful language/preconceptions apparent in the file? (Is this from family or from staff??)

Applying observations to the staff as a whole:

- ❖ Do active listening skills need review?
- ❖ Do note taking/form completion need review?
- ❖ Is continued training available?
- ❖ Are there any emerging needs for new areas of training?

Case studies

Go back and look at the table above, after reading each case scenario below.

- Can you identify additional strengths or issues for these cases?
- Can you identify additional implications for those strengths and issues listed or for those that you added to the list?
- What would you do in response to these implications?
- Can you add more considerations to the table based on your actual clients?

Wendy Forester must attend mandatory counseling in order to maintain her visitation rights with her daughter. Her inability to take care of her own physical needs is why her daughter is not currently living with her. She is short whenever asked a direct question by staff and often sarcastic; otherwise she avoids interaction with staff. You know that there was a history of violence in the household, but Wendy, as the victim, never reported it. Instead the authorities intervened on the tip of a neighbor.

Anna Wilkinson grew up in poor Spanish speaking migrant camps in the US. She never finished grade school, and soon after she turned 18 was a victim of rape, and became pregnant. She has used illegal drugs but cleaned up because she wanted to keep the baby. She sometimes gets very angry with the staff or her toddler, and other times she is severely emotionally distraught. Her emotional condition has kept the courts from allowing her full guardianship of her child. She is now clean and has a minimal wage job, but no reliable transportation.

Going Further:

Look again at the table of behaviors, implications, and outcomes. As a staff, are there rows that do not apply to your clients, or information that should be added anywhere into the chart. Use this tool for a brainstorming session on what are real, current issues for your staff and for the clients served by your program.

Then here are a few other questions to consider. Try to imagine daily and long term issues from the clients' perspective.

- Do you see themes in your clients' lives similar to the characters?
- Can staff help to clarify or achieve family goals?
- Is the client empowered?
- Is the family committed to the supervised visitation schedule and plan?
- What issues and challenges does each client bring to the program?
- Is the family connected to other community resources?
- Does their SV schedule facilitate this?
- Are families able to rely on others for support (do they have friends, extended family)?
- How has your program built community among clients and celebrated diversity?
- Are there any new or revised policies that could better support clients?

A Reminder about Family-Centered Practice

Family Centered Practice focuses on the family as an entity, considering the concept of the whole being greater than the sum of its parts. Supervised visitation has the expressed purpose of trying to build constructive relationships between family members. The family is not a competitive group, but should be a cohesive entity. This concept needs to be remembered during intake and work with the family. They are the best expert of their own experiences. They bring many strengths to the experience, but may need some mutual respect and enhanced communication skills in order to best interact with each other and the staff. We do not want to marginalize any member in these processes.

A Refresher Course:

HOW TO REPORT CHILD ABUSE

Editor's Note: All SV staff should know the process for following up on suspected child abuse. Here are the most important points to remember.

When a child discloses abuse information to you:

- **Do not** react with shock, fear or disgust.
- You should tell the child you are glad he or she told you.
- Get down to the child's level to talk to him or her.
- Get as much identifying information as possible to make a more accurate report, without pushing the informant or child to give information they are not comfortable providing.

If you suspect child abuse:

- A call to the Abuse Hotline must be made any time you know or "have reasonable" cause to suspect a child is being abused, abandoned or neglected.
- The Abuse Hotline counselor can make the decision as to whether it warrants a report.

Who should make the call?

- If a supervisor is available, it is better for him or her to make the report.
- However, any person who hears about, or suspects abuse must report it. Mandatory reporters must provide their own names.

By statute, mandated reporters in Florida are:

- Physicians, osteopaths, medical examiners, chiropractors, nurses, or hospital personnel
- Other health or mental health professionals
- Practitioners who rely solely on spiritual means for healing
- Teachers or other school officials or personnel
- Social workers, daycare center workers, or other professional child care, foster care, residential, or institutional workers. (The Clearinghouse believes that supervised visitation staff/volunteers are included here)
- Law enforcement officers or judges

(http://www.childwelfare.gov/systemwide/laws_policies/statutes/manda.pdf)

How to make the report:

- Call **1-800-96-ABUSE** or 1-800-962-2873.
- Or for Telecommunications Device for the Deaf (TDD): 1-800-453-5145
- Or online at: https://abuse-report-bc.dcf.state.fl.us/AbuseWebReport/Home.aspx
- Mandated reporters **do** have to disclose their names to the hotline.

For more information visit:

- http://www.dcf.state.fl.us/programs/abuse/
- http://www.childwelfare.gov/systemwide/laws_policies/statutes/manda.pdf

Remember, if you or your staff suspects abuse, MAKE THE CALL.

We wish everyone a safe and happy holiday season! - Karen