FLORIDA STATE UNIVERSITY

A Training Manual
for Florida's
Supervised Visitation Programs
with Administrative Supplement

CLEARINGHOUSE ON SUPERVISED VISITATION

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Clearinghouse on Supervised Visitation

The Clearinghouse on Supervised Visitation was created in 1996 through an appropriation from the Office of the State Courts Administrator to provide statewide technical assistance on issues related to the delivery of supervised visitation services to providers, the judiciary, and Florida's Department of Children and Families. Since 1996, the Clearinghouse has received contracts on an annual basis from the Department of Children and Families to continue this provision of technical assistance. In 1998, the Clearinghouse published a training manual, *A Competency-Based Training Manual for Florida's Supervised Visitation Providers,* covering the recommended training content for providers developed by the Florida Supreme Court. The current manual is a completely revised and updated curriculum of the 1998 curriculum for supervised visitation programs.

Since 1996, The Clearinghouse has also produced two semiannual newsletters: *The Bar & Bench Visitation Report* and *The Family Visitation Times.* Additionally, the Clearinghouse has produced other technical assistance tools, including the 2003 manual *Child Sexual Abuse Referrals: A Curriculum for Supervised Visitation Providers* and the 2004 *Referrals to Supervised Visitation Programs: A Manual for Florida's Judges*, a curriculum for which judges receive continuing judicial education credit. In addition to producing two comprehensive administrative guides, *A Toolkit on Monitored Exchange* and *A Toolkit for Collaboration Between Florida's Colleges and Universities and Supervised Visitation Programs*, the Clearinghouse has provided on-site training around the United States and Canada, conducted telephonic and web-based training for providers, and responded to telephone requests for assistance from providers and the courts across the country. In 2003, the Clearinghouse received funding from the U.S. Department of Justice's Office on Violence Against Women to provide technical assistance and training to federal Safe Havens-Supervised Visitation grantees. This funding was renewed for 2005-2006.

The Clearinghouse is a component of the Institute for Family Violence Studies in the Florida State University College of Social Work. The Institute is directed by Wendy P. Crook, Ph.D.. Karen Oehme, J.D., is the Clearinghouse Program Director. Other College of Social Work faculty contribute to the design, development, and evaluation of work products. Ms. Oehme has served on the board of directors of the National Supervised Visitation Network.

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CHAPTER 1

WELCOME & ORGANIZATION OF THE MANUAL

Welcome! We are pleased to introduce this Training Manual for Florida's Supervised Visitation Programs. It replaces the *Competency-Based Training Manual for Florida's Supervised Visitation Providers*.

Supervised visitation programs have been in existence in Florida since 1993. They have grown in importance and scope, and currently serve as a cornerstone for Florida's child welfare system.

These crucial programs provide the opportunity for noncustodial parents to have contact with their children in a safe, supervised setting. Families are referred to these programs by family law judges, criminal law judges, and staff of the Department of Children and Families (DCF) or Community-Based Care Organizations (CBCs). Referrals are made because of issues such as domestic violence, child maltreatment, parental substance abuse, parental mental illness or developmental disabilities, parental criminal history, or long-term parental absence.

Since the first manual was published by the Clearinghouse on Supervised Visitation, many developments have occurred in the field of supervised visitation that affect the training and skills necessary for visitation monitors to adequately oversee referrals. Additionally, many more providers are now offering supervised visitation services. Data collected by the Clearinghouse on Supervised Visitation, experience of program staff, and new national efforts including state and federal initiatives have led to an identified need to update the prior manual.

Throughout this manual, the term "visit monitors" is used to describe all personnel – whether paid or volunteer – who may supervise visits between children and their noncustodial parents. These individuals must have the appropriate knowledge base in child welfare, mental health, domestic violence and related topics. They must also have the skills necessary to adequately and safely supervise visits coupled with an understanding of ethical, legal and administrative issues. Some visit monitors will have specific educational and experience backgrounds consistent with these responsibilities, but others may not. Some of these variations may be the result of program resources and staff size. The content of this manual is not meant to replace education and/or background but rather to focus on particular topics and issues germane to the unique needs of supervised visitation programs so as to insure a base level of knowledge and skills.

Organization of the Manual & Administrative Supplement

This manual is divided into thirteen chapters and an Administrative Supplement on compact disc (CD).

The Manual

The first two chapters of the manual (Chapters 1 and 2) contain an overview of the manual and introductory material about the framework and function of supervised visitation programs in Florida. The next seven

chapters (Chapters 3 through 9) contain substantive information on family dynamics that often result in referrals to supervised visitation programs. These topics include child physical and sexual abuse, child neglect, domestic violence, divorce and separation, parental substance abuse, parental mental illness, and chronic parental illness and disability. The final four chapters (Chapters 10 through 13) focus on the practice skills required for working with the courts, facilitating safe visits, and working with culturally diverse families.

Each of the chapters from Chapter 2 through 13 is organized into distinct sections. These are the Introduction, Overview, Objectives, Snapshots, Case Examples, Exercises, and Quizzes.

The length of each chapter varies; thus, the length of time needed to complete each chapter will vary as well. Supervisors may choose to use the manual as in-service training over a period of time for existing staff, or may make it a requirement of orientation for new staff. It may also be used to supplement other existing staff training. The total time needed to teach the entire manual is 25 hours, which meets the training requirement in the Florida Supreme Court's Minimum Standards for Supervised Visitation Program Agreements.

The Administrative Supplement CD

The Administrative Supplement CD offers advice and tools for program directors. The CD is organized into sections that mirror each chapter of the manual, from Chapters 1 though 13. In addition, the CD includes Florida Statutes, the Florida Supreme Court's Minimum Standards for Supervised Visitation Program Agreements, and a set of forms for program use. All forms can be modified to reflect individual program needs; however, the words "Reprinted with Permission of the Clearinghouse on Supervised Visitation" should be included anytime a program circulates them.

Although this manual provides a broad and comprehensive overview of many topics, it is in no way a substitute for formal training, an educational degree, or professional experience in the issues addressed. The information provided herein has an extremely limited application and is intended to be used solely for the training of visit monitors for commonly referred cases at supervised visitation. Complex cases may require the intervention of more highly skilled professionals.

CHAPTER 2

FLORIDA'S FRAMEWORK FOR SUPERVISED VISITATION PROGRAMS

Introduction

The visit monitor's role in facilitating contact between a noncustodial parent and child requires a different perspective than that of a mental health worker, child protective investigator, attorney, or parent educator. The primary responsibility of a visit monitor is to ensure safe contact between a parent and child in a neutral setting.

Supervised visitation programs offer a variety of services in response to the needs of families experiencing dysfunction and victimization. Strong reactions on-site are common in parents, children, and visitation monitors; these require skillful management to ensure a safe experience for all.

Overview

This chapter discusses the purposes of supervised visitation, the types of supervised visitation services currently available in Florida, the characteristics of families referred to supervised visitation, and common reactions of families at visitation. Additionally, this chapter reviews current Florida Supreme Court Minimum Standards, provides a glossary of supervised visitation terminology, and describes the role of supervised visitation staff, volunteers, and other personnel involved in the litigation.

Objectives

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

1. List the purposes of supervised visitation programs;
2. Describe different types of services offered at supervised visitation programs;
3. Identify the Florida Supreme Court Minimum Standards for Supervised Visitation Program Agreements;
4. Describe common dynamics of families referred for supervised visitation services;
5. Describe common reactions to orders for supervised visitation;
6. Identify roles of providers, judiciary, and staff of the Department of Children and Families and Community Based Care agencies;
7. List the knowledge base necessary to facilitate effective supervised visitation services;

8. List key components of program agreements and court orders for supervised visitation; and

9. Describe the process by which program directors accept, decline, or terminate supervised visitation services.

Snapshots

- There are currently 43 programs (totaling 47 sites) offering supervised visitation in Florida.
- Every judicial circuit in Florida is home to at least one supervised visitation program.
- In 2005, Florida programs reported over 36,000 services in the Florida Supervised Visitation Database.
- Five programs in Florida have received federal Safe Havens funding from the US Office on Violence Against Women to provide supervised visitation in domestic violence cases.
- Twenty-one programs receive federal Access and Visitation funding from the U.S. Office on Child Support Enforcement through the Florida Department of Children and Families.

Purposes of Supervised Visitation

Supervised visitation programs provide an opportunity for nonresidential parents to maintain contact with their children in a safe and neutral setting. Other purposes of supervised visitation include:

1. To prevent child abuse;
2. To reduce the potential for harm to victims of domestic violence and their children;
3. To enable an ongoing relationship between the noncustodial parent and child;
4. To facilitate appropriate child/parent interaction during supervised contact;
5. To help build safe and healthy relationships between parents and children;
6. To provide written factual information to the court regarding supervised contact, where appropriate;
7. To reduce the risk of parental kidnapping;
8. To assist parents with juvenile dependency case plan compliance; and
9. To facilitate reunification, where appropriate.

Types of Supervised Visitation Services

Supervised visitation programs may offer a variety of services to enable this contact to occur*:

- One-to-one supervision;
- Supportive or educational supervision;
- Monitored exchanges;
- Group supervision;
- Telephone monitoring;
- Ancillary services, such as parent education or community referrals; and
- Therapeutic supervision.

The Clearinghouse has a Toolkit for Monitored Exchange Services available in hardcopy and on the web at http://familyvio.csw.fsu.edu

Florida's Minimum Standards

Supervised Visitation Programs are an essential element of a model family court in Florida. The Florida Supreme Court's Minimum Standards for Supervised Visitation Program Agreements set forth standards for independent programs. The Standards can be found on the Clearinghouse website and in the Administrative Supplement.

The Minimum Standards provide a skeletal structure for the following:

- The purposes of supervised visitation;
- The scope of services;
- The roles and minimum qualifications of staff;
- Operating policies and procedures;
- Rules governing case acceptance;
- Maintenance of records;
- Disclosure of case information;
- Complaints, insurance, and security;
- Certification and training requirements; and
- Reports to the court.

* *Please see Glossary at the end of this chapter for definitions of these services.*

The standards provide direction for chief judges and trial court judges as well as programs. The chief judge of each circuit is required to enter into an agreement with supervised visitation programs that are willing to comply with the standards; moreover, trial court judges may only order parties to supervised visitation programs that have entered into agreements with the chief judge. Independent programs must annually submit an Affidavit of Compliance with these minimum standards to the chief judge and any changes to programs' role, function, operational policies, procedures and/or capacity must be immediately reported to the chief judge.

Case Referrals to Programs

The majority of families at Florida's 43 supervised visitation programs have been *ordered* by the court to do so. Parents may be ordered to use a supervised visitation program by a dependency court judge in cases of child abuse or neglect, by a family court judge in divorce or modification cases, by a judge hearing domestic violence cases, or by a criminal court judge.

At any point in the judicial proceedings, the court may order supervised visitation if the judge believes that it is in the child's best interest. The parties may request the use of a program, or the court may order it *sua sponte* – on its own.

Letters of Agreement

As specified in the Supreme Court's Minimum Standards, Letters of Agreement between the supervised visitation program and the court provide a written, basic outline of the understanding between the chief judge of the circuit and the program director. *Each agreement must contain information as to the following:*

- The scope and limitations of the program's services. This would include a list of the kinds of cases that the program can and cannot accept, the hours of operation, and the qualifications of staff.
- The procedures for court referrals to the program. This would include the means by which the program can receive referrals from the court, who writes the court order, and who delivers the court order to the program.
- The manner and procedures for communicating with the court and providing written reports to the court. Supervised visitation programs need a way to send documentation to the court because they are not parties to the cause.

In addition to the Program Agreement with the Court, each program must provide an affidavit of compliance annually.

More information about this topic is included in the Administrative Supplement.

Court Orders

When ordering a family to use a supervised visitation program, courts often use a standard court order developed by the program itself. A Sample Court Order is included in the Administrative Supplement.

Mandatory Reporting of Child Abuse

Florida Statutes 39.201 states that any person who knows or has reasonable cause to suspect that a child is abused, abandoned, or neglected shall report it to the Florida Child Abuse Hotline. If a visit monitor suspects abuse or neglect, it must be reported by calling 1-800-96-ABUSE. Supervised visitation programs have exceptions to their confidentiality policies for child abuse and neglect. Programs also should have protocols for making hotline calls.

Common Family Characteristics & Reactions

Almost all families using supervised visitation services have experienced severe family dysfunction or victimization. This may include:

- child abuse;
- child neglect;
- parental substance abuse;
- parental mental illness;
- threats of parental kidnapping;
- parental disability;
- chronic and ongoing parental disputes regarding the child;
- domestic violence; and/or
- other parental criminal activity.

Family members may have experienced emotional or physical reactions to such victimization. Victims may feel pain, shock, denial, fear, anger, or ambivalence, and their reactions may continue well after visitation begins.

The supervised visitation process may help reduce family members' fears and safety concerns. However, participants at supervised visitation may feel many other emotions during visits, including anxiety and fear about the visitation process. Table 2.1 lists some of the common reactions to supervised visitation for family members as well as visit monitors.

Table 2.1
Reactions to Supervised Visitation

Offending Parent	Child	Non Offending Parent	Visitation Monitor
Blaming the victim	Fear of being revictimized	Fear that the child will not be safe	Anxiety
Fear of the legal system	Anger at offending parent	Shock at the victimization	Fear
Fear of reprisals by staff	Anger at non-offending parent	Shame or depression about the victimization	Anger
Shame at the offending behavior	Confusion about rules of supervised visitation program	Confusion about the legal system	Sadness
Anger at being required to have supervision	Guilt about the separation of the family	Ambivalence about the contact between the child and the offending parent	Frustration
Denial and minimization of victimization	Shame or embarrassment about victimization	Denial about the harm to the child	Uncertainty
Confusion and frustration with the legal system	Longing to have contact with the offending parent	Fear for own safety	
Transference of emotions onto visitation program staff	Fear of parent's anger		

Roles of Supervised Visitation Staff and Cooperating Entities

Cases referred to supervised visitation may include many professionals and quasi-professionals involved in the underlying child custody and child abuse/neglect litigation. The general roles and responsibilities of supervised visitation staff and cooperating entities are described below.

Visit monitors, staff and interns

- Maintain confidentiality and neutrality;
- Ensure that the court's directives are followed;
- Monitor safety of all participants at visits;
- Relay relevant information relating to the child's welfare between the custodial parent and the noncustodial parent at the commencement and conclusion of supervised contact (e.g. special needs, medication, diet, etc.);
- Facilitate appropriate visit interaction, if necessary;
- Effectively communicate with program staff on issues related to family dynamics;
- Provide constructive feedback, correction, or redirection to the parties when necessary;
- Suspend or terminate any visit in which the safety of participants or staff cannot be maintained;
- Keep written records of facts observed at visits in formal program forms, pursuant to the program's Agreement with the Court and directives from the program director;
- Provide community referrals, where appropriate;
- Testify in formal court hearings, when appropriate; and
- Report child abuse pursuant to state law.

Program directors/coordinators

- Maintain and ensure the overall quality of service;
- Assume role of visit monitor when necessary;
- Supervise staff, volunteers, and interns;
- Enter into program agreements with the chief judge of the judicial circuit;
- Ensure that staff receive adequate and on-going training according to the Minimum Standards;
- Make decisions regarding whether the program can accept referrals, based on provisions for case acceptance outlined in the Minimum Standards;
- Decide whether to accept or decline out-of-circuit referrals;
- Suspend or terminate any visit in which the safety of participants or staff cannot be maintained;
- Testify in formal court hearings, when appropriate; and
- Maintain or assist in maintaining the program's policies and procedures, personnel records, financial records and client records pursuant to the Minimum Standards.

Cooperating Entities

Personnel representing cooperating entities should remain passive observers to the visit, staying as unobtrusive as possible. During a visit, these personnel should not interview the child or ask questions relating to the court case, interact with the parent or the child, talk with staff in the presence of the child or parent, redirect parent-child interaction (this is the job of the visitation monitor), or in any way take over supervision of the visit.

Additional information on this topic is included in the Administrative Supplement.

Basic roles of cooperating entities are as follows:

- The Chief Judge in each judicial circuit has responsibility for the oversight of programs operating under the auspices of the court and for entering into program agreements that are in compliance with the Minimum Standards;
- The Guardian Ad Litem (GAL) is certified by the state GAL program to act in a child's best interest in dependency, criminal, and/or family court cases;
- The protective investigator/caseworker representing the Department of Children and Families or the Community-based Care Organization is responsible for receiving, investigating, and acting on reports of child abuse, abandonment, or neglect;
- Law enforcement receives written reports of allegations of criminal activity from DCF and determines whether a criminal investigation is warranted;
- Children's Advocacy Centers provide a neutral, child-friendly setting for interviews, medical examinations, and counseling of child abuse victims;
- Attorneys: There are at least five types of attorneys who may be involved in cases referred to supervised visitation: prosecuting attorneys, attorneys for the Department of Child and Families, attorneys for the Guardian Ad Litem, the Public Defender and private attorneys for the parties; and
- The Child Protection Team (CPT) is a group of professionals established by the Florida Department of Health to receive referrals from the protective investigators and protective services staff at DCF.

Confidentiality

Supervised visitation program staff must protect the confidentiality of the children and parents who receive program services to the extent required by law. This entails maintaining records according to the Minimum Standards and protecting location information regarding victims of domestic violence and their children. Staff must refrain from discussing individual cases except in formal court proceedings, with program staff, or pursuant to program policies with lawyers, social services agencies or parties to the case.

Case Example & Discussion Questions

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

Julia Mathers is a volunteer at the Great Kids Supervised Visitation Program. She monitors a visit between Mr. Carter and his son, Jake. Shortly thereafter, she is shopping with a friend at the mall, and sees Mr. Carter. She walks up to him and introduces him to her friend as the "father I've been helping at Great Kids."

Discussion Questions:

1. Is it appropriate for the volunteer to identify a person as a client of the program?

2. What kinds of reactions might Mr. Carter have to this introduction?

3. What kinds of reactions might the friend have to this introduction?

4. Do you think that the volunteer should be allowed to continue monitoring visits in the Carter case?

Neutrality

Neutrality entails impartiality and lack of bias and is an important part of supervised visitation programs. Supervised visitation programs, which derive their authority from judicial referrals, should ensure that staff members maintain neutrality in order to sustain the public's confidence in the administration of justice.

Key issues related to neutrality are that staff treat all parties respectfully, and are not aligned financially, emotionally or legally with either party. Neutrality acknowledges the inequality of risks, i.e., visitation staff may need to take action in response to inappropriate behavior exhibited by one party. Neutrality does not require staff to ignore the fact that a parent may be a risk to the children or other parent. Neutrality requires that class bias, race bias, and occupational bias are avoided. Neutrality does not preclude making referrals to community resources such as victim services.

Judges who send families to supervised visitation programs clearly presume that the services offered by supervised visitation staff will be neutral. If they are not, the program will lose credibility.

Case Example & Discussion Questions

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

When Mr. Sims is ordered to use the Sunshine Visitation Program to visit his daughter, Jennie, staff review the court file, which recounts a long history of domestic violence. At the first visit Mr. Sims shows up fifteen minutes late, which results in a concurrent arrival with Mrs. Sims. Russ, the monitor, tells Mr. Sims that he is not to show up late again. During the next visit, Russ interrupts Mr. Sims twice while Sims asks Jennie where she is going to school. During the third visit, Mr. Sims abruptly pushes past Russ to open the waiting room door to see Mrs. Sims when she arrives to drop off Jennie. The program files a critical incident report with the court. Mr. Sims files a motion to have unsupervised visitation, claiming that the staff is biased against him and cannot be neutral.

Discussion Questions:

1. On these facts, do you think that the program staff is acting in a biased way against Mr. Sims?
2. If the program staff takes the above steps to increase safety for Mrs. Sims and Jennie, does that lessen the program's neutrality?
3. What kinds of steps could the program take to assure Mr. Sims that it is unbiased?
4. Discuss under what circumstances, if any, the program can continue supervising visits in this case.

QUIZ

1. List four purposes of supervised visitation programs.
2. Describe the role of the judiciary in supervised visitation programs.
3. List three reasons why neutrality is important at supervised visitation.
4. Describe the circumstances under which it is appropriate for a program to decline a case referred by the court.

GLOSSARY

This section of the chapter will provide definitions for terminology relevant to supervised visitation. These are drawn primarily from the Supreme Court's Minimum Standards for Supervised Visitation Program Agreements. These will assist programs and staff in communicating with the courts and social service agencies.

Authorized Person is a person authorized by the court to be present, in addition to the noncustodial parent, during supervised contact

Chief Judge means the chief judge of a judicial circuit or his or her designee.

Child means an unmarried person under the age of 18 who has not been emancipated by order of the court and whose contact with a noncustodial parent is supervised pursuant to a court order. Child may mean more than one child.

Client means the custodial parent, noncustodial parent, or child receiving supervised contact services pursuant to a court referral to a supervised contact program.

Custodial Parent means a natural or adoptive parent, guardian, or state agency and its representatives, who has temporary or permanent legal custody of a child.

Documented Exchange means that the program documents the transfer of the child between the parents. This type of exchange can be used when there is a history of missed, late, or inconsistent visitation.

Exchange Monitoring means the supervision of a child's movement from the custodial to noncustodial parent at the start of noncustodial parent/child visit or from the noncustodial parent back to the custodial parent at the end of the visit. This type of supervised contact is for those cases in which contact causes conflict between the adults but the contact between the parent and child could be expected to proceed without incident.

Facilitate means to encourage age-appropriate activities, promote a child's safety and welfare, and discourage inappropriate conduct. "Facilitate" should not be construed to mean therapeutic intervention.

Group Supervised Visitation means one supervision monitor/observer for several families.

Individual Supervised Visitation means one visitation monitor/observer for one family.

Noncustodial Parent may refer to a biological parent or other adult authorized by a court order to have supervised contact with the child.

Off-site Supervision is supervision of contact between the noncustodial parent and child that occurs away from a site under the control of the program and visit supervisor. Off-site supervision may occur in a group setting or on an individual basis.

On-site Supervision refers to the supervision of a noncustodial parent and child at a site under control of the program and visit supervisor. On-site supervision may include a range of closeness of supervision from continuous close monitoring to periods of time during which the noncustodial parent and child are intermittently monitored by video or audio. On-site supervision may occur in a group setting or on an individual basis.

Phone Monitoring may be when the program contacts parties by phone to verify that visitation occurred as

ordered, or when the program monitors an actual phone call between the parent and child.

Program means a person, society, association, or agency, operating independently or under the auspices of the court.

Program Agreement is a written understanding between the court and an independent provider of supervised contact services that includes but is not limited to, the scope and limitations of the provider's services, the procedures for court referrals to the provider, and the manner and procedures for communicating with the court and providing written reports to the court. The Program Agreement incorporates the program's written operational policies and procedures.

Therapeutic Supervision is the provision of therapeutic evaluation or therapeutic intervention to help improve the parent-child interactions. Therapeutic supervision may only be provided for these specified purposes, only by order of the court, and only by trained certified or licensed mental health professionals.

Supervised Contact may include supervised visitation, monitored exchange, and third party exchange services provided by a program pursuant to a Program Agreement and court order.

Visitation Agreement is a written agreement between the program and each custodial and noncustodial parent including, but not limited to, specific rules, responsibilities, and requirements of the program and the consequences of failing to abide by the same. The visitation agreement shall also advise the clients that no confidential privilege exists as to the program's records, except as provided by law or order of the court.

Visitation Monitor/Observer is the individual trained and authorized by a program to observe the contact between the noncustodial parent and the child and to document such observations, as provided by the program agreement and these standards.

Visitation Supervisor means the individual authorized to facilitate, intervene, and terminate a visit, if necessary. The visitation supervisor may also be the visitation monitor/observer.

CHAPTER 3

THE IMPACT OF CHILD PHYSICAL & SEXUAL ABUSE ON SUPERVISED VISITATION

Introduction

Many of the children referred to supervised visitation programs by the Department of Children and Families, a Community Based Care agency (CBC), and/or the court have been physically and/or sexually abused. Both physical and sexual abuse not only result in physical injuries to the child but also have emotional, behavioral, and societal consequences that impact the provision of supervised visitation services. Visit monitors must have an understanding of these consequences in order to provide appropriate services.

In most cases of this type, DCF or the CBC has temporary custody of the children and works with the family to ensure pre-reunification case planning. In some cases, DCF works to terminate parental rights due to the severity of the abuse, the failure of the parents to follow through on their case plan, or other factors. Some children referred to supervised visitation may be in relative placement outside of the home, living in emergency shelter, or staying with foster parents.

Overview

This chapter provides current information and research findings about child physical and sexual abuse in order to assist visit monitors in their roles. For more comprehensive information on child sexual abuse, however, visit monitors should refer to the manual ***Child Sexual Abuse Referrals: A Curriculum for Supervised Visitation Providers*** published by the Clearinghouse on Supervised Visitation.

Objectives

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

1. Identify types of physical and sexual child abuse;
2. State the prevalence of child physical abuse based upon the most current research findings;
3. Recognize risk factors and mediating factors for child physical abuse;
4. Discuss the developmental impact of physical abuse upon child victims;
5. State the prevalence of child sexual abuse based upon the most current research findings;
6. Recognize risk and mediating factors for child sexual abuse;

7. Discuss the developmental impact of child sexual abuse on child victims;
8. Assess the impact of abuse experiences on supervised visitation;
9. Identify role of visit monitors in observing visits involving child physical and sexual abuse; and
10. Prepare a child for visits, monitor visits, and follow-up visits.

Snapshots

Physical Abuse

- The third annual National Incidence Study of Child Abuse and Neglect found that boys had a greater risk of emotional neglect and of serious injury than did girls.
- Children of single parents had a 77% greater risk of being harmed by physical abuse and an 80% greater risk of suffering physical injury from abuse or neglect than did children living with both parents.
- A child's age and gender are related to the rate of maltreatment, but race is not.
- Sixty-two percent of abused children were abused by their birth parents.
- Studies have found abused children to be 25% more likely to experience depression, teen pregnancy, low academic performance, drug use, and mental health problems than non-abused children.
- Data from the National Child Abuse and Neglect Systems reported an estimated 1,400 child fatalities in 2002.
- Of these fatalities, children under one year of age accounted for 41% of deaths.

Child Sexual Abuse

- Girls are sexually abused three times more often than boys.
- Twenty-five percent of sexually abused children were assaulted by a birth parent.
- Between one in three and one in four adult women report that they were sexually abused as children.

Types of Physical and Sexual Abuse

Physical and sexual abuse vary by type and severity. Physical abuse ranges from bruising to choking to brain trauma, and sexual abuse ranges from exposure to pornography to fondling to anal or vaginal penetration. Table 3.1 presents types of physical and sexual maltreatment along with descriptions or examples. It is derived from the State of Florida, Department of Children and Families' Child Abuse Allegation Matrix.

Table 3.1
Types & Examples of Physical & Sexual Abuse

Physical Abuse	Description/Example
Bruises, welts	Injuries resulting from bleeding within the skin when skin is discolored but not broken.
Cuts, punctures, bites	A cut or break in the skin caused by an object or teeth.
Burns/scalds	Tissue injury resulting from exposure to heat or chemicals.
Dislocation of bones	Displacement of a bone from its joint.
Bone fractures	Broken bone: simple, compound, complicated or spiral.
Internal injuries	No visible injury to organs in chest or abdomen.
Skull fracture, brain or spinal cord damage, intracranial hemorrhage	Broken bone in skull, injury to nervous system, Shaken Baby Syndrome.
Asphyxiation, suffocation	Choking, smothering, or drowning which interfere with oxygen intake.
Deadly weapon	Injury caused by or threatened through a deadly weapon such as a knife or gun.
Beatings and/or excessive corporal punishment	Striking a child resulting in temporary or permanent disfigurement or impairment of a body part or death.
Sexual battery (incest)	Sexual battery or sexual intercourse with a child by a blood relative who is responsible for the child's care (includes anal, vaginal, penile penetration, placing an object in a child's anus or vaginal oral sex – fellatio, cunninglingus, anal-lingus).
Sexual battery (not incest)	Sexual battery or sexual intercourse with a child by a person not related to the child by blood but who is responsible for the child's welfare (step-parents) or who is an adult household member.

Table 3.1 (cont'd)
Types & Examples of Physical & Sexual Abuse

Physical Abuse	Description/Example
Sexual molestation	Sexual conduct with a child when such contact is used to arouse or sexually gratify the abuser. May include voyeurism, showing a child pornography, having a child masturbate while adult watches or vice versa, exposure of genitals, fondling, frontage, digital penetration, breast sucking, tongue kissing, or sexual contact with animals.
Sexual exploitation	Use of a child for sexual arousal or sexual gratification for profit. May include allowing a child to participate in or watch pornography or engage in prostitution.

Sexual battery under Florida Statues is defined as oral, anal, vaginal penetration by or in union with the sexual organ of another, or the anal or vaginal penetration of another by any object.

Exercise
Responding to Child Physical & Sexual Abuse

Instructions: Using newsprint and markers, list types of physical and sexual abuse that have been referred to the supervised visitation program in the past or that have appeared in the newspaper or on television. For example, monitors might list a case in which a parent burned a child's hands on the stove-top, or an incident in which a parent was accused of taking pictures of a sexually-posed child.

Next, discuss the following questions:

- What feelings do you think you will have to overcome to be able to facilitate visits between abusive parents and their children?
- Do you feel supervised visitation services should be offered to these families? Why or why not?
- How might your feelings as a visit monitor interfere with your ability to be respectful in observing visits?
- How might a non-abusing parent or foster parent respond emotionally?
- Many workers identify the following reactions: fear, anger, feeling overwhelmed, disgusted, anxious, ambivalent, depressed, frustrated. Do you have any of these feelings about monitoring child sexual abuse cases?

Risk Factors
of Child Physical & Sexual Abuse

Research on the causes of child physical and sexual abuse typically examines factors from four systems: 1) the child, 2) the family, 3) the community in which the child lives, and 4) the larger social system. Each of these is discussed below.

Child Risk Factors

Children are ***not*** responsible for the abuse they experience, but research does indicate that *certain* characteristics of children may increase their risk for abuse. These characteristics include the following:

- Premature birth, birth anomalies (defects), low birth weight, exposure to toxins in utero;
- Temperament – especially if the child is difficult or slow to engage with the parent;
- Physical, cognitive, or emotional disabilities;
- Chronic illness – seizure disorders, cystic fibrosis, etc.;
- Childhood trauma;

- Anti-social peer group;
- Age (younger children at greater risk for physical abuse); and
- Child aggression, behavioral problems, attention deficits.

Parental or Family Risk Factors

Research has found that certain characteristics of a child's family may also increase the risk for child physical or sexual abuse. These include:

- Substance abuse by parent;
- Domestic violence;
- High parental conflict;
- Social isolation;
- Family structure (single-parent, large number of children in home, step-parent or parent's live-in partner);
- Parental mental illness;
- Separation/divorce;
- Age (younger parents are more likely to be physically abusive);
- Poor parenting skills (unrealistic expectations of child, disregard of child's needs, negative perception of child, over-control of child, and poor boundaries); and
- Emotional & behavioral characteristics (anger and control problems, depression/anxiety, low frustration tolerance, low self-esteem, poor impulse control, lack of trust, or rigidity).

Community Factors

A number of community factors have been associated with child maltreatment as well. These include:

- Low socioeconomic level of community/neighborhood;
- Inadequate schools;
- Poor accessibility to or availability of health care, child care, social services;
- High unemployment;
- Youth gangs; and
- Exposure to institutional racism or gender bias.

Societal Factors

Research on child maltreatment also acknowledges the impact of larger societal factors on the prevalence of child physical and sexual abuse. These may include:

- Societal acceptance of violence as evidenced by the media or in entertainment;
- Religious views that support non-interference by public entities in child-rearing practices; and
- Lack of agreement by society as a whole about the definition of child abuse, the prevalence of abuse, or even consensus on appropriate interventions and treatments.

Mediating or Protective Factors for Child Physical & Sexual Abuse

Research conducted in the past decade acknowledges that there are mediating and protective factors within children, families, communities, and societies which help *reduce* the risks of child maltreatment, build family capacity, foster resiliency, and reduce the impact or consequences of abuse. These factors help explain why some children with the risk factors previously presented become abused and other children do not. They also help us understand why some child victims suffer long-term consequences, while others with the same risk factors do not. (This is not an exhaustive list. Factors do not imply causality.)

Child Protective or Mediating Factors

- Good health;
- No problems during pregnancy or birth;
- Above-average intelligence;
- Hobbies or outside interest;
- Good peer relationships; and
- Personality factors (good coping skills, social skills, easy temperament, self-esteem, internal control).

Parental/Family Protective or Mediating Factors

- Warm parent-child relationships;
- Supportive family environment;
- Extended family support;
- Advanced parental education;

- Household rules/structure;
- Parental monitoring of children;
- Good parental coping skills;
- Strong parenting skills; and
- Non-violent family environment.

Community/Societal Protective or Mediating Factors

- Stable socio-economic status in community;
- Accessible health care, child care, and social services;
- Low unemployment;
- Safe housing;
- Good schools and educational opportunities;
- Supportive adults outside of family; and
- Faith-based institutions or other social networks.

Exercise
Physical & Sexual Abuse Risk Factors

Instructions: If doing this exercise as a group, assign participants to groups of three to four people. If having trainee read the manual on his/her own, have him/her write reactions or responses for review by a supervisor. Ask trainees to read the following case examples and identify which risk factors are present.

Case One: A father with developmental disabilities has charges of sexual battery pending, but has been allowed to visit his six-year-old daughter. The mother also has developmental disabilities but was awarded custody. The family lives in a rural community with no transportation; the nearest health care facility is twenty miles away.

Case Two: A father is ordered to have access to his eight-year-old daughter and ten-year-old son at a visitation center. The parents are involved in a bitter custody dispute with a history of high parental conflict. There are allegations of sexual abuse, domestic violence, and substance abuse against both parents.

Case Three: A mother and father are referred to your program to visit their five children whom they have been accused of abusing. The children were kept in cages at their home and, when found, were severely malnourished with physical evidence of old and new injuries. Three of the children are developmentally delayed and another has significant mental health problems. The mother has a history of depression. The father is an immigrant who comes from a culture that values authoritarian discipline and dominance over women.

Consequences of Physical and Sexual Abuse for Children

Physical and sexual abuse of children causes physical health, psychological, behavioral, and intellectual consequences, which are presented below. Visit monitors should also remember that the protective or mediating factors discussed in the previous section may reduce the impact of these consequences in some child victims.

Physical Health Consequences

Broken bones, burns, Shaken Baby Syndrome, failure to thrive, and genital damage are all examples of the physical impact of child physical or sexual abuse. The severity of the abuse can have both short-term and long-term consequences. Abuse can lead to blindness, learning and developmental delays or disabilities, sleep disturbances, hyperactivity, and recurring chronic health conditions. Sexually-abused children may be at risk for sexually transmitted diseases. Additionally, children may be at risk for HIV/AIDS if their sexual abuse entailed rectal, anal, oral, or vaginal exposure to HIV-positive body fluids.

Psychological or Emotional Consequences

Poor emotional health is typically a consequence of child maltreatment. This can be manifested in a variety of ways, including panic disorders, post-traumatic stress disorder, attachment disorder, cognitive disorders (language delays, poor motor skills, limited intellectual functioning), or social difficulties (aggressiveness, fighting, poor peer relations, problems in school, etc.). Children who have experienced abuse often appear emotionally "needy."

Behavioral Consequences

In a study conducted in 1997, children were found to be 25% more likely to experience delinquency, teen pregnancy, drug use, and have mental health problems if they had been abused. The National Institute on Drug Abuse (2000) found that two out of three clients in drug treatment had been abused as children.

Societal Consequences

Communities and larger societal systems (courts, child welfare agencies, law enforcement agencies) experience consequences of child abuse, too, including increased caseloads and increased demand on public services such as jails and emergency rooms.

Reactions of Parents, Children and Staff

Parents (both those who are abusive and those who are not), children, and staff may have reactions or concerns about scheduled supervised visits in cases of physical or sexual abuse. These are discussed below.

Reactions of Parents

- Either parent may have anger, sadness, apprehension, or anxiety about the visit.
- Parents may be distressed at seeing injuries to the child that have resulted from their abuse. They may try to minimize or ignore the injuries or blame some other party for them.
- Parents may minimize or deny that their actions were abusive – they may try to force the child to recant the allegations or convince the visit monitor to agree that they are "good" parents.
- Parents may also experience psychosomatic complaints before a visit: headaches, stomach problems, tiredness, etc.
- Parents may be physically or verbally aggressive toward visitation staff.
- Non-abusing parents may have been engaged in losing court battles trying to confirm the abuse and have given up in the process. These parents may appear "worn-down" not only by the child's abuse but also by the child's recanting or the lack of support from family or social systems.

Reactions of Foster Parents or Relatives

Foster parents or relatives who bring an abused child to a visit may also have concerns:

- Anxiety about potential adverse effects of the visit on the child;
- Concern that the staff cannot keep the child safe;
- Anticipation that the child will experience emotional or behavioral problems following the visit; and,
- Anxiety that the parent will seek them out and harm them.

Reactions of Children

Among the reactions to supervised visitation experienced by children are concerns about physical health, psychosomatic reactions, developmental issues, and behavioral reactions.

- *Physical Health Concerns*

  A child may experience ongoing repercussions of physical or sexual abuse such as scars, disfigurement, pain, difficulty in urination, or difficulty in speaking that may impede the visit. Children who have experienced sexual abuse may have specific concerns related to their sexual orientation (if abused by a same-sex parent) or concerns about their sexual development. Female children who have been sexually abused may have concerns that they are pregnant or concerns about carrying a pregnancy to term if the abuse has resulted in a pregnancy. Children whose abuse has resulted in scarring or disfigurement may be embarrassed or feel shame or feel guilt around their parents or other visiting families.

- *Psychosomatic Concerns*

  A child who has experienced abuse and who is now having emotional reactions to the abuse may respond with psychosomatic symptoms when informed that he/she will see an abusive parent. The child may report headaches, stomachaches, or feeling tired before, during, or after a visit.

- *Developmental Concerns*

  A physically or sexually abused child may have a number of developmental concerns that impact the visit including attachment issues (refusing to leave a foster parent to visit a parent), feelings of loss of control, vulnerability, impulse control, suicidal ideation or attempts, interpersonal concerns involving loss, self-blame, betrayal by the parent and/or the visit monitor, or intrapersonal issues (fear, trauma, anxiety, depression, flat affect, loss, or grief).

- *Behavioral Concerns*

  Children may manifest avoidant and/or aggressive behavior – refusing to go into the visit, fighting with visit monitor or other staff, or cursing. A child may also manifest sexualized behaviors toward other children, the visiting parent, or staff if there is a history of sexual abuse.

Reactions of Staff

Abusive parents present particular issues for visit monitors. The success of a visit may depend on the skill and education of the visit monitor as well as the nature and severity of the abuse, the age of child, the response of the family system, the case management plan for the family, and other factors.

Visit monitors assigned to parents who have been physically or sexually abusive to their children must be aware of their own feelings toward the parents and not allow these feelings to interfere with their ability to monitor the visit. At the same time, however, visit monitors must be fully aware of the impact of prior abuse experiences upon the child and his/her reaction to the visit and the potential for the child to be re-victimized during a visit with a parent.

Visit monitors may have been victims of child sexual abuse. If they have not addressed their own experiences of victimization, they may have difficulty effectively and objectively observing cases involving child sexual abuse. Program directors should be sensitive to this possibility and offer visit monitors the option of refusing certain types of cases without requiring them to reveal details of their personal histories.

Preparing a Physically or Sexually Abused Child for a Visit

Before scheduling a visit between a physically and/or sexually-abused child and his/her abusive parent, a number of factors must be considered, including the child's concerns regarding her/his safety and protection, feelings of the child toward the parent and the visit itself, needs and wishes of the child, and the child's willingness to interact appropriately with the parent seeking visitation.

Other factors that require attention by the visit monitor are a full understanding of the status of any protective service investigation that might be underway. Specifically, the monitor should be aware if the investigation is ongoing, if abuse has been founded/unsubstantiated, or if DCF is moving toward termination of parental rights. These issues are important for pre-visit planning.

Strategies for Preparing a Child for Visitation

If the child has visible injuries or scars from the physical abuse the visit monitor may want to:

- Explore the child's embarrassment or thoughts about the injuries.
- Use role-play to practice responses if questioned about the injuries from other children, parents, or staff.
- Understand or anticipate parents' reactions to seeing scars or injuries caused by parental abuse.

To address emotional concerns of a child anticipating contact with an abusive parent, a visit monitor may:

- Help the child express his/her fear, anger, or anxiety about seeing the parent. Anticipate that some children may exhibit temper tantrums, be argumentative, or refuse to discuss a pending visit.
- With older children and adolescents, the visit monitor should explore potential risk for self-harm, mutilation, or suicidal attempts/thinking.
- Visit monitors should educate foster parents or relatives caring for the child to anticipate possible acting-out behavior before or after a visit with an abusive parent.
- Help the child recognize her/his ambivalence toward the abusing parent – i.e. acknowledge both feelings of love and hate. Abused children express strong attachment and loyalty to the parents who have abused them. At the same time, they may express fear over continuing harm and rejection by the parent.
- Offer a nurturing environment where children can experience unconditional positive regard.
- Help the child express, either verbally or through play activities, his/her feelings about the visit.
- Initiate interventions that allow the child to "manage" or "control" the visits: for example, choosing to end a visit by using a pre-arranged signal with the visit monitor, or cooperatively setting parameters for physical contact.
- Educate the child about the parent's responsibilities, the role of the visit monitor, and the role of the foster parent.
- Inform the child about the structure of the visit: where it will take place, who will be present, how long it will last, and if it will take place again.
- Put responsibility for the abuse on the abuser – never make the child think it was his or her fault!

Monitoring Visits Involving Child Physical or Sexual Abuse

Visit monitors observing and facilitating visits between an abusive parent and child can engage in a number of techniques to assist the visit:

- Anticipate a range of emotional reactions by both the parent and child such as detachment, depression, anger, or guilt.
- Insure that the parent in no way assigns "blame" or responsibility for the abuse to the child nor tries to minimize or deny that the abuse occurred.
- Anticipate that children, even those who have been severely abused by a parent, may ask when they can return home if they are living in an out-of-home placement.
- Anticipate that children may plead with their parents that they will be "good" if they can return home.
- Allow the child, if he or she chooses, to discuss the abuse, the status of her/his injuries, and treatment that he or she has received. Do not allow the parent to minimize the injuries.

- Do not express alarm if the child engages in sexualized behavior if he or she has experienced sexual abuse. At the same time, do not assume that a child who is referred because of allegations of sexual abuse will always engage in sexualized behavior. Do not assume that abuse did not occur simply because the visit is unremarkable.
- Look for evidence of fear in the child during visits. For example, the child may fear that the parent will be abusive, retaliate for disclosure of the abuse, or fear that something else will occur.
- While it is unlikely that a parent will physically or sexually abuse a child during a visit, it is not unheard of. Be visually aware of any contact between a parent and child and be sensitive to physical "triggers" that may remind the child of the abuse. Listen for coded messages.
- Recognize behaviors that may be sexually arousing for the parent: holding the child on the lap, prolonged lip kissing, etc.
- Be sensitive to emotionally abusive statements made to the child by the parent during visits such as, "I can't hug you, it would be called abuse."
- Intervene *at any point* during the visit by redirecting the parent or terminating the visit if the child becomes tearful, frightened, anxious, obviously distressed, or begins acting out or exhibiting regressive behavior such as urinating on him/herself. In some cases, a short time-out may allow the visit to resume, but in others, the visit should be terminated.
- Allow the child to signal when he or she becomes uncomfortable with anything that is happening during the visit. This can be a code word or physical sign, such as asking to get a drink of water.

Following a Visit

- Allow the child an opportunity to express his/her feelings about the visit either verbally or through play activities.
- Review with the child the schedule for further visits.
- Discuss suggestions the child may have for making the visit better or more comfortable/tolerable.
- Discuss with the foster parent (or other caregiver picking up the child after a visit) any concerns or problems that arose during the visit that may affect the child later in the day.
- Prepare the foster parent or caregiver for possible regressive behavior (bedwetting, sleep disturbance, sucking thumb, withdrawal) or aggressive behavior (angry, fighting, breaking things, defiance, sexual acting out) following a visit.
- Follow program protocols for having custodial parent or foster parent report back to staff any unusual behaviors or problems.

Mandatory Reporting of Child Abuse

Florida Statutes 39.201 states that any person who knows or has reasonable cause to suspect that a child is abused, abandoned, or neglected shall report it to the Florida Child Abuse Hotline. If a visit monitor suspects abuse or neglect, it must be reported by calling 1-800-96-ABUSE. Supervised visitation programs have exceptions to their confidentiality policies for child abuse and neglect. Programs also should have protocols for making hotline calls.

Supervised Visitation in Cases of Termination of Parental Rights

In some cases of physical or sexual child abuse, the Department of Children and Families works to terminate parental rights. This is a legal process whereby parents have voluntarily relinquish their parental rights because they have recognized their inability to provide care, or the court has terminated their parental rights without their consent because of abuse or neglect.

When this is the outcome of a case, a supervised visitation program may be ordered to allow the parents an opportunity to see their children for a final time. Depending upon the age of the child and the circumstances around the termination, some parents may use this opportunity to accept responsibility for their actions and to let the children know that they are loved and are not responsible for either the abuse or the termination. In other cases, parents may express great hostility, remorse, or grief during the visit. Visit monitors need to be prepared for a range of reactions from both children and parents if the visit is to be the final time the family will be together. Whenever possible, a mental health professional should be involved to assist staff with these difficult final visits. They are sometimes called "goodbye visits."

Exercise

Instructions: Read the following case studies of families who received services from supervised visitation programs. Discuss or express in writing how these visits should have been handled.

Case One: A father is visiting his five-year-old daughter. During the visit, he picks her up and holds her over his lap as if she were an infant. The visit monitor notices that the child seems uncomfortable – she is squirming and pushing away from her father. The visit monitor intervenes and removes the child from the father's lap. The monitor then observes that the father appears to be sexually aroused. The child asks to go to the toilet by herself. When she comes out of the bathroom, the visit monitor discovers that the girl has had a bowel movement and spread it on the walls of the stall.

Case Two: Two sisters, ages eight and ten, are in state custody due to sexual exploitation and abuse. The parents had received money from the father's employer for allowing him to have sex with the girls. The father requested that the court allow him visitation at the local supervised visitation program. Initially, the visits went well, but later the girls began to show signs of re-victimization. The ten-year-old would fall into a deep sleep immediately after the visit and the eight-year-old would stand in the hallway and urinate on herself after the visits.

Case Three: A father was ordered into supervised visitation with his four-year-old daughter due to allegations of child sexual abuse. The father claims the mother is making false allegations to gain custody. During a visit, a visit monitor observes the father holding a stuffed toy near his genitals and having his daughter try and bite the toy as part of a game.

QUIZ

1. Describe child, family, community, and societal risk factors associated with child physical and sexual abuse.
2. Describe mediating factors associated with reducing the impact of child physical and sexual abuse.
3. Discuss physical health consequences and the emotional, behavioral, and societal consequences of child abuse.
4. Identify techniques to employ in preparing a child for a visit with an abusive parent.
5. Identify techniques to employ while monitoring visits.
6. Identify reactions that foster parents or caregivers might notice in a child following a visit.

CHAPTER 4

THE IMPACT OF CHILD NEGLECT ON SUPERVISED VISITATION

Introduction

Child neglect is the most common form of child maltreatment and accounts for approximately 55% of all child protective services reports. Often child neglect is a secondary result of a parent's substance abuse, mental illness, or developmental disability. Child neglect can involve inadequate shelter or nutrition, parental refusal to obtain appropriate needed medical or educational assistance, or lack of supervision resulting in child injury or harm. Neglected children who are removed from their parents may be placed in out-of-home or relative placements and may be brought to supervised visitation programs to maintain contact with their parents. Often parents who are neglectful are required to participate in parent education, household training, substance abuse treatment, or other services in order to show evidence that they are complying with a case management plan. Although the caseworker from DCF or the CBC is responsible for developing a case plan for the parent, supervised visitation staff may be able to assist with identifying additional community resources for the family if the program engages in collaboration with local agencies and professionals.

Overview

This chapter presents information on the most common categories of child neglect, discusses common research theories on ecological causes of this neglect, and describes common consequences of neglect. Additionally, information is provided about how characteristics of neglectful parents may affect visits and what strategies may be used to facilitate visits between a neglectful parent and a child.

Objectives

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

1. State the prevalence of certain indicators of child neglect based upon current research findings;
2. Define child neglect;
3. Identify types of child neglect and give examples of each;
4. Discuss common theories regarding causes of child neglect;
5. Discuss intellectual, physical, social, and psychological consequences of child neglect;
6. Identify risk factors and determine necessary interventions during visits;

7. Understand the impact of neglectful parents upon supervised visitation staff;
8. Employ effective techniques to facilitate visits between a neglectful parent and child; and
9. Understanding mandatory reporting laws regarding child abuse and neglect.

Snapshots

- Almost 43% of identified child neglect is reported to be physical: inadequate shelter, nutrition, and clothing.
- The average age of a neglected child in the U.S. is six years of age.
- Children whose parents are abusing drugs or alcohol are four times more likely to be neglected than children whose parents are not substance abusers.
- Child neglect occurs across all societal levels, but rates are higher in families with very low incomes, who are unemployed and/or who rely on public assistance.
- In a substantial number of child neglect cases, the neglect is secondary to the parents' drug use, mental illness, or low level of intellectual functioning.
- Neglected children experience social difficulties, intellectual deficits, emotional and/or behavioral problems as well as physical consequences of their neglect.
- Drug and alcohol abuse has been documented in up to 70% of newly reported cases of child neglect.
- Child fatalities due to neglect most often result from lack of supervision.
- The estimated rate of neglect among families with four or more children was almost double the rate among families with three or fewer children.
- Families of color are over-represented in social services agency case loads.

Definition of Child Neglect

Child neglect, unlike child physical abuse, is not easily defined. Researchers and law enforcement personnel differ in their definitions of what constitutes neglect. Traditional definitions of child neglect have focused on the failure of the caregiver(s) to act in culturally sanctioned ways to fulfill responsibilities for the development of the child. Definitions that are more current consider systemic factors that may also contribute to neglect. In defining neglect of a child, it is important to consider the following:

- What are the basic needs of a child?
- What actions or failures to act on the part of parents or other caregivers constitute neglectful behavior?
- Are the parents' actions or inactions intentional?
- What are the effects of these actions/inactions on the child's safety and development?

- Is the family's situation a result of poverty?
- What are the developmental stage and age of the child?

Florida's Statutory Definition

Florida Statutes 39.01 defines neglect as occurring when

…a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, mental, or emotional health to be significantly impaired or to be in danger of being significantly impaired. The foregoing circumstances shall not be considered neglect if caused primarily by financial inability unless actual services for relief have been offered to and rejected by such person. A parent or legal custodian legitimately practicing religious beliefs in accordance with a recognized church or religious organization who thereby does not provide specific medical treatment for a child shall not, for that reason alone, be considered a negligent parent or legal custodian; however, such an exception does not preclude a court from ordering the following services to be provided, when the health of the child so requires:

(a) Medical services from a licensed physician, dentist, optometrist, podiatric physician, or other qualified health care provider; or

(b) Treatment by a duly accredited practitioner who relies solely on spiritual means for healing in accordance with the tenets and practices of a well-recognized church or religious organization. Neglect of a child includes acts or omissions.

Types of Child Neglect

Most typologies of child neglect are comprised of four major categories: physical neglect, lack of supervision, emotional neglect, and educational neglect. Other categories of neglect, such as failure to protect in cases of domestic violence or prenatal exposure to drugs are more debatable at present and, depending on current legal interpretations, may or may not be considered neglect.

Table 4.1 presents the most commonly accepted categories of child neglect with definitions and examples of each.

Table 4.1
Categories of Child Neglect with Definitions & Examples

Physical Neglect	
Refusal of Health Care	Failure to provide or allow needed care in accord with recommendations of competent health care professional for a child's physical injury, illness, medical condition, or impairment.
Delay in Health Care	Failure to seek timely and appropriate medical care for a serious health problem.
Abandonment	Desertion of a child for an extended period time without arranging for reasonable care and supervision.
Expulsion	Refusal of custody of a child; kicking a child out of the home.
Other Custody Issues	Moving a child repeatedly from place to place to avoid custody; leaving a child with others for long periods of time.
Other Physical Neglect	Inadequate housing, poor environment, inadequate nutrition, clothing, attention to hygiene; disregard of the child's safety and welfare.
Supervision	
Inadequate supervision	Child left unsupervised or inadequately supervised for extended periods of time, or child allowed to remain away from home without parent knowing child's whereabouts.
Emotional Neglect	
Inadequate Nuturance/ Affection	Marked inattention to the child's needs for affection, emotional support, or attention.
Chronic Extreme Abuse or Domestic Violence	Chronic or extreme spouse abuse or other domestic violence in child's presence.
Permitted Alcohol/Drug Abuse	Encouraging or permitting drug/alcohol use by a child.
Permitted Other Maladaptive Behavior	Encouraging or permitting other maladaptive behavior (e.g., delinquent acts).
Refusal of Psychological Care	Refusal to allow needed and available treatment for a child's emotional or behavioral problem.
Delay in Psychological Care	Failure to seek or provide needed treatment for a child's emotional or behavioral problem

Table 4.1 (cont'd)
Categories of Child Neglect with Definitions & Examples

Other Emotional Neglect	Other inattention to the child's emotional/developmental needs.
Educational Neglect	
Permitted Chronic Truancy	Habitual truancy, if the parent is informed of the truancy but fails to intervene.
Failure to Enroll	Failure to register or enroll a child of mandatory school age; requiring a school-aged child to remain at home to work or care for other siblings.
Inattention to Special Education Need	Refusal to allow or failure to obtain recommended remedial educational services for child's diagnosed learning disorder without reasonable cause.

Causes of Child Neglect

Research on child neglect has found that there are multiple causes of child neglect, some are parental or child characteristics, but others are identified as "ecological" factors.

Parental Characteristics

Research indicates that neglectful parents share common characteristics:

- Low educational achievement;
- Impaired intellectual functioning;
- Unemployed or underemployed;
- History of substance abuse;
- History of mental illness (depression);
- Poor social skills;
- Low self-esteem;
- Poor or inadequate problem-solving skills;
- History of victimization; and
- Parent at young age.

Child Characteristics

Research also suggests that there are child-produced factors or stressors, which arise from a child's developmental history or health status that may be associated with parental neglect:

- Children with developmental disabilities, such as Down Syndrome, or intellectual deficits;
- Children exposed prenatally to drugs;
- Children with chronic health conditions; and
- Children with emotional or behavioral problems.

Social-Cultural Factors

These include particular cultural values or norms regarding child-rearing practices that may affect an identification of neglect. For example, in some cultures, children may be asked to care for younger siblings when it would not be acceptable to families of other cultural backgrounds to make similar requests.

Relevant Considerations:

- What are the child-rearing norms in a culture?
- How does a particular ethnic group view traditional medical care? Are traditional healers used over Western health care providers?
- What are differing cultural expectations regarding childhood?

Social-Situational Factors

These refer to family characteristics or dynamics in the community that may contribute to child neglect:

- Limited informal or formal helping networks;
- Low income neighborhoods;
- Social isolation;
- Limited employment opportunities;
- Domestic violence;
- Single-parent families with children having different fathers; and
- Lack of stability in housing arrangements, child care, etc.

Consequences of Child Neglect

Child neglect can have both short and long-term consequences for children. These may affect their intellectual, physical, social, and psychological development. Visit monitors should be aware of these consequences but should keep in mind that not every neglected child experiences them. Research indicates that certain factors, such as appropriate interventions, length of time the child has been neglected, the age of the child, and the type of neglect can affect the severity of these consequences.

Cognitive Consequences

- Language delays;
- Academic delays;
- Less prepared for learning; and
- Score lower on measures of school performance.

Physical Consequences

- Greater risk of death from accident or lack of supervision;
- Failure to thrive;
- Persistent hunger;
- Poor hygiene;
- Persistent skin rashes (impetigo, scabies, etc.);
- Excessive dental decay or gum disease;
- Malnutrition and chronic anemia;
- Ringworm, head or body lice, roach or other insect bites;
- Weight loss or inadequate weight gain;
- Chronic or persistent digestive/intestinal disorders;
- Persistent cradle cap or severe diaper rash; and
- Flattened skull shape of infants left on their backs for extended periods of time.

Social Consequences

- Juvenile delinquency in adolescents who were neglected;
- Poor peer relationships;
- Poor parent-child attachment;

- Physical aggressiveness;
- Passivity; and
- Isolation or social withdrawal.

Psychological/Emotional Consequences

- Low self-esteem;
- Poor coping skills;
- Affective disorders (Anxiety disorders, depressive disorders);
- Psychiatric symptoms;
- Poor impulse control; and
- Lacking creative initiative.

Consideration for Supervised Visits in Neglect Cases

Three important practical issues must be considered when a program accepts a neglect case for supervised vistation: risks associated with the visit, the effects of neglect during a visit, and techniques to facilitate a safe visit.

Identifying Risk Factors for Supervised Visits

Supervised visitation directors should attempt to identify a child's risk factors to determine whether court ordered services can be provided by a particular program and, if so, what types of interventions and assistance may be most appropriate during visits. In neglect cases, this should address the following: indicators of neglect from the referral source; determination of whether the neglect is recent or chronic; an understanding of the parents' perception of the neglect; any causes or barriers to adequate remediation of the neglect at the individual, family, and/or agency level; and an identification of the family's cultural understanding of neglect.

The Department of Children and Families or other child protection agencies may have conducted a formal assessment before the supervised visitation referral. If so, the program director should review this assessment before scheduling supervised visitation services. The referring agency may have employed structured assessment measures to determine risk of child neglect, such as the Childhood Level of Living Scale (CLL), the Child Well-Being Scale, the HOME Inventory, the CLEAN Checklist, and/or the Home Accident Prevention Inventory. If any of these assessment measures have been used, they should be reviewed by the supervised visitation director as part of the decision-making process in accepting or rejecting the referral as well as in determining the level of assistance that a particular family may need at visits.

If a formal risk assessment has not been conducted, programs might be able to refer the case for assessment to social service agencies with which they are affiliated. Some programs may have professional staff on-site with the skills necessary to administer formal assessments.

A traditional risk assessment for neglect cases is included in the Administrative Supplement.

Effect of Neglect Experiences on Visitation Services

Parents with a history of neglect may require assistance from visitation staff in order to have effective interaction with their child(ren) during supervised visitation services. The type of assistance or techniques required will differ depending upon the nature, severity, and duration of neglect as well as the age of the child and parental characteristics as discussed in the previous section.

Understanding how characteristics of neglectful parents may impact a visit monitor's effectiveness in observing visits is important. Table 4.2 presents some common behaviors of parents who have a history of neglecting their children and descriptions of how these behaviors impact supervised visitation.

Table 4.2
Characteristics of Neglectful Parents

Behavior/Characteristic of Parent	Impact
Poor Parenting Skills	Staff may need to provide information on the child's developmental stage and modeling of good parenting – show how to play, discipline, interact with child. Staff may have to assist parent in giving child medication or feeding young child during visit.
Lack of Education/ Intellectual Deficits	Staff may need to assist parent in filling out forms, may need to read program rules to parent.
Substance Abuse	Staff may need to screen for use of substances prior to visits.
Social Isolation	Staff may not be able to readily contact parent if family lacks phone service. Staff may have to reschedule visits due to family's lack of transportation.
Depression	Staff may have to assess impact of parent's depression upon child during visit – if weeping, child may become upset.
Problems with Social Support	Staff may have to anticipate other family members or friends coming to visits if parent relies on others for transportation. Likewise, parent may rely on unreliable friends/neighbors to get to visits.

Effective Techniques for Facilitating Visits

When facilitating visits between a neglectful parent and child(ren), a visit monitor should be prepared to employ a variety of techniques to make the visit more effective. Techniques based on an understanding of the ecological nature of child neglect are most helpful. While the role of a typical visit monitor may not include some of these suggestions, it is important to keep in mind that whether it is the case worker or the visit monitor that assists with these, the family will benefit more if they are provided.

Concrete resources: Help with housing, transportation to visits, medical care, child care, home maker aids.

Social support: Referrals to parenting groups, support groups, parent education, religious groups.

Developmental remediation: Referral to mental health services, cultural activities, parent education.

Individual interventions: Referrals to substance abuse counseling, adult education, mental health services, health care.

Family focused: Referral for home-maker, legal assistance, public assistance.

During visits with a neglectful parent, visit monitors can employ the following specific techniques:

- Help parent understand child's level of development and skills;
- Facilitate greater involvement in parent/child interactions than other types of cases;
- Ensure that a variety of toys, games or materials are available during a visit and that the parent is able to use them with the child either alone or with assistance from a monitor;
- Use sensitivity about a parent's illiteracy or other developmental conditions that may impede his/her ability to read or play board games;
- Demonstrate good parenting skills by modeling;
- Recognize that the parent may need to be "parented;"
- Provide therapeutic interventions as indicated (and appropriate to the program design);
- Use art mediums to allow both the parent and child opportunities to express feelings;
- Use positive feedback to reward parents for initiating play or communication with child;
- Use music to engage parents who become frustrated or withdrawn during visit, e.g., sing songs or play instruments with child;
- Teach stress management techniques to parents who become angry (e.g. deep breathing or visualizations); and
- Read and use the suggestions for facilitating visits in cases involving substance abuse if the parents are drug or alcohol involved. (See Chapter 7 of this manual.)

Mandatory Reporting of Child Abuse

Florida Statutes 39.201 states that any person who knows or has reasonable cause to suspect that a child is abused, abandoned, or neglected shall report it to the Florida Child Abuse Hotline. If a visit monitor suspects abuse or neglect, it must be reported by calling 1-800-96-ABUSE. Supervised visitation programs have exceptions to their confidentiality policies for child abuse and neglect. Programs also should have protocols for making hotline calls.

Case Studies & Discussion Questions

Read the case examples below and then answer the questions about the cases.

Case One: Liza Alvarez, 17, is the mother of Miguel, an 18-month-old toddler. DCF has custody of Miguel after he was found unattended in an apartment with no food except for a baby bottle containing sour milk and lying in a crib covered in feces. Liza was away for a day and a half with her boyfriend. She is drug involved and possibly developmentally delayed. She is ordered to come to supervised visitation twice a week as part of her case management plan.

Case Two: Bob and Tilly McCollum have been living in their car for three months with their three children: a six -week-old infant, a two-year-old, and a seven-year-old. The family moved from another state in hopes of starting over, but they haven't found jobs and there has not been enough money for adequate food. DCF is working with the local housing authority to find housing for the family. In the interim, the children were placed in emergency care and the parents are staying in a homeless shelter. The mother and father are scheduled to visit their children on a weekly basis for the time being.

1. How has the parents' neglect affected the children in both cases?
2. What differences in reactions to visiting their children might be observed in each family?
3. What might visitation staff assigned to monitor Liza and her son do to help facilitate her visit more effectively?
4. What staff/family feelings regarding these families' respective histories might impact the visits?
5. How might cultural differences impact services to Liza and/or the McCollums?

QUIZ

1. List categories of child neglect and give examples of each.
2. What are some ways in which the behavior/characteristics of neglectful parents may impact visitation staff?
3. Describe some common consequences of child neglect.
4. What are some of the causes of child neglect?
5. Discuss why it is difficult to come to a common definition of child neglect.
6. Describe some of the suggestions for facilitating a visit between a child who has been neglected and his parent.

CHAPTER 5

THE IMPACT OF DOMESTIC VIOLENCE ON SUPERVISED VISITATION

Introduction

Domestic violence impacts not only the adult victim but also the children living in the home. Half of all female victims of domestic violence live in households with children under the age of twelve. This exposure to domestic violence causes both short-term and long-term consequences for children. Supervised visitation services in cases of domestic violence reduce but do not eliminate the threat of harm to either the adult victim or the child witness. Research suggests that women who leave violent relationships are at a much greater risk of being murdered by their abusers than those who remain in the relationship. The typical referral to supervised visitation programs from the court in domestic violence cases occurs when the victim has left the home and obtained an Injunction for Protection Against Domestic Violence. Thus, there is an enhanced need for both security arrangements and risk identification at visitation programs.

Supervised visitation programs can assist not only victims but also the court and law enforcement in ensuring safe contact between perpetrators and their children. However, this safe contact can only occur if visit monitors fully understand the nature of domestic violence, the impact this violence has on victims and children, and the patterns of behavior commonly exhibited by perpetrators.

Overview

This chapter is designed to assist visit monitors in understanding the dynamics of domestic violence, its impact on child witnesses, as well as identifying risks and unique safety concerns in these cases.

Objectives

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

1. Cite Florida's legal definition of domestic violence;
2. Describe different types of domestic violence and give examples of each;
3. Employ guiding principles for facilitating visits involving domestic violence;
4. Identify common behaviors of perpetrators that may impact supervised visitation services;

5. Conduct a risk identification or understand the components of a risk identification in domestic violence cases; and

6. Assess the unique safety concerns in domestic violence cases.

Snapshots

- In a national survey of more than 6,000 families in the United States, half of the men who frequently assaulted their wives also frequently abused their children.
- In 17 of the 22 (77%) child deaths reviewed by the North Carolina Division of Social Services in 2000, the families involved were affected by both substance abuse and domestic violence.
- Long-term exposure to battering can result in delinquency, higher rates of substance abuse, propensity to use or tolerate violence in future relationships, and a pessimistic view of the world.
- Short-term effects of children's exposure to domestic violence can include post-traumatic stress disorder, sleep disturbances, separation anxiety, aggression, passivity, or desensitization to violent events.
- Eighty-five percent of assaults on spouses or ex-spouses are committed by men against women with an estimated 3.3 million children exposed nationally to violence by family members against their mothers or caretakers each year.
- At least 75% of children whose mothers are battered witness the violence.
- Women who leave domestic violence relationships are at a 75% greater risk of being murdered by their abusers than those who stay; one out of three women killed in the U.S. is murdered by a spouse, ex-spouse or boyfriend.
- In one study, forty-seven percent (47%) of homeless parents reported a history of domestic violence and one in four stated that a primary reason they sought shelter was domestic violence.
- It is estimated that there are 1.35 million homeless children in the US; nearly half of these are under the age of 5.

What is Domestic Violence?

According to Section 741.28, Florida Statutes, domestic violence means

...any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another family or household member.

A nonlegal definition of domestic violence is: "A pattern of assaultive and coercive behavior that may include physical, sexual, and/or psychological abuse as well as economic coercion, property destruction, and/or child abuse that occurs between partners in intimate relationships."

Although both men and women can be victims of domestic violence, the U.S. Department of Justice estimates that 85% of reported assaults on spouses or ex-spouses are committed by men against women.

More information about this topic is included in the Administrative Supplement.

Guiding Principles for Domestic Violence Cases

Guiding principles should be used by visit monitors when facilitating visits involving domestic violence:

- Recognize that children cannot be safe unless their mothers are safe. Employ safety protocols and enforce visitation rules to enhance the safety of both the mother and children during scheduled visitation services.
- Hold perpetrators of domestic violence, not their victims, accountable for the abuse. Providing effective supervised visitation services or interventions means that the batterer must be held accountable for the consequences of his behavior so that neither the victim nor the children feel that they are responsible for the abuse that has occurred. Visit monitors can accomplish this by being respectful to the abusive parent, but not condoning or excusing the violence.
- Screen for domestic violence. Screening should take place as part of the referral process, at intake, and during the provision of supervised visitation services.
- Further insure safety by developing a safety plan with the domestic violence victim. This should include a plan that addresses what the victim should do if she is stalked immediately prior to or after visits.
- Ensure that the victim is referred to a certified domestic violence center that can provide her with additional resources.

Table 5.1
Types of Domestic Violence

Physical Abuse

- Slapping
- Kicking
- Burning
- Threatening with a knife, gun, or other weapon
- Destroying loved objects or pets
- Mutilating

Sexual Abuse

- Raping
- Forcing victim to have unwanted sex
- Forcing victim to perform scenes from pornographic material
- Forcing sex in front of children or with third party
- Sexually mutilating
- Threatening to sexually abuse

Emotional Abuse

- Humiliating
- Name-calling
- Harassing
- Isolating
- Withdrawing
- Threatening to kill
- Accusing of affairs, infidelity
- Threatening children and/or pets
- Breaking household objects
- Depriving of sleep

Economic Abuse

- Lying about money
- Withholding all information about family finances
- Withholding money from victim, even for basic necessities
- Ruining the victim's credit
- Stealing the victim's money

Control Through Children

- Forcing children to spy on their parents
- Forcing children to assault their parent
- Forcing children to witness degradation of parent
- Physically assaulting children or threatening children in order to control victim
- Using children as go-betweens
- Intimidating children to reveal their living arrangements during supervised visits
- Intimidating children to reveal other parent's whereabouts during supervised visits

Understanding the Victim of Domestic Violence

It is important for visit monitors to have an understanding of common victim characteristics and behaviors in order to be able to effectively facilitate visits:

- Domestic violence victims can be found in all age ranges, in all racial/ethnic backgrounds, and in all socioeconomic, educational, occupational, and religious groups.
- Some, but not all, of domestic violence victims have been abused as children or in previous adult relationships.
- As part of their abuse experience, many victims have become isolated from friends, families, or their normal activities because of their perpetrator's controlling behavior.
- Victims of domestic violence experience traumatic effects from their experience including:
  - denial or minimization of the abuse;
  - hypervigilance/suspiciousness;
  - anxiety;
  - difficulty concentrating;
  - shame;
  - substance abuse to self-medicate;
  - low self-esteem;
  - numbing or depression;
  - anger; and
  - impaired functioning in occupational, social, and parental roles.

These emotional reactions are normal, but they may result in a visit monitor mistakenly assuming it is the victim's fault – instead of the perpetrator's fault – that visitation is ordered. Understanding that these victim reactions are common will prevent visit monitors from inaccurately assigning psychopathological labels to the victim, such as "she's crazy," "she's hysterical," etc.

Victims of domestic violence engage in a variety of strategies to escape abuse:

- Legal methods such as obtaining injunctions, requesting orders for supervised visitation/monitored exchanges, calling law enforcement, proceeding with prosecution of perpetrator, or seeking separation or divorce.
- Formal requests for help from social service agencies, religious, domestic violence shelters, or other groups, including supervised visitation programs.
- Escaping to a domestic violence shelter or relocating.
- Using various methods of self-defense.

Because of the perpetrator's undermining of the victim and the resulting decreased parenting capacity, some mothers who are in domestic violence relationships are at risk of harming or neglecting their children. Research suggests that by keeping abused mothers safe, children's safety can be increased.

Understanding the Perpetrator

Likewise, it is important for visit monitors to have an understanding of common perpetrator characteristics and behaviors.

Like victims, perpetrators of domestic violence can be found in all age, socioeconomic, occupational, and religious groups. It is a mistake to think that only certain individuals, for example, poor people or minorities, are batterers.

Perpetrators of domestic violence engage not only in physical abuse but also in the following:

- sexual abuse;
- emotional or psychological abuse;
- child abuse;
- destruction of personal property or pet abuse;
- financial control; and,
- isolation.

All of these types of abuse are an effort by the perpetrator to exhibit power and control over the victim.

- Frequently, perpetrators deny responsibility for their abusive behavior by minimizing, denying, or lying about it, blaming their partner for it, or attempting to justify their abuse.
- Although perpetrators may blame alcohol or drugs for their behavior, or even abuse alcohol to have an excuse for their behavior, they are typically abusive even when not using these substances. However, research does suggest that if a perpetrator is abusing substances, there is a higher likelihood of serious injury or death for the victim.
- Most perpetrators are not mentally ill.
- Perpetrators can also exhibit good characteristics – they are not abusive all the time, in all places, or with all individuals.
- Some, but not all, perpetrators may have been abused as children.
- Perpetrator behavior is not caused by anger management problems or stress.

Exercise
Reactions of Children to Domestic Violence*

Instructions: Explain that the group will discuss:

- The various ways that children are drawn into domestic violence.
- How children of different ages are affected by exposure to violence against their mothers.
- How these children may react to supervised visitation services.

Divide the participants into five groups of the same size. Each group will consider a different age range and/or gender of children. These are: 0-1 years, 2-4 years, 5-12 years, teen boy, and teen girl.

Ask each group to answer these questions. (Write these questions on the board.)

- How would a child of that age be exposed to or be drawn into violence toward his or her mother?
- What are the ways a child of that age would be affected by violence?
- In what ways do perpetrators use children to control the adult victim?
- How might a child of that age react to supervised visitation services?

Instruct each group to choose a recorder who will be responsible for reporting answers to the larger group. After 15 minutes, reconvene the groups to report their findings. Start by listing the answers from the 0-1 year-old group's flip chart, then proceed sequentially through the other groups. Supply answers that each group omits and elaborate on the key effects.

**Modified from group activity conducted in Emerge Program, Boston, Mass.*

Table 5.2
The Effects of Domestic Violence on Children

Age Group	Ways of Being Drawn In	Effects of Abuse	Effects on Visitation
0 - 1 Year	Seeing it Hearing it Being awakened from sleep by it Being pulled out of mother's arms by the perpetrator Having toys broken Being born prematurely Being hit while in the mother's arms Being thrown	Physical injuries Death Fright Being traumatized Sleep disturbances Eating disturbances Being colicky or sick Being nervous, jumpy, crying a lot Insecurity from being cared for by a traumatize mother Not being responsive/ cuddly	May become fearful or anxious during visitation Older infant might cling to mother and cry when separated May not experience any adverse effects
2 - 4 Years	Seeing it Hearing it Trying to stop altercation Becoming abused themselves Being used as a physical weapon against victim Being interrogated by perpetrator about victim's activities Being held hostage by perpetrator	Acting out violently Withdrawal Problems with relating to other children Delayed toileting Eating problems Being nervous, jumpy Sleep problems Insecurity Fear Depression	May exhibit fear or anxiety May cling to mother May not experience any adverse effects May regress in toilet-training after visit, experience nightmares

Table 5.2 (cont'd)
The Effects of Domestic Violence on Children

Age Group	Ways of Being Drawn In	Effects of Abuse	Effects on Visitation
5-12 Years	Seeing and hearing it Picking one parent to defend Physically intervening Calling the police Running to neighbors to help mother Being used as a spy by father against mother Being forced to participate in attack on mother Being physically or sexually abused as a way to control mother Being restricted from contact with others	Fear Insecurity, low-self esteem Withdrawal Depression Running away Early interest in alcohol or drugs School problems Becoming an over-achiever Bed-wetting Sexual activity Becoming caretaker of adults Becoming violent Developing problems to divert parents from fighting Becoming embarrassed by his/her family	May express loyalty to abusive parent May refuse to visit May cling to mother May express anger toward visiting parent Fear of visiting parent May experience sleep disturbances May cry May not experience any adverse effects May adopt facial expressions that are not congruent with their feelings (e.g. smiling when scared)
Teen Years	Killing or trying to kill Trying to stop abuse Hitting parent or sibling Becoming physically abused Being used as a spy	School problems Social problems Shame and embarrassment about his/her family Sexual activity	May be embarrassed at having to use visitation services May refuse to come to visit May act withdrawn

Table 5.2 (cont'd)
The Effects of Domestic Violence on Children

Age Group	Ways of Being Drawn In	Effects of Abuse	Effects on Visitation
Teen Years (cont.)	Being used as a confidante Being coerced by perpetrator to be abusive to mother	Tendency to get serious in relationships too early in order to escape home Truancy Running away	May try to protect their siblings and the non-offending parent by attending visitation even when they don't want to
Specific Effects on Teen Girls	Learning that male violence is normal Learning that women don't get respect Possibly accepting violence in their own relationships Embarrassed about being female Becoming pregnant	Becoming superachiever at school Depression Suicide Alcohol and/or drug abuse Confusion about gender roles Becoming violent	Anger at victim/perpetrator for making them visit May want to confront parent about abuse
Specific Effects on Teen Boys	Learning that males are violent Learning to disrespect women Using violence in his own relationships Confusion or insecurity about being a man Attacking mother, father, or siblings	Becoming a super-achiever at school Depression Suicide Alcohol and/or drug abuse Confusion about gender roles Becoming violent	Anger at victim/perpetrator for making them visit Aggressiveness toward abusive parent

Case Example & Discussion Questions

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

Jason, age seven, and his sister Sally, age 13, had not had contact with their father for two years due to an ongoing custody dispute and domestic violence investigation. Both children attended a visit with their father at the visitation center. At the end of that visit, Sally asked the on-site supervisor to escort her back into the room with her father, as she had something to tell him. The child was escorted in and she proceeded to tell her father that she did not wish to see him anymore. When her father asked why, Sally responded, "Because of all the things you did to me and mom, like that time you got in a fight with Mom and slapped me." The father began to deny the allegations being made, then looked toward the supervisor and just listened.

Jason did not take part in the conversation between his father and sister; however, he has refused four attempted visits. Immediately upon entering the center, Jason now clings to his mother and does not let go until they turn to leave. Jason is also involved in ongoing counseling due to the trauma that family went through from domestic violence. Jason stated to staff during his child intake that he was scared of his father. Jason's mother reports that since the initial visit, Jason's nightmares and bed-wetting have returned.

Discussion Questions

1. How has abuse affected each child?
2. How has the experience impacted the program?
3. How should a program intervene in this case?

Behaviors of Batterers That May Impact Visitation

If, after conducting an intake, the program director accepts a referral for visitation in a domestic violence case, it is important to identify behaviors that may subsequently impact visitation. It is critical to keep in mind that the goal of providing supervised visitation services, including monitored exchanges, is to provide a safe, neutral setting for parent-child access. ***If this cannot be accomplished, the visitation program must not accept the referral.***

The following are behaviors sometimes used by batters that may affect a program's ability to provide safe visitation:

- Threats of violence toward the victim. This may include verbal abuse as well as attempted or actual physical assault.
- Threats of violence toward children. This may include verbal abuse, threats, attempted or actual physical abuse, kidnapping.
- Using visitation to send messages to the victim through the children.
- Stalking the victim and children upon arriving or departing from visitation program. This can be done in person or through a thoird party family member or friend.
- Intimidating children to reveal their current living arrangement, their custodial parent's activities, their phone numbers.
- Testing or violating staff or volunteers.
- Intimidating visitation staff or volunteers.
- Pitting one staff member against another to encourage divisiveness.
- Requesting "special" privileges, such as unsupervised time with children.
- Denial or minimization of abusive behavior ("It's all a misunderstanding.")
- Blaming other parent for necessity of having to use visitation services.
- Attempting to bring weapons (guns, knives, etc.) into program.
- Threats or attempts to commit suicide.

Table 5.3 illustrates these behaviors and gives actual examples from supervised visitation programs.

Table 5.3
Common Behaviors of Batterers at Supervised Visitation Programs

Behavior	Manifestation at Supervised Visitation Programs
Denial of Abuse/Minimization	Children may ask parent, "Why did you hit Mommy?" Visiting parent may deny hitting child's mother, say it was an accident, or minimize his action. He may also say it is the fault of the mother that he has to see child in a visitation program. One program reported that a 12-year-old asked his father why he chased his mother with a knife. The father denied doing it, saying that the mother told him to say that. This occurred despite witnesses to the knife incident.
Blaming Partner	Batterer will tell staff, "This is all my wife's fault," or, "She's the one who brought this on."
Control/Manipulation	Batterers may question or challenge program rules or demand exceptions to rules. This is seen in examples of refusing to arrive or depart as required, bringing unauthorized individuals to visits, or tearing up rules or throwing intake forms across the room.
Attacking Parenting Skills	Batterer may attempt to manipulate staff in apparent false allegations of child abuse against a victim parent, or try to use staff to call the Abuse Registry. Batterer may also make disparaging remarks to the child about her mother: "You need to clean up better than Mommy. She's a slob."
Making Covert/Overt Threats	Batterers showing a weapons permit when asked for identification, driving around the visitation program at the time of the scheduled visits but not coming into program, or verbally threatening staff, volunteers, judges, and others during visits.
Involving Children	During scheduled visitations, batterers may attempt to question children about their current living arrangements (particularly if they are staying at a shelter or another undisclosed location) or inquire about their plans, where they are attending school, etc. They may try to find out whom the child's mother is dating. Additionally, batterers may utilize visitation times as a vehicle to have children convey messages to the other parent.

Table 5.3 (cont'd)
Common Behaviors of Batterers at Supervised Visitation Programs

Behavior	Manifestation at Supervised Visitation Programs
Stalking (in person or through a third party)	Batterers may follow the parent who is leaving a program and record the license number of her car. One program reported two examples of cases when the perpetrator had custody. In one case he left with the child but waited for his wife in a nearby parking lot. In another, a non-custodial mother picked up her child for a monitored exchange and was followed to a neighboring city by her abuser. Perpetrators may reveal stalking incidents during conversation with children during visit. Questions such as "Where were you last night?" or "Why weren't you in school yesterday?" are common.
Financial Abuse/Manipulation	Batterers may refuse to pay for scheduled visits; others say, "I am not going to pay to see my kids," or pay in pennies or other small coins.
Animal Abuse	A batterer may inform his child during a visit that a beloved pet has died or had to be given away because the child was no longer in the home. One program reported a father bringing the child's pet rabbit to the program, knowing the child would not be able to take it back to the shelter where he was staying.
Physical Violence	At least three murders have occurred on-site or in parking lots of supervised visitation programs in recent years. Other programs report murders or physical assaults by non-custodial parents off-site but while family was utilizing services.
Child Abduction	Batterers may try to abduct children during visitation, or may try to abduct them offsite if the child's home address, school, or other location is revealed during a visit.

The Victim as Visitor

When the perpetrator of domestic violence is granted primary residency of the children, the policies for supervised visitation must be altered to account for the risks to the victim at visits.

There are several ways in which a perpetrator may gain primary residency of his children:

- The batterer may have won a "race to the courthouse" in which he obtained an Injunction for Protection Against Domestic Violence against the victim before she filed for an injunction herself.
- He may have alleged that the victim was falsely accusing him of violence and wrongly withholding the children from him. If she flees to stay in a shelter, he will accuse her of denying him access.
- He may have many more resources than the victim, and has used these resources in a protracted court battle with repetitive motions and petitions against the victim.
- If the victim flees to a domestic violence center without the children, the batterer will accuse her of abandoning the children.
- He may have admitted substance abuse, minimized his violence by blaming the substance abuse, and claimed that both parties were violent. He may even agree to counseling for his substance abuse to improve how the court perceives him.
- He may have witnesses who will testify that the victim is hysterical, out of control, and mentally ill. Remember that victims who are subjected to violence may seem unstable because of the long-term trauma they have been subjected to. This is especially true when the batterer appears very calm, in control, and quite personable.
- He may have evidence of the victim's substance abuse, which she has used to cope with the violence. A victim's substance abuse usually severely discredits her in custody litigation.

Below is a list of several policies that should be reviewed in light of the relative risks to the parties when the victim is the visitor. An individual safety plan should be created for each case.

Program Policy	**Changes made to account for violence**
Entrances/Arrivals	Programs should consider altering their policies so that the batterer custodian arrives first with the child. This may minimize opportunities to stalk the victim. In addition, the program should be flexible in its arrival policies. Some victims may wish to wait at a nearby location until the batterer is on-site. Others may not want to leave a domestic violence center until they know that the batterer has arrived at the supervised visitation program.
Referrals	Programs should have a relationship with, and be able to make referrals to, local agencies that can provide the victim with an array of needed services, such as domestic violence advocacy, child counseling, housing assistance, Medicaid and health services, job placement, and legal aid.

Conversation Limitations	The victim should be advised of risks in discussing her location information with the child during visits. The child should not be made an unwitting pawn of the batterer, who wants to find out where the victim is residing.
Facilitation Assistance	Children whose custodial parents are batterers may be alienated from their victim parent by the batterer. Visiting parents who are victims may need additional support at visits to re-connect with these children.
Exit Policies	Programs should consider allowing victims to leave the program first so that the batterer cannot follow and stalk the victim.

If a supervised visitation program is receiving a large percentage of cases in which the perpetrator of domestic violence has gained custody of the children, this issue should be addressed by the local domestic violence coordinating agency.

Case Example

Instructions: Ask participants to read this case example and then discuss safety concerns presented by the case.

In the Flowers case, Mrs. Flowers has accused Mr. Flowers of domestic violence. However, Mr. Flowers gained custody of their daughter after alleging that Mrs. Flowers was an alcoholic. After the first visit, Mr. Flowers returned to pick up his daughter. Mrs. Flowers was instructed to wait 10 minutes before she was allowed to leave the program. When she walked to her car, Mrs. Flowers discovered a note that Mr. Flowers had left her. She returned to the program and told staff that she was scared and that Mr. Flowers was stalking her "again."

Mrs. Flowers was told that if Mr. Flowers was anywhere in sight when she left the center, she should either return to the center (where there was a police officer) or drive directly to the police station. She walked out, and then returned immediately, stating that Mr. Flowers was sitting at the gas station next door. The police officer and the program coordinator went outside to walk to the gas station. When Mr. Flowers saw them, he got into his car and left. The police officer then took Mrs. Flowers to her car and followed her for several blocks. Once the police officer turned the corner and Mrs. Flowers went straight ahead, Mr. Flowers turned onto the same roadway and tried to pull up beside her. Mrs. Flowers quickly changed lanes, pulled into a mall parking lot, and called the center on her cell phone. Mrs. Flowers was instructed to drive to a nearby police station, where the program coordinator met with her.

Safety planning was discussed and the possibility of filing a police report was addressed. Mrs. Flowers decided not to make a police report, for fear of further retaliation by Mr. Flowers. Part of the safety planning included mapping out several different ways for Mrs. Flowers to leave the visitation center and changing her path to keep Mr. Flowers from being able to predict where she was after leaving the visitation center.

Homelessness and Domestic Violence

Women who are financially dependent upon their violent partners often face an untenable choice: to remain in dangerous situations or become homeless. This choice is undeniably more difficult for women with children because they are making decisions with consideration for their children's safety and well-being as well as their own.

Homelessness has many detrimental effects on both children and adults, and these can be exacerbated by the domestic violence such families experience. Visit monitors can develop skills in detecting the possibility that families are experiencing homelessness in cases where the family does not readily disclose this fact during the intake process. Supervised visitation staff need to be aware of local resources available to such families and by taking proactive steps to foster collaborative relationships, can ensure that referral mechanisms are readily available for these families.

Detrimental effects of homelessness on women:

- Post Traumatic Stress Syndrome
- Deteriorated Social Bonds
- High Pregnancy Rates
- Rape, Physical and Sexual Abuse, Robbery
- Antisocial Personality Disorders
- Physical Illness

Detrimental effects of homelessness on children:

- Low Birth Weight and High Infant Mortality Rates
- Anemia
- Malnutrition and Undernutrition
- Skin disorders
- Pulmonary diseases
- Upper respiratory and ear infections
- Lice infestatations
- Gastrointestinal problems
- High blood concentrations of lead
- Physical and developmental delays
- Teens: HIV, substance use
- Depression, anxiety

Chapter 11 includes practice skills to help heighten visit monitors' awareness of homelessness at visitation.

Reducing Risk and Enhancing Safety

The point at which visitation services are ordered is often the period of greatest risk to the victim and children. Research indicates that victims leaving violent relationships face the greatest risk of death or serious injury in the period following separation. To enhance victims' and children's safety, programs should structure services in the following ways:

- Providing well-designed security arrangements on site. This may include a formal policy for using on-site law enforcement officers, panic buttons to alert local law enforcement to problems, and other tools that staff are thoroughly trained in using, such as weapon detectors;
- Having a safety plan in place for each family. This plan includes initial and ongoing identification of the risks to each member of the family;
- Ensuring that perpetrators and victims do not come in contact with each other during visitation or monitored exchanges;
- Arranging for separate arrival and departure times for victims and perpetrators;
- Intervening in the visit if perpetrator denies, minimizes, or blames his or her partner for violence;
- Reporting to the referring court any incident which affects the safety of program participants or staff; and
- Requiring victims to bring a copy of their injunctions for protection for program records.

Red Flag Security Issues

At any time during provision of supervised visitation services, it may be necessary to reassess the danger presented to victims, children, staff, and even the batterer.

Below is a list of "red flag" security issues. If the batterer engages in any of the following behaviors while utilizing visitation services, a decision should be made to terminate services and to notify the court immediately.

- Waiting in a car or outside facility for victim and children to arrive.
- Attempts to follow victim and/or children when visit is over.
- Any verbal or physical threat to harm victim.
- Any verbal or physical threat to harm children.
- Any threat to harm staff.
- Attempts to force children to reveal their whereabouts, the mother's activities, etc.
- Any effort to bring weapons to the program.

Risk Identification for Domestic Violence Referrals

Before the first visit or monitored exchange, supervised visitation providers should make a routine effort to identify risk factors in cases in which an Injunction for Protection Against Domestic Violence has been granted. This risk identification is critical for the following reasons:

- To ensure that staff are aware of the level of risk presented by the referral;
- To ensure that staff/volunteers have adequate training and sufficient skill to address the issues present in the referral;
- To assess a need for additional security or modifications in existing security arrangements during scheduled visitations or exchanges; and,
- To justify the decline or refusal of a referral because of risk factors.

When should a risk identification be conducted?

A risk identification should be conducted by a program director or other designated staff whenever a case is referred by the court in which an Injunction for Protection Against Domestic Violence has been granted. Such an identification should also be completed in family law cases in which the judge orders supervised visitation because of prior history of domestic violence. Further risk screening should be an on-going process as long as services are being provided. Risks in individual domestic violence cases may increase, decrease, or stay the same after the case has been referred to supervised visitation. Staff should not assume that the risk decreases simply because the court has ordered supervised visitation.

How should a risk identification be completed?

Program staff should conduct a risk identification by completing the following tasks:

1. Require both parties or their attorneys to produce all relevant court, law enforcement or related records, such as orders for protection, law enforcement reports, custody orders, violations of protection orders, etc. This is the responsibility of the parties. It should not be the responsibility of the program's staff to copy this material from court files.
2. If the adult victim or alleged adult victim is staying in a domestic violence shelter, obtain a release of information form from the victim and discuss any safety concerns shelter personnel may be aware of. Staff may also want to participate with shelter staff in the development of a safety plan relative to the victim and children. For example, discuss safety concerns relative to the victim's transportation to and from the visitation program. Be aware of the limits of confidentiality in these discussions; alerting the victim to the fact that the information she provides to supervised visitation staff may be subpoenaed at some point during the litigation.
3. Interview both parties, reminding them of the limits of the program's confidentiality policies, and conduct a risk identification using the assessment presented in this chapter. Be alert to denial and minimization of abuse.
4. Determine whether to accept or decline the referral, notify security, or assign particular staff with expertise in domestic violence issues to the case.

Risk Identification

Table 5.4 identifies factors that show a strong association for increased violence or even lethality to occur. This can be used by program directors or other designated program staff after reviewing court documents, background information, and intake notes.

Note: Program directors should be aware of these risk factors to ensure the safest visitation possible. Factors indicated by asterisks (**) indicate a heightened risk of harm. If these risk factors are present, program directors should re-assess the program's existing security arrangements and the training and expertise of staff and either make appropriate accommodations or decline the referral. Appropriate accomodation might mean the case is assigned to a staff member with domestic violence or other expertise and that the visit is scheduled at a time when the program has security personnel on site.

Table 5.4
Risk Identification for Domestic Violence Victims

	Present in this Case	Not Present	Unknown
1. In the past twelve months, there has been an increase in the level of physical or other types of violence.			
2. The victim/alleged victim has been choked or her partner has attempted to strangle her.**			
3. Abusive or allegedly abusive partner has recently acquired guns or knives.			
4. Abusive or allegedly abusive partner has become more threatening with guns or knives which he previously possessed.			
5. Batterer has stalked or attempted to use other surveillance tactics to monitor partner in the past thirty days.			
6. Batterer has threatened to kill himself in the past thirty days.**			
7. Batterer has threatened to kill victim in past thirty days.**			
8. Batterer has threatened to kill children in past thirty days.**			
9. Batterer has criminal charges pending.			
10. Batterer has violated victim's order for protection.**			
11. Batterer has failed to appear for final hearing or order for protection.**			

Table 5.4 (cont'd)
Risk Identification for Domestic Violence Victims

	Present in this Case	Not Present	Unknown
12. Batterer has threatened to harm or has harmed family pets.			
13. Batterer has mental health conditions which increases violence.			
14. Batterer has destroyed mother's or child's personal property (clothing, furniture, personal belongings or car) in past thirty days.			
15. Batterer has threatened other family members or neighbors.			
16. Victim has filed for divorce and/or requested custody of children.			
17. Victim is pursuing criminal charges against the batterer.			
18. Batterer has tried to stop victim from seeking help from law enforcement, domestic violence shelter, supervised visitation program, court, or other agencies.			
19. Batterer has locked victim in the home or otherwise imprisoned her against her will in the past thirty days.**			
20. Victim is currently in domestic violence shelter or has made other efforts to leave batterer.			
21. Batterer has told victim he cannot or will not live without her and their children.**			
Please note that an absence of these factors does not mean that danger is not present for the victim.			

QUIZ

1. Define “domestic violence.”
2. Give examples of different types of domestic violence.
3. How are children of different ages affected by domestic violence?
4. How might the behaviors of perpetrators impact upon visitation services?
5. How might children’s experiences witnessing domestic violence impact visitation services?
6. Identify some red flag security issues when providing services to families experiencing domestic violence.
7. What can providers do to reduce risk of a violent incident and enhance the safety of visitation participants and staff?
8. How might a perpetrator of domestic violence obtain custody of the children? What strategies might a program employ in dealing with a custodial parent who is the batterer?

CHAPTER 6

THE IMPACT OF DIVORCE & SEPARATION ON SUPERVISED VISITATION

Introduction

Courts sometimes order supervised visitation in cases in which the parents are separating or divorcing, but it is not the separation or divorce itself that causes the need for supervision. Instead, it is an allegation or evidence that the contact between one parent and the child needs to be supervised because of a parent's misconduct, illegal behavior, or some other issue that interferes with his or her ability to raise a child. Parental behavior – or alleged behavior – that may result in supervised visitation in separation and divorce cases includes, but is not limited to the following: parental substance abuse, child abuse or neglect, domestic violence, long-term parental absence, parental sabotage of the other parent's relationship with the child, parental mental illness or disability, and chronic conflicts over the children and custody/visitation arrangements that threaten the best interest of the children.

The underlying reason for the court referral to supervised visitation creates *additional* trauma for the family, but it is crucial to remember that divorce and separation *alone* can cause trauma to both parents and children. The impact of divorce and separation on a child can be significant, affecting a child's psychological, social, and behavioral development.

Overview

This chapter provides an overview of the losses that children suffer when their parents separate and/or divorce, and presents visitation staff with common responses to divorce/separation that children may exhibit during visits. Research on children's and parents' adjustment to divorce is also presented in this chapter, along with a summary of Florida's laws governing parental responsibility. Finally, information is provided to assist visitation staff in preventing further trauma to the child during visits by identifying, deterring, and intervening in parental behavior that can be harmful to the child's physical or emotional well being.

Objectives

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

1. Discuss the prevalence of divorce in the U.S.;
2. Describe the impact of divorce on children;
3. Discuss the needs of children at the six major developmental stages of childhood;

4. Understand how divorce/separation may affect children's behavior at visits;
5. Describe the impact of divorce on adults;
6. Describe Florida's law relating to divorce and custody and explain how judicial decisions on parental responsibility can impact visitation; and
7. Identify strategies to facilitate visits between a child and parent in divorce/separation cases.

Snapshots

- In the U.S. approximately 51% of marriages end in divorce.
- In the U.S. approximately 45% of children witnessed their parents go through a divorce.
- Eighty-eight percent of divorcing spouses with children agree on custody arrangements without a ruling from the court.
- About 27% to 50% of all children will spend some or all of their time in a single parent household before the age of 18.
- Mothers serve as the primary residential parent in an estimated 86% of custody cases.
- In 2005, 59% of single women with children under 6-years-old were living in poverty.
- In 1999 there were approximately 300,960 children in the U.S. abducted by a parent.

The Impact of Separation & Divorce on Children

Children's lives are affected when their parents separate or divorce. According to researchers, children with divorced parents, as a group, fare more poorly than children with continuously married parents. Children of divorce and separation often have the following characteristics:

- Lower scholastic success;
- Poorer classroom behavior;
- More emotional and behavior problems;
- Lower self-esteem; and
- Problems with interpersonal relationships.

Studies suggest that divorce exacerbates behavioral problems in boys, because they are already more prone to behavior problems than girls. Girls, however, also experience a significant impact from their parents' divorce.

What Children Lose

The psychological, environmental, and social impact of divorce on children is fraught with change and loss. By the time children arrive at a visitation center, they have had to face many if not all of the following changes because of the divorce or separation:

- Loss of the family as they have known it;
- Loss of one parent from the household, and distinct changes in the amount of time spent with both parents;
- Loss of familiar routine at home and school;
- Loss of financial resources, which may include poverty in many cases;
- Loss of the attention and emotional support of one or both parents if they are so engaged with their own conflicts that they are not available to the child in the same way; and/or
- Loss of their home, their neighborhood and sometimes their school if the custodial parent relocates. This includes loss of friends, who become more important to children as they become adolescents.

Case Example & Discussion Questions

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

Joshua Miller, age six, is visiting with his father for the first time at the Sunshine Visitation Center. When he walks into the lobby with his mother, he clings to her and whines. He cries briefly when she leaves. The visit monitor takes his hand and leads him in to the visit room, decorated with bright murals and filled with toys. Joshua smiles when he sees his father, and runs to him. Then he shouts, "Daddy, I want to go home right now, and I want you to come with me." He stamps his feet and starts to cry.

Discussion Questions:

1. What emotions is Joshua experiencing?
2. How might his father respond?
3. What might a visit monitor do to help facilitate this visit?

Grieving the Loss of the Intact Family

The grief that children and parents feel over separation and divorce is a process, not a time-limited event. Dr. Elisabeth Kubler-Ross, a Swiss psychiatrist, identified five stages in the grieving process. The stages are not necessarily sequential or linear, but are highly individual. People may move through the stages of denial, anger, bargaining, depression, and acceptance in any order, or may skip one stage and repeat others. In Table 6.1, the five stages are described.

Table 6.1
The Stages of Grief

Stage	Thought/Realization	Feeling/Attitude
Denial	"No, it's not true."	"This isn't happening to me."
Anger	"This should not be happening to me."	"Why is this happening to me."
Bargaining	"Maybe I can change things if I do better."	Hope, striving, turmoil
Depression	"I do not know how to go on."	Sadness, depression, shame
Acceptance	"I can go on."	Life is still worth living.

Developmental Needs of Children & Responses to Separation or Divorce

Children have different needs at different stages of development. Children's overarching needs during the respective stages of development are the following:

Infancy – To learn basic trust.

Toddlers – To explore the environment, build up self-confidence, develop symbols, and socialize.

Preschoolers – To develop self-sufficiency and mastery, to become socialized, to explore the environment.

Middle childhood – To develop emotionally, develop concrete operational thought, become more independent, develop self-worth, and associate with friends.

Early Adolescents – To accept one's physical self, attain mature relationships, attain emotional independence from caregivers, and attain socially desirable behavior.

Late Adolescents – To achieve emotional independence from caregivers, prepare for an economic career, prepare for significant intimate relationships, achieve masculine or feminine sex roles.

Table 6.2 lists children's specific needs and their responses to separation or divorce. Behavior observed during visits is also described.

Table 6.2
Developmental Needs of Children & Responses to Separation or Divorce

Needs	Responses to Separation or Divorce	Behavior that may be Observed During Visits
Infants Connection and attachment to caregiver Safe environment Consistent eating and sleeping pattern Frequent time with parents, length of time can be shorter	If child is less than 6 months, divorce will most likely not affect the child if his/her needs are still met Infants over 6 months, may experience separation anxiety if they have formed a secure attachment with their caregivers and may fear abandonment	Developmentally appropriate behavior Becomes upset easily Ill-tempered Cries easily Demonstrates insecure attachment Emotionally withdrawn or shy
Toddler (1-3 years old) A safe environment for exploration Parent attentive to needs Verbal explanations appropriate for age Caregiver reassurance A patient caregiver Consistent daily routine	Toddler may fear separation Toddler may fear abandonment	Becomes upset easily/ ill-tempered Cries/whines Physically hangs onto parent Emotionally withdrawn Throws temper tantrums Shows aggressive behavior (hitting biting, kicking, etc.)
Preschoolers (3-5 years old) Protective parent Freedom to explore Defined roles for parent Contact with same-sex parent Reassurance of love and support Contact with other children for socialization and play To show autonomy and mastery	Blames self for parents' problems Feels guilty or ashamed Fears punishment/rejection Feels frightened or confused Feels jealous Has fantasies of parental reconciliation May regress to an earlier age	Has difficulty expressing feelings Acts younger than true age May have toileting accidents Fights with siblings

Table 6.2 (cont'd)
Developmental Needs of Children & Responses to Separation or Divorce

Needs	Responses to Separation or Divorce	Behavior that may be Observed During Visits
School-age (5-11 years old) To be shielded from parental conflict and negativity To be talked with and listened to Contact with both parents To be involved at school Parents to be involved at school Support from friends Develop a sense of competence	Feelings of sadness/anxiety Feelings of fear/guilt Feelings of shame/low-self esteem Has fantasies of parental reconciliation Experiences loyalty conflicts Believes parents are all good or all bad Feelings of anger	Unable to express feelings Gets frustrated Shows hostility towards others Acts younger than true age Acts older than true age
Adolescents (12-18 years old) Parents to be emotionally stable Low levels of parental conflict Parents to act mature Parental supervision Quality time with both parents To be treated as an individual To achieve emotional independence from caregivers and other adults To prepare for economic independence	Feelings of sadness/depression Feelings of anger/disappointment Feelings of self-doubt Lacks high self-esteem Shows parental behavior Emotionally unbalanced Partakes in sexual behavior prematurely May feel relieved parents are divorced	Insincere disconnection/apathy Expresses sadness, anger, shame, disgust Questions family relationships Pulls away from family

Children's Adjustment to Divorce

The following factors determine how well children adjust to divorce:

- How well parents are able to handle conflict is strongly associated with children's adjustment to the divorce.
- Children's adjustment is also strongly related to the amount and intensity of parental conflict before the divorce, with children who have witnessed high parental conflict faring worse.
- Divorce proceedings that extend over a long period of time add to children's poor adjustment to divorce.
- Parental depression and financial difficulties also lead to poor adjustment to divorce in children.
- Children that have good relationships with their parents adjust better to divorce than those that have conflicted relationships with their parents.

Parents' Adjustment to Divorce

Recent research has suggested that the following factors determine how well parents adjust to divorce:

- Parents who communicate to discuss their children, make decisions in the best interests of the children, and who are supportive of one another fare better than those who do not.
- Parents who adjust well to divorce understand they have to reconstruct their parental roles and do so in a proactive way.
- The parent who initiates the divorce usually adjusts better to the divorce because of the psychological sense of control over the situation.
- The parent who did not initiate the divorce tends to feel victimized.
- The more drawn out and conflicted the divorce proceedings the worse the parent's adjustment.

Chronic Parental Conflict

Researchers consistently note that the vast majority of couples divorce and come to agreements on custody and visitation ***without*** a court order. However, over 10% of divorcing couples have chronic post-separation conflict, helping make family court cases the largest and fastest growing segment of state civil court caseloads. There is considerable consensus that these cases, which consist of on-going litigation concerning the custody and care of the children, actually cause *serious harm* to the children involved. Supervised visitation programs receive referrals in these cases, and staff should understand their dynamics. These cases may include:

- Parents who initiate frequent court hearings on the subject of custody;
- Parents who consistently make the child unavailable to each other for visits;
- Parents who chronically and wrongfully accuse each other of misbehavior;

- Parents who threaten other members of the family with physical violence;
- Parents who consistently refuse to work together to decide educational and medical issues regarding their child; and/or
- Parents purposely try to turn a child against the other parent, to sabotage the child's relationship with that parent. This sabotage might include the following behavior, which can look like a parental tug-of-war:
  - A parent promising the child rewards to turn against the other parent;
  - A parent repeatedly calling the other parent names, or speaking critically of him or her in the presence of the child;
  - A parent threatening the child with loss of love or support unless child rejects the other parent; and
  - A parent threatening the child physically or emotionally to reject the other parent.

Cautions Regarding Parental Conflict

Although visitation staff may see case referrals which involve post-separation conflict, it is essential for them to do the following:

Differentiate Domestic Violence: It is crucial for staff to understand that parental conflict is different from domestic violence and post-separation violence, which is common in domestic violence cases. Domestic violence, as explained in Chapter 5 is about the power and control of the batterer. A victim of domestic violence should not be blamed for returning to court and litigating to protect herself and her children if she is stalked or fears for her safety. In addition, if a victim moves out of the home into shelter because she fears for her safety, she should not be accused of intentionally making the children unavailable.

Avoid the term "Parental Alienation": While a parent may accuse the other of sabotaging the child's relationship with that parent, staff should avoid the label of Parental Alienation Syndrome, which was coined and used by Dr. Richard Gardner. Such a "syndrome" has never been recognized by the Diagnostic and Statistical Manual of the American Psychological Association, and has been discredited by many scholars.

Avoid assuming mutual blame: Although there are some couples who engage equally in prolonged and mutual contests using the children as pawns, it is far too easy for staff to assume that both parents are always to blame for the continued litigation Staff should recognize that in some cases – especially in domestic violence and child sexual abuse cases – the non-offending parent appears to be the one who is causing the conflict simply by raising the issue. A thorough understanding of the dynamics of these crimes is essential for all supervised visitation staff, who should remember that there are *far more unreported cases* of these crimes than there are reported cases of them.

Visit monitors must focus on the parent's behavior toward the child and intervene when that behavior is harming the child.

Avoid Diagnosing: Most supervised visitation staff in Florida are *not* mental health professionals and should not assume that they can accurately determine whether allegations are true or false. Supervised visitation

referrals contain only partial descriptions of family dynamics; thus, staff have only one piece of the puzzle of families in crisis.

Prohibit Damaging Behavior: Even though they should not diagnosis a family, visit monitors ***should*** intervene when a parent's behavior is harmful or potentially harmful to the child's physical or emotional well being. This mandate to intervene can arise from the many situations, including the following:

- Parent criticizes or blames other parent to child during visit;
- Parent criticizes or blames other parent to staff in child's presence during visit;
- Parent scolds child for "behaving just like" other parent;
- Parent discusses particulars of court case to child or in child's presence;
- Parent quizzes child about other parent;
- Parent uses corporal punishment;
- Parent threatens the child with physical or emotional harm;
- Parent repeatedly tells the child how he should feel about other parent;
- Parent looks to child for the emotional support, resulting in role reversal, where the child begins to "parent" the adult at visits;
- Parent tests the child's loyalty ("If you say you'll live with me, I'll promise to always love you"); and,
- Parent promises the child things that can't be delivered ("I will be home next week, and we will all be together.")

Understanding Florida Law

Prior to divorce, both parents have equal rights of custody, care, and control of children. Upon divorce – called dissolution of marriage – Florida gives preference to the continuing contact between both parents and their children as "shared parental responsibility." Chapter 61 of the Florida Statutes deals with children's issues after separation and divorce. Supervised Visitation staff should know, at minimum, the following:

Shared parental responsibility describes the preferred parenting arrangement between a child and his/her parents. There are two components of shared parental responsibility:

1. ***Decision-making*****:** In this arrangement, both parents have the same legal rights to make major decisions regarding the child's care, such as those involving education, health, etc. However, the court may grant one parent ultimate authority to make decisions for one aspect of the child's life or when the two parents cannot agree. This is called sole parental responsibility.
2. ***Residential Responsibility*****:** In this arrangement, there may be a parent with whom the child primarily resides. Although the Florida Statutes use the term *residential* and *non-residential responsibility*, the terms custody, custodial and *non-custodial* are also often used throughout the state. This is the case even

though the Florida legislature expressly states that the word "custody" is not appropriate because it denotes control.

Courts award parental responsibility according to the best interest of the child, regardless of the age or sex of the child.

a. The other parent may have secondary residential parenting (and is sometimes called the non-residential parent). He or she is the parent with whom the child resides when not with the primary residential parent.

b. Visitation is used to describe contact, access, and timesharing with children.

Sole Parental Responsibility. The courts prefer that both parents be involved in the life of a child, if possible. In supervised visitation referrals, however, one parent may have ***sole*** parental responsibility for the major decisions that affect the child. Sole parental responsibility is awarded regarding issues such as educational, medical and religious decisions only in cases in which the involvement of the other parent would be detrimental to the child.

It is incumbent upon the supervised visitation program to determine the legal status of both parents prior to the first visit, because the court's decisions regarding parental responsibility impact visitation. There are several possible combinations of court-ordered parental responsibility explored in Table 6.3.

Table 6.3
Impact of Parental Responsibility on Visitation

Parental Responsibility	Example of Impact at Visitation
Visiting parent has shared parental responsibility	If child gets a headache during a visit, the visiting parent can advise staff to give the child appropriate medicine. Both parents separately may be consulted regarding the comfort and needs of the child during visits.
Residential parent has sole parental responsibility over all issues.	Visiting parent has no right to attend program's child intake session with the child. Visiting parent has no right to make decisions about the child that contradict the parent who has sole parental responsibility.
Visiting parent has shared parental responsibility over some issues, but the residential parent has sole parental responsibility over one or two issues.	If the child has a disability, the parent with sole parental responsibility over health decisions is the only one who can be consulted regarding the child's disability. The other parent cannot bring alternate medical equipment to the visit to use with the child. If one parent has sole parental responsibility over religious decisions, the other parent is not allowed to bring alternate religious material to the child during the visit.

How the Courts Determine Parental Responsibility

According to Florida Statute §61.13(3), there are a number of factors the court may weigh in making its determination for shared responsibility. Evaluation of these factors allows the court to determine what is in the best interest of the child. The court will consider:

- Frequent and continuing contact, because
  - It is Florida's public policy to maintain continuing contact between the child(ren) and both parents and to have both parents share parental responsibilities,
  - The primary residential parent has a duty to encourage the relationship between the child and the nonresidential parent;
- Emotional ties between child and parents;
- Capacity and disposition to provide food, clothing, and medical care;
- Mental and physical health and moral fitness of parents;
- Child's physical, mental and educational status;
- Length of time the child has lived in a stable, satisfactory environment;
- Permanence of existing or proposed custodial home;
- Preference of child, if the court determines the child is old enough and sufficiently able to express an opinion based on understanding and experience;
- Evidence of domestic violence or child abuse in the home;
- Evidence that either parent has provided false information in a domestic violence proceeding; and,
- Any other relevant factor.

Evidence of domestic violence and child abuse is considered evidence of detriment to the child. Whether or not there is a conviction of any offense of domestic violence or child abuse or the existence of an injunction for protection against domestic violence, the court can send cases to supervised visitation to protect the child or victim.

More information about this topic is included in the Administrative Supplement.

Restrictions on Visitation

A court may restrict or deny visitation when it is necessary to protect the child(ren). Child abuse and domestic violence are considered in determining shared parental responsibility and/or visitation. Even if the parent's rights are limited by the court, the parent may still be responsible for financially supporting the child.

Staff should check the court records to determine what judicial decisions were made regarding parental responsibility in each case. Additionally, a thorough and on-going assessment should be conducted to determine what other information is necessary to keep the children safe.

Facilitation Strategies in Divorce/Separation Cases

There are many ways for visit monitors to facilitate visits in divorce/separation cases. Below are suggestions to assist in facilitating visits:

1. Review the case file to attempt to determine the depth of the relationship between the visiting parent and the child. For example, if there has been long term parental absence, staff should be on notice that a great deal of modeling and assistance may be necessary for at least the first few visits while the parent and child develop a stronger bond.

2. Remember that the child may be very aware of each parent's hostile feelings toward the other and may feel that each parent must be defended. Thus, staff must remain respectful to both parents.

3. If one of the parents has attempted to sabotage the child's relationship with the other parent, the child may be openly antagonistic, disrespectful, or angry with the parent who has been criticized. Staff should be prepared to model respectful behavior toward the parent. At a minimum, staff should insist on calling the parents Mr. or Mrs. or Ms. in the presence of the child to show respect. Consider also using praise generously toward the criticized parent so that the child sees that staff hold the parent in high regard, despite the words and actions of the other parent.

4. Ask the custodial parent if a young child has a special comforting toy or blanket (or pacifier) that might make him/her feel more secure during the visit. Be sure that the child does not leave the toy at the program when he/she leaves.

5. Inform both parents at intake that visits are not to be used to speak critically of the other parent. The most important strategies are those used at intake to *prevent* damaging behavior at visits. If a parent needs to be reminded of the requirement for respect and appropriate references to the other parent, staff should consider more than redirection: an additional intake "refresher course" may be necessary.

6. Remember that the child has been in a great deal of transition during the separation/divorce. Younger children may feel more comfortable having the same visit room and the same toys for the first few visits. If the program rotates visit rooms, be sure to allow the child to see all the "special" elements of the new room.

7. If possible, have some idea of a parent's literacy level before suggesting books the parent and child can read together.

8. Offer at least two activities at the beginning of the visit so that the parent and child can choose an activity together. This helps make the parent and child a "team."

9. If a parent is angry or frustrated with the child's misbehavior, suggest ways to calm down as alternatives to hitting or yelling. For example, suggest that the parent may want to count to ten, or assist the parent in redirecting the child's attention.

10. When parents have multiple, active children visiting at one time, the program may need to have more than one monitor to assist with the children (especially for toileting). However, the parent should be encouraged to plan the visit ahead of time to include as many of the children as possible in activities.

11. If new spouses/partners are part of the visit, the program should conduct intake with these persons also, to determine whether a relationship already exists with the child.

12. If a visit ends in mid-activity (e.g., if a game is not yet finished), make a note about this in the file and ask the parent and child at the beginning of the next visit if they want to continue that same activity or move on to another one.

Case Example & Discussion Questions

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

Carol and Deborah Phillips were married for eight years and have two children, Brittany, age five and Mark, age seven. Mrs. Phillips filed for divorce two years ago, after discovering Mr. Phillip's infidelity, and requested primary residency of the two children. Mr. Phillips alleged that Deborah was an alcoholic and not suitable for primary residency. The divorce was granted last month, after extensive pleadings over issues including Mr. Phillip's alleged substance abuse, watching pornography in the presence of the children, and his refusal to return the children to Mrs. Phillip's apartment on time. The court found evidence that Mrs. Phillips denied Mr. Phillips visitation by scheduling events during his parenting time, making up false excuses such as automobile problems, and claiming that the children were sick. Over two years, the parties scheduled nine court hearings for temporary relief, emergency relief, and clarification of court orders, modifications, and contempt of court. The court ordered supervised visitation "to ensure that Mr. Phillips could maintain contact with his children until a court-ordered therapist recommended non-supervised visits." During the first visit, Brittany told the monitor "Mom says we don't have to visit Dad if we don't want to." Mark asked Mr. Phillips why he "keeps bothering us and making us come here." Mr. Phillips answered, "Don't listen to that b*&%#."

Discussion Questions:

1. What steps might the program director take *before visits begin* to lessen hostility during visits?
2. How should staff re-direct Mr. Phillips or his children?
3. Should staff say anything to Mrs. Phillips regarding the children's remarks?

QUIZ

1. Name four losses that a child may experience when his parents divorce.
2. List five factors that help determine how well a child adjusts to her parents' divorce or separation.
3. Define shared parental responsibility.
4. Name two issues that a parent might have sole parental responsibility over if the court finds shared parental responsibility to be a detriment to the child.
5. List six examples of behavior that should be prohibited at visits.

CHAPTER 7

THE IMPACT OF PARENTAL SUBSTANCE ABUSE ON SUPERVISED VISITATION

Introduction

Substance abuse accounts for a significant number of referrals to supervised visitation programs. Substance abuse may involve alcohol abuse, abuse of prescription medications and/or street drugs. Parental substance abuse is one of the primary reasons for children being removed from the home by child welfare workers. Children who witness parental substance abuse are more likely to experience physical, sexual, and emotional abuse and neglect than their peers in non-substance abusing homes. There are short- and long-term consequences of children's exposure to parental substance abuse; these include educational, emotional, medical, and behavioral consequences.

Overview

Visit monitors will encounter parents in varying stages of substance abuse and recovery. This chapter describes the reaction of substance-abusing parents to seeing their children in supervised visitation settings. These reactions may include anger, depression, hostility, denial, and/or aggression. Likewise, this chapter describes the broad spectrum of reactions that children may experience when visiting a parent with substance abuse problems. These reactions may include anxiety, fear, and shame. Finally, the chapter presents specific techniques for monitors to use in cases with a parental substance abuse history in order to provide a safe setting for visits and to reduce the risk to children or other program participants.

Objectives

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

1. Describe the stages of substance abuse;
2. Describe the varying effects of parental substance abuse on children;
3. Identify the most commonly abused drugs and symptoms of use associated with each;
4. Discuss how identified behaviors of substance abusing parents may affect supervised visitation staff;
5. Differentiate symptoms of substance abuse from other conditions;
6. Discuss how identified behaviors of substance abusing parents may affect children during scheduled supervised visitation services;

7. Identify effective techniques to employ when supervising cases involving parental substance abuse;

8. Identify risk factors during visits; and

9. Discuss the interface between domestic violence and substance abuse issues.

Snapshots

- Substance abuse is one of the primary causes for the increase in child maltreatment reports.
- Substance abuse is a factor in 75% of all out-of-home placements of children.
- Children of substance-abusing parents stay in out-of-home placements longer than children of non-substance abusing parents.
- Eighty-five percent of states name substance abuse second only to poverty as the greatest challenge to families reported to child protective services.
- Research shows that almost 10% of children under 12 years of age in the United States are living with a family member who has a substance abuse problem.
- Methamphetamine use is resulting in the dramatic escalation of severe child abuse and child abuse homicides.
- Thirty to thirty-five percent of seized methamphetamine labs are in homes where children reside.

Commonly Abused Drugs and Their Effects

Individuals with histories of substance use may have abused legal and/or street drugs. Certain drugs move in and out of popularity for abuse; thus it is important that visit monitors keep up-to-date on the types of drug abuse most commonly found in their communities. For example, crack cocaine use has diminished in many communities in the past ten years, while the use and manufacture of methamphetamine has dramatically increased. Although each drug has its own properties, it is not always possible to predict what a person's reaction will be to any particular drug. This is because it is common for substance abusers to mix alcohol and drugs or to use multiple drugs at the same time. However, visit monitors should not assume that a parent's behavior is due solely to substance use. Some medical conditions may mimic substance use.

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

Taking drugs by injection can increase the risk of infection through needle contamination with staphylo-

cocci, HIV, hepatitis, and other organisms. Moreover, certain drugs are associated with sexual assaults: these include flunitrazepam (also called Rohypnol and roofies); and GHB (also called G, or liquid ecstasy).

Commonly abused drugs and their associated behaviors are summarized below:

- Cannabinoids (hashish and marijuana): euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination.
- Depressants (barbiturates, flunitrazepam): feeling of well being, lowered inhibitions, slowed breathing, poor concentration, slurred speech.
- Dissociative Anesthetics (ketamine, PCP): impaired motor function, delirium, and memory loss.
- Hallucinogens (LSD, mescaline): altered states of perception, weakness, and tremors.
- Opioids and Morphine Derivatives (codeine, heroin, morphine, opium): euphoria, drowsiness, nausea, and staggering gait.
- Stimulants (amphetamine, cocaine, methamphetamine): energy, weight loss, nervousness, feelings of exhilaration.
- Other Compounds (anabolic steroids, inhalants): hostility and aggression, loss of inhibition, nausea or vomiting, slurred speech.

Additional information on this topic is included in the Administrative Supplement.

Continuum of Substance Abuse and Its Risks for Children

Substance abuse, or chemical dependency, involves a progression from casual use to abuse to dependency. As an individual moves through the progression, both the physiological and psychological consequences to the abuser escalate, as does the risk of impact on children.

Table 7.1 presents an overview of this progression.

Table 7.1
Progression of Substance Abuse

Stage	Risks for Children
Casual Use To experience effects, reduce anxiety, stress, or to socialize	Even casual use during pregnancy can harm fetus. Drowsiness or other effects when using may cause inattentiveness to children.
Increased Frequency/Abuse Characterized by routine of sporadically heavy or binge use. Tolerance increases; changes in behavior may be apparent as well as changes in user's emotional state. Denial, shame & guilt are common. *Results in:* • Failure to fulfill work, school, home responsibilities • Substance-abuse related legal problems • Recurrent social or interpersonal problems	• Children left in unsafe care • Driving with children while under the influence • Neglect of child's needs for regular meals, clothing, hygiene • Unsupervised children in home while parent is using drugs/alcohol or recovering from use • Inconsistent discipline/emotional availability or lability
Chemical Addiction/Dependence Characterized by compulsive use of substances; user cannot cease usage despite attempts to do so; ability to function deteriorates; health status is compromised; social isolation occurs. *Results in:* • Tolerance: needing more drug/alcohol for desired effect • Withdrawal: physical symptoms (tremors, nausea, sweating) when not using • Using substances in larger amounts and more frequently • Unsuccessful attempts to control or reduce use • Time spent focused on obtaining substance, using it or recovering from use • Withdrawal from social, occupational or recreational activities due to substance use • Continued use of substances despite knowledge of their impact on user's physical, psychological status • Increased risk for significant chronic physical and emotional problems • Increased risk for divorce or separation; loss of children due to neglect or abuse	• Despite clear danger parent may engage in behaviors that put child at risk such as leaving child alone or with an inappropriate supervisor for extended periods while seeking drugs • Parent may divert family resources to buy drugs in lieu of food for children or diapers or instead of paying rent or utilities • Parent may not be able to think logically or make rational decisions about a child's needs or care • Parent may seriously harm or kill child during binge

Impacts of Parental Substance Abuse on Children

Children of alcoholics or substance abusers typically experience behavioral, medical, educational and emotional consequences of their parents' abuse. Parental substance abuse negatively affects a child's normal development, causing increased risk of long-term problems for a child including greater risk for child abuse and neglect.

Behavioral impact: Children in substance-abusing homes are more likely than their peers to have problems in school, to be diagnosed with learning disabilities, to miss school routinely, to have to repeat grades or repeat classes, to transfer schools frequently, to experience economic problems and transportation issues, to be aggressive, and to have encounters with law enforcement. Additionally, children may be more at risk for both physical and sexual abuse than children in non-substance abusing homes.

Medical impact: Child neglect is highly associated with parental substance use including the failure of the parent to seek appropriate and timely medical care for children, to provide adequate nutrition, and to safeguard the home against poisoning or accidents. Additionally, significant alcohol use by women during pregnancy can result in Fetal Alcohol Syndrome or Fetal Alcohol Effects in infants, which in turn results in lifelong, organic dysfunctions in children. Further, children of substance abusers may exhibit "failure to thrive" syndrome because of their neglect experiences.

Educational impact: Children whose parents abuse drugs or alcohol often experience problems in school performance, anxiety, and household disruption. Thus, research indicates that these children – much more than their peers – have problems completing schoolwork, with absenteeism and poor concentration in the classroom resulting in failure in classes and grade progression.

Emotional impact: Almost all children who have been exposed to parental substance abuse experience a number of types of emotional consequences of this experience, including mistrust, guilt, anger, shame, confusion, fear, ambivalence, insecurity, loss of self-esteem, anxiety, and/or sexual conflict. These types of emotional experiences can led to eating disorders, anxiety and depressive disorders, drug or alcohol dependence and sociopathy, such as antisocial personality disorder.

Table 7.2 describes various parental behaviors and characteristics with the associated impacts on staff and children at supervised visitation programs.

Table 7.2
The Impact of Parental Behaviors and Characteristics on Staff and Children

Parental Behavior/ Characteristic	Impact on Staff	Impact on Child at SV
Denial of abuse	Feelings of frustration or annoyance with parent	Frustration, anger, mistrust
Anger	Feelings of fear or annoyance with parent	Fearful, may try to intervene to reduce parent's anger
Aggressiveness	Becoming a victim of attack by parent	Embarrassment, fear
Verbal abuse	Being yelled at, cursed, or insulted by parent	Fear, attempts to comply to reduce verbal abuse, self-blame
Poor impulse control	Seeing unpredictable behavior results in staff anxiety over response	Mistrust, uncertainty, anxiety, frustration
Physically ill	May need to provide first aid for parent	Shame, guilt, fear
Poor hygiene	May be offended by parent's poor hygiene, which impedes the visit	Shame, guilt, blame
Threatening behavior	May be frightened and feel the need to retaliate	Fear, anger, self-blame, attempts to appease
Poor reliability	May have to reschedule visits when parent fails to arrive	Sadness, mistrust, anger

Identifying Parental Intoxication

Visitation staff may be called upon to determine whether a parent is intoxicated during intake for either supervised visitation or monitored exchange. Beyond the commonly described signs such as staggering, loss of motor control, inappropriate verbal responses, and slurring of words, there are other observable signs of intoxication. The following table may provide some guidelines to identify this, but it is crucial for visit monitors to also acknowledge that other conditions may mimic drug/alcohol intoxication.

Some programs use breathalyzers or other tools to assess whether a parent has been using drugs/alcohol before visits or have security staff make this assessment. Others require a drug test be administered in a specified period preceding a scheduled visit. In these programs, visits are cancelled if the test is positive.

While it may be beyond a visit monitor's expertise and skill to confirm whether a parent is intoxicated, a visit monitor can determine by the parent's presenting behavior whether the visit or exchange should proceed. For example, if the parent is extremely agitated and behaving in a hostile manner to staff, a decision needs to be made about the risk in allowing a visit to proceed – whether or not the parent's behavior is due to drug use or something else.

Visit monitors should focus on the parents' behavior and whether it justifies terminating or canceling a visit.

Additional information on this topic is included in the Administrative Supplement.

Symptoms that Mimic Intoxication

As stated previously, visit monitors should be aware that a number of health conditions unrelated to substance use may account for a parent's behavior. The primary ones are noted below:

- Over-the-counter medicines (OTCs)

  Examples: Antihistamines make users drowsy; both decongestants and OTC diet formulations can make users agitated and/or dazed.

- Prescription medications

  Examples: Some anti-emetics (anti-nausea) pills are opium-based and make users sleepy as do medically prescribed and legitimately used barbiturates, tranquilizers and painkillers. Some antipsychotic medications make users appear to be stuporous – lethargic, unresponsive.

- Physical disabilities/illnesses

  Examples: Diabetes patients may appear faint or feel woozy if their blood sugar is low or if they are having an insulin reaction. Meniere's syndrome and vertigo can cause dizziness and loss of balance or coordination. Fever can cause individuals to appear lethargic, confused or even disoriented.

- Mental disabilities or illnesses

  Examples: Closed head injuries can cause confusion or agitation; psychoses can produce hallucinations or delusions; bipolar disorder can cause euphoria, exhilaration and excitation. Presumably visitation staff would become familiar with the typical behavior of parents at intake so that they would not deny visitation to parents with mental health conditions unless their behavior threatened the safety and well-being of others.

Case Example & Discussion Questions

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

A father and a mother in a dependency case arrive for their scheduled visitation. The court had ordered the father to receive substance abuse treatment, and to refrain from drinking alcohol as a prerequisite for receiving visits. The monitor could smell alcohol, but could not determine where the smell was coming from. Neither party was staggering nor acting intoxicated, but the odor was very strong. The monitor asked another staff member to make sure the smell was alcohol. She agreed that there was a definite alcohol smell; however, she could not discern where it was coming from. The monitor telephoned the CBC worker and requested that she come and provide an alcohol test to both parents, as was the program's policy. The father was found to have been using alcohol, although he denied doing so in the past four hours. The monitor terminated the father's scheduled visitation with his children and the CBC worker escorted him from the premises. The mother was allowed to continue with her visit. She reported to her children that their father had violated the court order and couldn't visit them that day, but that he would be there next week. The children accepted this and the visitation went as usual.

Discussion Questions:

1. Do you think the incident was handled appropriately?
2. What are the policies about informing children of cancelled visits at your supervised visitation program?
3. If the staff could not determine the source of the alcohol smell, and the father complied with all other program rules, could the visit have continued?

Techniques for Dealing with Substance Abuse in Visitation Programs

Interacting with Parents:

- If the worker has observed parental behavior that indicates substance abuse may be a problem (for example, the parent arrives at the program intoxicated), recognize that risks for unpredictable behavior or violence exist and that a crisis could develop. Program-specific policies and procedures must be followed in these situations. General tips for dealing with parents are:
  - Use assertive communication skills: 1) avoid lecturing; 2) use "I" statements, not "You" statements; 3) keep verbal communication simple and direct – e.g. "I need you to wait here" as opposed to "You must stay here;"

- Separate the parent from others coming for intake;
- Focus only on disruptive behavior at the moment – not on what the parent has or has not done in the past;
- Assess for medical need – If the parent passes out, has difficulty breathing, exhibits signs of withdrawal (seizures, vomiting), or appears to be an immediate threat to himself or others, call for medical or law enforcement help;
- End the visit – "I'm sorry Mr. Jacobs, the visit won't be held today. We will reschedule for next week;"
- Document the termination after the parent has left the premises; and,
- Provide reports pursuant to program policy.

Interacting with Children

Children living with parents who abuse substances like drugs and alcohol need support and constructive strategies for surviving their life situations. Some general interactions that can help children in these situations include:

- Recognize children's resiliencies;
- Help parents during visits recognize children's skills and resiliencies;
- Encourage problem-solving skills;
- Assist them in attaching to other positive adult role models;
- When and where appropriate, remind children they did not cause parent's addiction, that they cannot cure it or control it but can learn to cope with it;
- Let them know they are cared about at your program.
- Encourage them to ask for assistance during visits if they need to do so;
- Try to provide consistency during visits;
- Stress to the older child that addiction is a disease and their parent may do things that are mean or stupid when they drink or use drugs; and,
- Use the 7C's of addiction developed by the National Association of Children of Alcoholics.

7C's of Addiction

I didn't CAUSE It

I can't CURE it

I can't CONTROL it

I can CARE for myself

By COMMUNICATING my feelings, making healthy CHOICES

And by CELEBRATING myself.

Substance Abuse Treatment

Substance abuse treatment models incorporate a variety of interventions, which include:

- Assessment and treatment planning;
- Prescription of specific medications (Antabuse or Methadone for example);
- Crisis intervention;
- Detoxification or other medical assistance;
- Case management;
- Individual and group psychotherapies;
- Family therapy;
- Alcohol and drug abuse recovery education;
- Integrative therapies: acupuncture, diet, exercise, yoga, meditation;
- Self-Help groups (AA, NA); and,
- Specialized services: domestic violence, HIV/AIDS, parenting, etc.

Treatment may range from a few weeks to years. The type, length and intensity of treatment is determined by: severity of addiction, type of drug being used, support system available for abuser, motivation of abuser as well as other factors. Relapse is quite common among substance abusers.

Substance Abuse Recovery

The National Institute of Drug Abuse has developed research-based principles that help to understand the process of substance abuse recovery. These principles may help in monitoring visits between substance abusers and their children:

- No single treatment is appropriate for all individuals;
- Treatment needs to be readily available;
- Effective treatment attends to multiple needs of the individual, not just his or her drug use;
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness;
- Treatment does not need to be voluntary to be effective;
- Possible drug use during treatment must be monitored continuously;
- Treatment programs should provide assessments for HIV/AIDS, hepatitis B & C, tuberculosis and other infectious diseases; and,
- Recovery from drug addiction can be a long-term process & frequently requires multi-episodes of treatment.

Risk Identification

Supervised visitation staff should routinely be alert to alcohol and drug abuse/use in parents or other caregivers referred to their programs. While substance abuse screening alone is never diagnostic, it can reveal whether a more comprehensive assessment or evaluation is needed. Some referrals to supervised visitation will be made while parents are receiving substance abuse treatment, but other referrals will be made with the acknowledgement that while substance abuse is a concern, the parent may or may not be seeking treatment.

More information about this topic is included in the Administrative Supplements.

Case Example & Discussion Questions

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

Lanie Armstrong is referred to the Sunshine Visitation Program. She has been using methamphetamine for over seven years but was arrested a few months ago when deputies raided her home. They found a meth lab that she and her partner had been using to manufacture meth. She has three children, ages nine, seven, and three. During the raid, deputies found meth oil in the refrigerator, but no food in the home. The house was filthy – strewn with drug paraphernalia and pornographic magazines and videos. Meth-making chemicals were hidden in the children's clothes and toys. After the children were placed in emergency shelter, it was discovered that the youngest child had to be fed through a gastric tube due to exposure to methamphetamine, which caused damage to his esophagus. The oldest child, Shelly, had been sexually abused by men coming into the home to buy meth. Lanie has been in rehab for four months but the judge has only recently granted her supervised visitation.

Discussion Questions:

1. What impact has the mother's substance use had on her children?

2. What might be some of the reactions of the children during supervised visits?

3. What techniques might visitation monitors use to facilitate the visits?

The Interface Between Substance Abuse & Domestic Violence

There are many similarities between substance abuse and domestic violence. Because many of the families at supervised visitation programs will be dealing with both of these problems, it is important for visit monitors to understand how they interface.

Both of these conditions are characterized by the following:

- Family isolation;
- Impacts on the mental, emotional, physical, sexual and financial condition of the individual;
- Negative impact on self-esteem;
- Denial, minimization, and/or blame for each problem;
- Use of substances and/or use of violence become more frequent and more severe over time;
- Relapse is common in substance abuse and a return to an abusive relationship is common in domestic violence relationships;
- Substance abuse can result in death; domestic violence can result in fatalities as well;
- Substance abuse and domestic violence often require intervention by legal, medical and criminal justice systems;
- Advocates for both concerns must address the stigma, myths and misinformation regarding each;
- Workers must be experienced managing crisis situations with substance abuse clients and domestic violence victims; and
- There are often limited resources available to help clients with either substance abuse or domestic violence problems.

Effects on Perpetrators and Victims

Substance abuse may affect the perpetrator of domestic violence and the adult victim in different ways. For the perpetrator of domestic violence, the use of substances may increase the severity of the abuse, it may be used as an excuse for the battering, or the perpetrator may not remember inflicting abuse during periods when he was high or in a blackout.

Some domestic violence victims may begin to use or abuse drugs/alcohol as a means of coping or self-medicating. Victims who are also substance abusing may be sabotaged in their recovery efforts by the abuser, who may prevent her from entering treatment or complying with treatment plans. For some victims, the use of substances allows them to have a false sense of security that they or their children are safe from further abuse. For example, the victim may believe that if she stays high she can keep her partner high and prevent further abuse. Or she may have received the message from her abuser that if she doesn't drink or use drugs with him then she or the children will be beaten. For both the victim and abuser, substance abuse

may increase the tension in an already stressful relationship, which then increases the potential for escalation of abuse.

Victims of domestic violence who abuse substances should be referred only to substance abuse treatment programs that understand the complex dynamics of domestic violence.

Case Example & Discussion Questions

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

Lourdes is a Cuban-American mother of three who is currently in a domestic violence center. While at the center, she was screened for substance abuse and acknowledged using heroin in small amounts. If she could not obtain heroin, she would drink until she passed out. During her assessment at the domestic violence center, Lourdes acknowledged that her husband (the children's father), had introduced her to heroin. She reported that he frequently beat her, threatened to kill her and threatened to report her for child abuse if she left him. Her husband has now obtained a court order to see his daughters at the supervised visitation center. Lourdes brings the children to the center but when she returns to pick them up she appears high to the staff.

Discussion Questions:

1. How does this case illustrate the interface between domestic violence and substance abuse?

2. Why might Lourdes get high before picking her children up?

3. If she is high, with whom should the staff allow the children to leave?

QUIZ

1. What is one of the primary causes for the increase in child maltreatment reports?
2. Describe the potential health consequences of hallucinogens, cocaine, and methamphetamine.
3. Discuss the stages of substance use from casual use to addiction, and describe the risk to children presented in each stage.
4. Discuss the behavioral, medical, educational and emotional impact of parental substance abuse on children.
5. Describe common behaviors of substance-abusing parents during supervised visitation and the impact of these behaviors on program staff and children.
6. Discuss how to use screening tools as part of an intake when substance abuse is of concern.
7. Describe techniques to employ to facilitate visits between substance-abusing parents and their children.
8. Discuss the interface between domestic violence and substance abuse.

CHAPTER 8

THE IMPACT OF PARENTAL MENTAL ILLNESS ON SUPERVISED VISITATION

Introduction

Supervised visitation programs receive case referrals involving parents with mental illnesses. Sometimes the mental health status of the parent is known at the time of the referral; it may in fact be a factor in the removal of children from a parent. In other cases, however, no mention of the illness may be made to staff prior to the parent arriving for intake or for scheduled visits. There are many types of mental illness with discrete symptoms which affect an individual's mood, communication skills, interactions with others, and behavior. The impact of parental mental illness on children can be significant and can impact their social, emotional and and/or behavioral growth. Visit monitors observing visits between a parent with mental illness and his or her child may experience unique challenges.

In addition to the mental illness itself, psychotropic medications used to treat the symptoms of mental illnesses may impair parenting by blunting a parent's affect or sedating him or her enough to interfere with the ability to interact during visits.

Overview

Information in this chapter provides the visit monitor with an overview of the major forms of mental illness, common impacts of parental mental illness on children, risk identification, and strategies for facilitating visits. Additionally, material is presented on the major categories of psychotropic medications and common adverse reactions to them.

Attention is also given to the mental health impact of domestic violence experiences on victims, which may impact their interactions in the supervised visitation setting.

Objectives

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

1. Define major terms associated with mental health issues;
2. Recognize major categories of mental illness and their respective symptoms and treatment;
3. Recognize the five major types of psychotropic medication used to treat mental illness;

4. Identify risks that may be present during visits;
5. Identify strategies to facilitate a visit between a parent with mental illness and a child;
6. Recognize the impact of parental mental illness at different developmental stages of a child's life; and
7. Recognize the mental health sequelae of domestic violence that may be observed during supervised visitation.

Snapshots

- Some studies have reported that as many as 70% of parents with mental illness have lost custody of their children.
- Research indicates that children who have a parent with a mental illness are at a significantly greater risk for multiple psychosocial problems.
- Bipolar disorders are the most common type of psychotic disorders women suffer during the perinatal period.
- About 1% of the population in the U.S. are diagnosed with schizophrenia; 1-2% with bipolar disorders.
- Major depression is diagnosed among 10-25% of women in their lifetime and among 5-12% of men.

Mental Health Terminology

The following terms are used in the mental health field to refer to certain medications used to treat mental illness and to describe categories of mental illness and their symptoms. The list is not all-inclusive but may be used to better inform visit monitors of terms used by mental health staff. It may also be useful as a reference for visit monitors to use when working with children whose parents have a mental illness or with the parents themselves.

Antidepressants are medications that help to reduce the symptoms of depression, which include feelings of sadness, anger, and/or lack of caring. These medications can help in restoring appetite, sleep, and overall mood. They also help redirect a person's thoughts, behaviors and low-energy levels; once the medication takes effect, the person is no longer feeling depressed.

Antipsychotics are medications that help individuals who have been diagnosed with schizophrenia, bipolar disorder, and certain other mental illnesses. These medications help individuals who are experiencing problems in their thinking. They can also help calm feelings and actions.

Anxiety is a problem that occurs when an individual worries to the point that the worrying prevents him or her from carrying out activities of daily living. Anxiety can cause sleep disorders, stomachaches, headaches, confusion, memory problems, pains in other parts of the body, and shortness of breath.

Bipolar disorder (**Manic-depressive illness**) is a mental illness in which a person has pronounced periods of

being very "up," and periods of being very "down." When "up," the individual feels very excited, high and energetic; when "down," he or she may feel very depressed, with little or no energy. These periods affect how the individual is thinking and acting. Sometimes an individual with a bipolar disorder can become psychotic.

Chemical imbalance refers to the condition in which the brain lacks the correct balance of chemicals to work properly. When this imbalance occurs, mental illness may result.

Electroconvulsive Therapy (ECT) is a type of therapy used when other treatments for mental illness do not work. The therapy involves the use of electric "shocks" administered by a physician to a person's brain. For a short period after receiving ECT, the individual may be confused and may have some temporary memory loss.

Depression is a mental illness in which the individual has problems with feelings or mood. A person may feel extremely sad, angry, discouraged, or hopeless. These feelings may affect how the person is thinking and acting. Some depressed individuals may try to harm themselves.

Lithium is a medication used to treat bipolar disorders. It helps by maintaining the correct balance of lithium in the blood, and produces more balanced feelings.

Obsessive-Compulsive Disorders are a type of mental illness in which the individual has problems stopping unwanted thoughts, feelings, or actions. An individual may do things over and over again (like washing the hands or locking doors), but not be able to stop either the thoughts or the actions.

Panic Disorders are a type of mental health condition in which individuals have intense anxiety, sudden attacks of fear, dramatic body changes (chest pains, shortness of breath, dizziness), or an overwhelming sense that something horrible is going to happen.

Paranoia is a symptom in which an individual has a unwarranted fear that someone is going to harm him/her, or that someone is controlling him/her.

Phobias occur when an individual has a fear of certain places, things, or events, and avoids these because the fear is so strong.

Psychosis occurs when an individual is unable to distinguish between what is real and what is not.

Post Traumatic Stress Disorder is a psychiatric condition in which an individual has experienced an event that is traumatic (e.g., war, hurricane, accident), and then cannot remember details or cannot forget the event. PTSD affects thinking, feeling and actions. Individuals with this diagnosis may have sleep disturbances, anxiety, and fear. Some domestic violence victims and victims of child maltreatment suffer symptoms of PTSD.

Schizophrenia is a mental illness in which the individual has difficulty in his/her thinking processes. The person may have delusions (e.g., thinking the FBI is chasing him) or may have hallucinations (e.g., hearing voices telling her to do certain things). This condition also impacts how individuals pay attention to personal hygiene and how they interact with others.

Defining Mental Illness

Mental illness is a broad term used to describe psychiatric conditions that impair a person's cognitive abilities, emotional reactions, behaviors, and abilities to perform activities of daily living. Mental illnesses differ in their characteristics, symptoms, prevalence, outcome, and duration. They can occur in people of all ages, races, or income levels. Most mental illnesses occur in an episodic fashion. This means that a person may have periods of dysfunction due to the mental illness, followed by periods of relatively normal functioning with no symptoms. Most mental illnesses respond to medications, psychosocial interventions, and family and community supports.

The Diagnostic & Statistical Manual IV is the official manual used to classify mental illnesses. The DSM-IV distinguishes between two major categories of mental disorders:

1. AXIS I disorders, encompassing the major mental health disorders such as depression, bipolar disorders, schizophrenias, and anxiety disorders; and,

2. AXIS II disorders, encompassing "personality disorders," thought to be life-long patterns of maladaptive behavior which result in significant impairment in a person's social, vocational, interpersonal functioning and/or subjective distress.

Table 8.1 presents major categories of mental illness with a short list of symptoms commonly associated with each. It also includes the typical age of onset, and common treatment interventions. This list is not exhaustive and does not present all of the sub-types of each disorder. Instead, it gives an overview of the major mental illness categories. If program directors have questions about more specifics of any of these mental illness, they should contact their local community mental health center.

Table 8.1
Categories of Major Mental Illness & Their Symptoms

Illness	Symptoms	Onset	Treatment
Schizophrenia	Disturbances in thought and perception Delusions Hallucinations Social withdrawal	Late 20s	Medication In-patient treatment Social supports
Bipolar disorders	Wide mood swings During manic phase, rapid flight of ideas, and reckless behavior	Over 35	Medications In-patient treatment

Table 8.1 (cont'd)
Categories of Major Mental Illness & Their Symptoms

Illness	Symptoms	Onset	Treatment
Major depressive disorder	Persistent depressed mood, sleep disorders, appetite and weight changes, feelings of worthlessness, doom Difficulty concentrating, thoughts of death or suicide, low energy Common sometimes in women following childbirth	Late 20s	Medication Therapy In-patient treatment
Schizoaffective disorder	Features of schizophrenia and mood disorder Women diagnosed more often than men Delusions Inappropriate affect Lack of interest in normal activities Sleep disturbances Racing thoughts Impaired judgement Decreased ability to care for self or others	Late 20s	Medication
Personality disorders	Difficulty with relationships Lack of empathy Problems with social skills, moods, emotional states Personality traits: inflexible, maladaptive or inappropriate	Late adolescence	Therapy
Anxiety disorders	Extreme sense of fear and worry Psychosomatic complaints Sustained sense of fear/ apprehension Difficult in carrying out daily activities Difficulty concentrating	All age groups	Medication Therapy Desensitization

Impact of Mental Illness on Parenting

There are no comprehensive studies documenting the percentage of parents with mental illness; however, several studies suggest that adults with mental illness are as likely to become parents as adults without mental illness. Findings from research studies do suggest that children with mentally ill parents are at significant risk for a number of psychosocial problems, depending upon the severity of their parent's mental illness, their age, family supports, and other interventions available to the family.

Table 8.2 looks at the impact of having a mentally ill parent on children at different developmental stages.

Table 8.2
Impact of Mentally Ill Parent on Children

Infant	**Child may**	**Parent may**
	Be neglected Experience tension and anxiety Have accidents Show lack of response Experience separation anxiety Fail to thrive	Be unable to focus on child's needs; Be unaware of infant's crying; infant may Become focus of delusions in severe cases; Be unable to bond with the child; Be distracted in caring for the child.
Toddler	**Child may**	**Parent may**
	Experience neglect (emotional, physical) Experience tension Have accidents due to lack of supervision Experience either over-stimulation or deficits in stimulation Be physically abused	Devote inadequate time to caregiving Misread cues from toddler Lack consistency Ignore health needs Experience stress in parenting toddler Provide inadequate structure Model inappropriate behavior Exact too little or too much control
Middle Childhood (6-12 yrs of age)	**Child may**	**Parent may**
	Feel shame & self-doubt Begin to be aware of social stigmas around mental illness Have difficulty with trust Be prone to accidents	Exhibit all the behaviors listed in earlier stages Be unable to assist with child's academic or social activities Be inconsistent with discipline

Table 8.2 (cont'd)
Impact of Mentally Ill Parent on Children

Middle Childhood (6-12 yrs of age)	**Child may**	**Parent may**
	Experience anxiety due to chaos at home	Be unavailable
	Experience emotional neglect	Be emotionally unstable so that child does not know what to expect from day to day
	Feel isolated, under socialized	Be unaware of issues of child who is entering puberty
	Experience educational risks	Have a disorganized life style
	Compensate for caregivers who may be under-involved	
	Have unclear boundaries	
	Experience unpredictability in daily life	
Adolescence	**Child may**	**Parent may**
	Experience loss or disorganization	Previous characteristics listed above plus:
	Anxiety	Not like change; be inflexible in meeting adolescent's needs
	Problems in socialization	Have disorganized life style
	More sensitive to social stigma	Intolerant of adolescent's moods
	Anger toward parent	Disengage from parenting due to stress
	Difficulty concentrating	Inconsistent with discipline
	Problems in peer relationships, school performance	Difficulty setting boundaries
	Greater risk for substance abuse, sexual behavior	Allow adolescent to take over care of younger siblings

Psychotropic Medications

Psychotropic medications are used to control the symptoms of mental illness. These medications do not "cure" mental illness; they only provide relief from some of the major symptoms. While psychotropic medications have improved since their first use in the 1960's, it is still a trial and error process for patients to learn what dosage works best and what type of drug provides the most relief. Compliance with medications is complicated in some instances because of their side effects, their expense, and the patient's lack of understanding that the drugs often have to be taken for some period of time before symptoms are reduced.

There are five classes of psychotropic medications which visitation monitors should become familiar with: antipsychotic medications, anti-depressants, mood-stabilizing drugs, anti-anxiety medications, and psychostimulants. Visit monitors may encounter parents who are taking these medications to control the symptoms of their particular condition. If the parent is complying with the prescribed use of the medication, the visit monitor may observe certain side effects of these drugs which can impact the parent's ability to interact with his or her children during visits. Sometimes it is not the medication that causes the parent difficulty but the mental illness itself (or even a combination of both the symptoms of the mental illness and the medication). It is not the role of the visit monitor in most situations to assess the parent's compliance with their medication. Rather, it is the monitor's role to be informed about the types of psychotropic medications and their role in controlling symptoms, as well as to be able to recognize common side effects which may impact visits. For example, some patients may experience jerking or tics from their medications; others may become so sedated that they are unable to attend to a child during a visit.

Anti-psychotic medications are used to reduce the symptoms of psychotic disorders, such as delusional thinking, agitation, disturbances in affect, and cognitive disorders. These medications affect individuals differently, due to differences in body chemistry, metabolism, and compliance with the recommended dosage.

Common trade names of anti-psychotic medications are *Thorazine, Haldol, Mellaril, Navare, Stelazine, Clozzril,* and *Risperdal*. Adverse reactions to anti-psychotic medications can range from relatively minor to quite severe. These reactions include dry mouth, sedation, blurred vision, muscle spasms, constipation, drowsiness, and gastro-intestinal problems.

Anti-depressant medications are specific types of prescription drugs used to treat major depressive episodes, dysthymia, and adjustment disorders.

Anti-depressant medications fall into one of three types: monoamine oxidase (MAO) inhibitors, tricyclic antidepressants, and serotomin receptola inhibitors (SSRI).

Examples of MAOs are *Parnate, Nardil, Marplan* and *Aurorix.* Examples of tricyclic are *Elavil, Tofranil, Vivactil,* and *Adapin.*

Trade names of SSRIs are *Prozac, Paxil, Zoloft, Zyban,* and *Celexa.*

Side effects or adverse effects include constipation, dizziness, insomnia, anxiety, lower sex drive, and sedation. Tricyclic antidepressants may take between two and six weeks to achieve full therapeutic affects.

Mood-Stabilizing medications are medications used to treat individuals diagnosed with bipolar disorders. Examples of mood-stabilizing medications include *Lithium, Depakene, and Tegretol.* (Note: the later two drugs are also used as anti-convulsion medications.) Side effects of these drugs include confusion, fatigue, muscle weakness, and gastro-intestinal problems.

Anti-anxiety medications are used to treat the symptoms of anxiety disorders such as panic disorders, phobias, obsessive-compulsive disorders, PTSD, and stress disorders.

Three types of anti-anxiety medications typically prescribed are benzodiazepenes, beta-blockers, and buspirone.

Examples of benzodiazepines include *Xanax, Librium, Valium, Ativan, and Dalmane.* Beta-blockers include

Tenormin, Lopressor, and Inderal. Side effects of anti-anxiety medications may include sedation, dizziness, confusion, and headache.

Psycho-stimulants are a class of drugs used to treat attention deficit hyperactivity disorder in children and adolescents. Trade names include *Adderall, Dexadrin*, and *Retalin*. Side effects of psycho-stimulants may include anxiety, insomnia, loss of appetite, and cardiac arrythmia.

Case Examples & Discussion Questions

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

Case One: Daphne is visiting her nine-month-old son, who is currently in an out-of-home placement due to Daphne's recent hospitalization for a major depressive episode. Daphne is separated from her husband (her son's father). Daphne was discharged from the hospital and was prescribed anti-depressant medication. She is very slow to respond to intake questions and seems to have problems staying awake – her head droops and her eyes close. She tries to interact with her son, but she doesn't seem aware that he needs to be changed or that he might be hungry.

Case Two: Wanda brings her three children to a scheduled visit with their father. There is a history of domestic violence in the family and the court has ordered supervised visitation. The children appear unwashed and wear dirty clothing. Wanda is very tearful and upset, confiding to staff that she has been unable to sleep, is anxious, can't concentrate, and is unable to tend to her children's needs.

Case Three: Fred is the father of two children, ages six and eight. He has a long history of depression, and six months ago attempted suicide by shooting himself in the head. The attempt left him disabled and in a wheelchair. He drools and is incontinent but his mother (the children's grandmother) has requested the court grant supervised visitation. Fred and the children's mother are divorced. The children have not seen their father for many months, and have not been told the details of their father's condition.

Discussion Questions:

1. How might each parent's behavior or symptoms impact visits?

2. How might a visit monitor facilitate visits in each of these cases?

Identifying Risks During Visits

The purpose of identifying risks regarding a parent's mental illness is twofold. First, it is to determine whether mental health status may impair a parent's ability to interact effectively with his or her child during a scheduled visit. Second, it is to determine whether the child is endangered or upset over the parent's behavior, emotional response or impaired thinking. Many parents may be fully able to interact in an appropriate manner during scheduled visits even if they have significant mental health issues, recent hospitalizations or problems with medication compliance. Some parents with mental illnesses, however, may experience severe disorders in their thinking or behavior, or may have problems with their medication such that their participation in a supervised visitation setting might present a risk to others. Being aware of potential risks can assist in the determination of whether the visit should take place as scheduled, if the visit should be rescheduled or if special considerations should be made to accommodate the needs of the parent.

While determining risks presented by a parent experiencing the symptoms of mental illness, a visitation program director might want to explore a variety of issues with both the parent and children prior to facilitating a visit.

Additional information on this topic is included in the Administrative Supplement.

Table 8.3 is a guide which visit monitors might use in on-going determinations of a parent's mental health status at intake and at visits. This guide may provide a framework to note observations in a consistent manner. Most experienced human services staff, whether or not in mental health settings, routinely look at these categories in their interactions with clients. The program director should consider these factors when determining whether visits can be facilitated.

Table 8.3
Assessing Parents at Intake & Visits

Appearance	**Check if present**
Disheveled	☐
Motor status	☐
Tremors	☐
Odd gestures	☐
Very slowed	☐
Bizarre dress or inappropriate dress	☐
Exaggerated make-up or hairstyle	☐
Other observations about appearance	☐
Behavior	
Posture	
Slumped	☐
Tense	☐

Table 8.3 (cont'd)
Assessing Parents at Intake Visits

	Check if present
Facial Expressions	
Fearful	☐
Angry	☐
Bizarre	☐
Movement	
Can't sit still	☐
Restless	☐
Lethargic	☐
Voice/speech	
Very loud	☐
Demanding	☐
Jumps from one topic to another	☐
Threatening	☐
Very little verbal response	☐
Feeling or Mood	
Fearful	☐
Depressed	☐
Elated	☐
Excited	☐
Agitated	☐
Angry	☐
Tearful	☐
Perception	
Seems to have auditory hallucinations	☐
Seems to have visual hallucinations	☐
Thinking	
Orientation	
Confused over where he or she is	☐
Doesn't know who he or she is	☐
Seems confused about date or time of day	☐
Memory	
Can't recall personal information	☐
Can't recall recent visits	☐
Can't recall past events	☐
Thoughts	
Expresses suicidal thoughts	☐
Expresses homicidal thoughts	☐
Has delusions (fixed, false thoughts about something – such as the CIA is following her or him).	☐
Expresses belief that he/she is controlled by external forces (aliens, CIA)	☐

Case Example & Discussion Questions

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

Bob Wood, a visit monitor, is assigned to facilitate the visit between Mr. Callaway and his three children, ages six, eight and nine. Mr. Callaway, is divorced from the children's mother and has a long mental health history involving multiple hospitalizations. The first three visits have gone well, but on the fourth visit, Mr. Callaway arrives looking very disheveled. His clothes are dirty, his hair is uncombed, he has not shaved, and, although it is 95 degrees outside, he is wearing an overcoat. He tells Bob Wood in a very agitated voice that the CIA has told him he must take his children out of the country or the Al Qaeda will kill them. He seems very confused about where he is and who Bob Wood is.

Discussion Questions:

1. What, if any, risks are present in allowing Mr. Callaway to visit his children?

2. What categories in the checklist above might a visit monitor use in determining risks?

Facilitation Strategies

There are several strategies or techniques a visit monitor might employ to help facilitate a visit between a parent with mental illness and his or her child. If these do not work, however, the visit monitor should work with the program director, mental health professional, or others to assess whether supervised visits are appropriate at this time for the child and parent.

- Review background information and areas of concern prior to observing a visit. Do this each time a visit is scheduled. A parent's assessment may vary depending on the episodic nature of the illness, compliance with medication, other treatment interventions, etc.
- Use the checklist in Table 8.3 to help organize observations. Note the items checked and determine if they are severe enough to warrant either canceling the visit, rescheduling it, or some other option. These decisions should be made by the program director.
- Try to reduce any excess noise or other stimulation (TVs, radios, loud toys) in the room where the visit will take place.
- If the program's resources allow it, assign one visit monitor to each family with a history of mental illness instead of using group visits. Try to place that family in a room apart from others.
- Use "I" statements – not "you" when requesting that the parent do something.
- Do not challenge delusional thinking – for example, if the parent says the FBI is chasing him, don't

challenge the statement or contradict it. At the point at which the parent expresses delusional thoughts, those thoughts are fixed and real – a visit monitor cannot persuade the parent to think otherwise.

- Likewise, do not deny hallucinations – either visual or auditory. If the parent asks if you hear what he or she hears, you can say you don't (if you don't) but don't say that the parent is "just hearing something that isn't there."
- Acknowledge the feeling the parent is having regarding either delusions or hallucinations – "I know it must be difficult to think or worry that the FBI is following you."
- Ask the parent if he or she needs to take a break during the visit. If so, have him or her go to a quiet area, and see if time away allows the parent an opportunity to recover adequately or control emotions well enough for the visit to continue.
- If the parent is planning to visit for a long period of time (e.g., several hours), the program director or visit monitor might want to ask the parent to help identify behaviors which may indicate a relapse – such as wearing unusual clothes, not sleeping, having disturbed thinking. Some parents might be able to do this, and might also agree that visits will be rescheduled if the behavior occurs.
- Have the child express any feelings of shame, guilt, or embarrassment prior to a visit or afterwards.
- Inform the child about the adverse impact of a parent's medication if the parent appears sedated or unable to communicate effectively.
- Arrange with the child a signal to use if the parent's behavior or emotions become too overwhelming. Have the child take a break or terminate the visit.
- Inform on-site security if the parent's mental health status is so unstable or unpredictable that the safety of the parent, child, staff or anyone else on site is at risk. In Florida, law enforcement officers can take custody of mentally ill individuals who present risk to themselves or others and can transport them to a mental health facility for examination under the provisions of the Baker Act.

Mental Illness and Domestic Violence

The vast majority of batterers do not have mental illnesses. Many victims of domestic violence, however, may exhibit behaviors which can be *mistaken* for mental illnesses. Adult victims of domestic violence commonly experience depression and symptoms of post-traumatic stress disorder, including sleep disorders, anxiety, hyper-vigilance, stress, and fear. A victim exhibiting these symptoms who brings her children to a visit should not be considered "mentally ill" because she appears upset while her partner appears calm. Perpetrators will often use the victim's anxiety and depression to try and "prove" that the victim is unfit to parent or that she is so ill that she must have exaggerated allegations of abuse. Be aware of this dynamic. The victim's depression and stress reactions are most often situational and will abate when she feels that she and her children are safe.

QUIZ

1. Define what is meant by mental illness.
2. Discuss the major categories of mental illness.
3. Describe the impact of parental mental illness on children.
4. List some of the names of commonly prescribed psychotropic medications and their side effects.
5. Discuss strategies to employ when facilitating a visit between a parent with mental illness and his/her child.
6. Identify potential risks that may affect a visit between a parent with mental health symptoms and his/her child.

CHAPTER 9

THE IMPACT OF CHRONIC PARENTAL ILLNESS & DEVELOPMENTAL DISABILITY ON SUPERVISED VISITATION

Introduction

Parents who have chronic illnesses or developmental disabilities present unique challenges in supervised visitation. Both conditions create parenting stressors that result not just from the parent's health status but also from related factors such as financial status, access to social services, and access to medical/therapeutic care. The outcomes for parents and children can include financial problems, social isolation, frustration, separation, depression, embarrassment, shame, or resentment.

Chronic illness of a parent, whether HIV/AIDS, multiple sclerosis, cancer, or other condition, can detrimentally affect that parent's ability to adequately respond to a child's needs due to fatigue, pain management issues, or the progression of the particular condition. Similarly, a parent's developmental disability may adversely affect his or her ability to recognize or engage in appropriate family interaction. Research suggests that parents with a developmental disability are at a higher risk for engaging in child neglect or child physical abuse than those without developmental disabilities.

Overview

This chapter provides the visit monitor with information about the impact on children of their parent's chronic illness or developmental disability. Additionally, the chapter offers strategies for facilitating visits when a parent has a chronic illness or a developmental disability. Information on the Americans with Disabilities Act (ADA) is included, and guidelines for using universal health care precautions are also provided.

Objectives

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

1. Describe common reactions of a child with a parent who is chronically ill or who has a developmental disability;

2. Identify behaviors of a parent with a chronic illness that may impact visitation services;

3. Identify behaviors of a parent with a developmental disability that may impact supervised visitation services;
4. Use effective strategies to facilitate visits between a child and a parent with a chronic illness;
5. Employ effective strategies to facilitate visits between a child and a parent with a developmental disability;
6. Understand how the Americans with Disabilities Act applies to supervised visitation programs;
7. Employ universal precautions for responding to the possibility of exposure to infectious agents; and
8. Identify risk factors which may present the potential for harm during visits.

Snapshots

- Children who have a parent who is HIV-infected tend to be from families who also experience poverty, lack of access to necessary social services, discrimination, or family disruption.
- Parents with a developmental disability are more likely to have children with developmental disabilities.
- Parenting with a developmental disability is becoming more common; this may be due to deinstitutionalization.
- Developmentally disabled parents who come to the attention of child protective services share many of the characteristics of non-developmentally-disabled parents who also have child protective service involvement: inadequate incomes, unemployment, poor vocational skills, and disadvantaged childhoods.

Parents with a Chronic Illness

A parent who has a chronic illness may not be well enough to attend to his/her child, or may allow her/his health concerns to take priority over the needs of the child. Children in this situation may have the following emotional reactions:

- Distress;
- Fear of losing the parent to chronic illness;
- Resentment;
- Anger;
- Embarrassment;
- Disappointment;
- Depression;

- Guilt;
- Feeling ignored; and/or
- Sadness over parent's inability to attend school or sporting events.

Children are not typically removed from the home of a parent with a chronic illness *solely* because of the illness; rather, removal occurs because of a constellation of problems resulting from the illness. These problems may include loss of income, the move to residential health care for treatment, loss of transportation, or a lack of another care-giver. Sometimes the parent's illness results from another problem, such as a diagnosis of HIV related to drug use, and it is the drug use, not the HIV infection, that has resulted in the children's placement outside the home. In other cases, a parent may have had to be placed in an assisted living facility or hospice and may decide to use a supervised visitation program to visit his/her children as an alternative to having the child see her or him in a hospital or medical setting.

Parents with a chronic illness may also experience a range of reactions to their illness as well as its impact on their parenting roles and responsibilities. These reactions may include:

- Guilt;
- Fear over what may happen to them and their children if their illness progresses or if death is imminent;
- Depression;
- Difficulty establishing limits with children due to fatigue;
- Anxiety; and/or
- Awareness that their level of pain prevents desired parent-child interaction.

Case Example & Discussion Questions

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

Louise, age 35, is referred for supervised visits with her ten year-old daughter and six year-old son. She has been HIV infected for over five years because of IV drug use. While she abused drugs, her children were placed in foster care. Louise attended a substance abuse program in the past year and has been drug-free for several months. However, earlier in the year, she was diagnosed with advanced AIDS. During the time she has come to the supervised visitation program, she has lost significant weight so that her clothes are visibly too large. In addition, she is very tired when she arrives and seems to lack the energy to interact with her children. She often has to run to the restroom due to bouts of diarrhea. Her children seem happy to see her but also embarrassed about her appearance. Some program volunteers have told other visiting families that Louise has AIDS. Other children tease and mock Louise's children, saying that they must have AIDS, too. Other parents express concerns over "catching" AIDS from either Louise or from using the same program restroom.

Discussion Questions:

1. How might a visit monitor might prepare Louise's children for their visit with their mother?
2. What suggestions might the program director or visit monitor use to address the reaction of other families to Louise's HIV status?
3. What are the ethical considerations inherent in this case example?

Strategies for Facilitating Visits in Cases Involving Parents with Chronic Illnesses

The case example of Louise provides an opportunity to present appropriate strategies for a visit monitor to consider when facilitating visits involving a parent with a chronic illness. These strategies may include:

- Understanding the progression of a parent's particular illness. Has the illness recently been diagnosed? Is it in an advanced stage? Is it terminal? Is the illness contagious? If so, under what circumstances (e.g., airborne, bodily fluids)?
- Employing universal precautions if the illness presents any risk of transmission to others in the program (See box on universal precautions following this section).
- Obtaining appropriate training and education on common chronic illnesses and avoiding misinformation or myths about certain conditions. For example, believing that touching someone with AIDS will cause you to become infected or that cancer is contagious are both erroneous.

- Being sensitive to the physical needs of parents during visits, such as tiring easily, not being able to physically play with a child, being in pain or appearing sedated because of pain medication.
- Accommodating the needs of parents during visits in compliance with ADA requirements. For example, making sure the facility is accessible to handicapped, that someone is available to sign for the hearing impaired.
- Responding to the child's reaction to the parent's health status in a sensitive manner. Children whose parents are receiving radiation or chemotherapy may notice marks from the radiation, loss of their parent's hair, or catheters placed in chests for drug infusions. Children may notice that their parent is very tired, has to take medications, or is unable to interact with them. These changes can be very frightening for children. Reassurance given by either the visit monitor or the parent can help alleviate the concern. A statement such as "Your mother is sick, and the doctor is doing what she can to make her better" may help the child cope with the emotions of seeing a sick parent.
- Referring the child or caregivers to resources or support groups for children who have parents with chronic illnesses.

The Americans with Disabilities Act states that no qualified individual with a disability shall, by reason of their disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity or be subjected to discrimination by any such entity. The ADA covers persons with HIV/AIDS and other chronic health conditions.

Additional information on this topic is included in the Administrative Supplement.

Universal Precautions

Universal precautions refer to a set of guidelines for the handling of body fluids to prevent the possible transmission of bacterial or viral infections. These precautions are based on the premise that the body fluids of all persons should be considered potentially hazardous. Generally, body fluids include blood, drainage from cuts, scabs & skin lesions, urine, feces, vomit, nasal discharge, semen, saliva, vaginal secretions and breast milk.

Guidelines for handling body fluids include:

- Avoiding direct skin contact with body fluids by using gloves;
- Avoiding contact with diapers and soiled clothing;
- Using effective hand-washing;
- Disposing of all soiled contents in plastic bags; and,
- Using freshly mixed household bleach and water solution for cleaning any area exposed to body fluids. This solution consists of one part bleach and ten parts water.

Further guidelines can be obtained from local health care providers or county health departments.

Case Example & Discussion Questions

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

Mr. Green was divorced from Mrs. Green several years ago after being diagnosed with Huntington's Disease, a neuromuscular condition that has progressed rapidly. He now uses a wheelchair, and has little control over his arms and neck. His two children, Amy and Ida, spent every other weekend with him at his home until several months ago, when he became unable to care for them. At visitation, the children are upset with Mr. Green's deterioration, and are alternately angry and afraid of him. They sometimes refuse to help him pick up toys or turn the pages in a book. They walk away from him and ignore him. The visitation staff observed Mr. Green's deterioration, and they are saddened by it. Mr. Green is still very upset with Mrs. Green about the divorce, and speaks very angrily about her at visits, especially when he is frustrated by the girls' actions. Staff feel so sorry for him that they allow him to "vent" and rarely redirect him.

Discussion Questions:

1. What emotions might Mr. Green be experiencing at visits?

2. What emotions might the children be experiencing at visits?

3. How might a visit monitor facilitate the visits in the Green case?

Characteristics of Developmental Disabilities

Individuals with developmental disabilities account for approximately three percent of the population. Developmental disabilities may be caused by genetic factors, including congenital infections, exposure to chemical agents, injury shortly before, during, or after birth, or other factors such as head injuries and accidents. They can also result from factors that occur during pregnancy or in the post-natal period.

Developmental disabilities are characterized by deficits in cognitive or physical abilities that can also cause problems in social development. Cognitive disabilities such as mental retardation are classified based on IQ: profound (IQ=20 or less); severe (IQ=20-35); moderate (IQ=36-51); and, mild (IQ=52-68). Visit monitors will typically encounter parents who are moderately or mildly disabled, since these levels of disability are more common among those who live independently or with supported assistance in the community.

Many individuals with developmental disabilities are cognitively intact, but experience significant challenges in motor coordination, speech, or both. It is important to understand the type of developmental disability presented because it can be extremely insulting to a person whose speech is disturbed if it is assumed he or she is mentally retarded. In these situations, it is helpful for visit monitors to review materials provided in case records that describe the capabilities as well as limitations experienced by the parent.

Exercise

Think about a person you may know or have seen who is developmentally disabled. What did you notice? How did he or she interact with you or others? How did others react to him or her? What was the reaction of your elementary or middle school classmates to children assigned to special education classes?

Now think about someone who not only is developmentally disabled but also is a parent. Do you feel that this person should have had a child? Do you believe that she or he can be a good parent? What do you worry about with respect to his or her ability to parent? Do you view this parent in the same fashion as you view parents who are not developmentally disabled?

Challenges Facing Parents with Developmental Disabilities

Life experiences of parents with developmental disabilities may take their toll over time, especially if others have negatively valued their parenting. Parents with developmental disabilities may report the following:

Socialization Experiences

- Learned dependency;
- Rewarded for obedience;

- Not trained for self-sufficiency;
- Loyal to kin;
- Learned not to question authority;
- Learned to fear authority figures;
- Lack normal problem-solving skills;
- Limited social skills;
- Expect social relationships to be unequal;
- Rely on a "benefactor" to make decisions;
- Felt stigmatized and unwanted;
- Learned to use cover-up techniques and compensatory behavior to conceal deficits; and
- Experienced harsh consequences for not meeting reasonable expectations.

Life Experiences

- Deprivation and neglect;
- Abuse and trauma;
- Poverty, unemployment and lack of job skills;
- Mistreatment at the hands of helpers; and/or
- Overwhelming circumstances.

Learning Style Differences (applies to those with cognitive disabilities)

- Learning deficits such as processing and/or memory problems;
- Limited functional academics, such as reading and writing;
- Limited ability to use problem-solving in complex or unfamiliar situations;
- Difficulty keeping track of time; and/or
- Difficulty applying knowledge from one situation to another.

As a result of these experiences and expectations, parents may display challenges such as low self-esteem, confusion, inability to cope, inability to comply with instructions, or mistrust. These parents may also engage in self-protective measures, which requires a great deal of sensitivity and support on the part of monitors.

Strategies for Facilitating Visits

When facilitating a visit between a developmentally disabled parent and his or her child, a visit monitor must be patient in establishing a positive, trusting relationship. This means taking the time necessary to establish rapport, convey interest, exhibit consistency, and show respect. Visit monitors should understand that there may be a period of "testing" during which time the parent misses scheduled visits, comes late, and/or fails to comply with program rules. To enhance the opportunities for a parent with developmental disabilities to have a positive visit, the visit monitor should make sure that that expectations for the visit are realistic, reasonable, and fair. In a supervised visitation setting this might mean:

- Investigating reliable transportation resources to ensure that the parent can get to the program as scheduled;
- Ensuring that the parent understands the necessity of following program rules;
- Breaking down intake procedures into sequential steps;
- Insuring that program forms can be read at the reading level of a parent or having a visit monitor read forms to parents;
- Not relying on the child to communicate information to the parent;
- Focusing on one task at a time;
- Modeling and demonstrating effective interactions with a child;
- Using corrective behavior and positive reinforcement;
- Using concrete examples and avoiding legal terms and jargon;
- Allowing extended time for the parent to complete the intake process, and anticipating that parent will need increased attention from visit monitor during scheduled visits; and,
- Being sensitive to signs of fatigue, inattention or disinterest.

Case Example & Discussion Questions

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

Because of a dependency court order alleging neglect, a mother with a developmental disability visited her three- year-old daughter at the visitation center. The neglect case continued for two years, during which time the mother visited her daughter once a week. As the child grew older during this period, she became more aware of her mother's limitations: the mother could not read and had difficulty following the visit monitor's instructions. Soon the child began to adopt more of a parenting role in order to accommodate the mother's deficits. For example, the child would tell the mother what to do or "interpret" the visit monitor's comments to her. If her daughter could not come to a visit, the staff would inform the mother. Nevertheless, she would appear for the visit and cry when told the visit would not occur.

Discussion Questions:

1. How does this case example illustrate the characteristics discussed in the previous section about developmental disabled individuals and their children?
2. How might the visit monitor in this case prepare the mother or the child for the visit?
3. How could the staff better deal with the mother when she comes for a visit, knowing she has been told the visit has been cancelled?

Challenges to Consider

Visit monitors observing visits between a developmentally disabled parent and his or her child need to be alert to the following challenges that might arise when working with a developmentally disabled parent:

- The parent's ability to follow program rules;
- The parent's ability to interact in an appropriate manner with the child during the visit;
- The parent's need for assistance from the monitor; for example, help holding an infant safely, giving an infant a bottle, or changing a diaper;
- The exhaustion of program resources; and
- The parent's ability to use appropriate discipline with the child.

Exercise
Role-Play

Role-play the following case example. One visit monitor can play Ms. Browning; one can play Noah, age five; and another can play the visit monitor.

At the end of the role play, discuss how staff might better facilitate visits in this case or in similar cases.

Ms. Browning is a moderately disabled mother of a precocious child, Noah, aged five. During scheduled visits with Noah, Ms. Browning often becomes incontinent, soiling her clothes. Noah lives with his father and grandmother who have appropriately toilet trained him. Although Noah is embarrassed by his mother's toileting accidents, he giggles as a way of compensating for her behavior. Mrs. Browning is also easily distracted; she often wanders into other visit rooms and tries to engage with both other adults and children. She has developed a particular attraction to one specific visit monitor whom she follows around and insists that *only* this person can monitor her visit. Her behavior has irritated all the visit monitors, disturbed other families and disrupted staff who have to spend time cleaning up urine and feces from furniture and floor surfaces following her toilet accidents. Staff members who have been with the program for a while and are familiar with the case request that they not be assigned the Browning case. This results in newer, less experienced visit monitors or interns being assigned the case.

QUIZ

1. Identify the typical reactions of a child who has a parent with a chronic health condition.
2. Identify the typical reactions of a child with a developmentally disabled parent.
3. What strategies might a visit monitor employ when a parent with a chronic health problem is visiting his or her child?
4. How does the ADA apply to supervised visitation programs?
5. What is meant by "universal precautions?"
6. What strategies might a visit monitor employ when a developmentally disabled parent is visiting his or her child?

CHAPTER 10

WORKING WITH THE COURT

Introduction

It is often judges who see the connection between what a family in crisis needs and how a new service in the community can respond. Supervised visitation programs have developed in Florida's communities as result of a judicial call to action to protect the interests of children and families in situations involving child maltreatment, domestic violence, substance abuse, and other related issues. Court referrals to supervised visitation are a result of a judge's determination that a family has problems necessitating that all contact between a child and parent only occur in a supervised setting.

Supervised visitation monitors work closely with the court in providing services; therefore, they must understand the court processes involved in case referrals to programs, recognize the limits on communicating with the court, and be aware of legal rules which govern the records made at visits. In addition, visitation monitors must be prepared to appear in court if subpoenaed to provide testimony about a case.

Overview

This chapter provides critical information on working with the court, including material on court communication, reports to the court, recording visits, and testifying in court. Many programs use staff and volunteers in dual roles – as visitation monitors as well as in administrative roles. Thus, it is important to note that this chapter is directed to all paid employees, volunteers and interns who may monitor visits as some part of their job descriptions. Additional information specific to program directors is included in the CD that accompanies this manual.

Objectives

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

1. Discuss why the supervised visitation program's primary obligation is to the court;
2. Discuss the differences between case specific and non-case specific communication with the court;
3. List four types of reports to the court that visitation monitors may be asked to write, and describe appropriate and inappropriate uses of such reports;
4. Identify the Rules of Judicial Administration that govern the maintenance of visitation records;
5. Identify the person who has authority to accept or decline a case referred by a court in another jurisdiction; and
6. List appropriate steps for a visit monitor to take before appearing in court pursuant to a subpoena.

Snapshots

- The American Bar Association encourages courts to provide or identify, and make use of, locations in which supervised visitation and visitation exchanges can safely occur.
- Statistics kept by the Florida Office of the State Courts Administrator reflect the following for 2004:
  - Over 13,000 Petitions for Dependency were filed;
  - Over 90,000 Petitions for Dissolution were filed; and
  - Over 63,000 Petitions for Injunctions for Protection were filed.

Program Obligation to the Court

Supervised visitation programs have obligations to many stakeholders: the children they serve, the victims they protect, the parents they assist, the staff and volunteers they utilize, and the communities, groups, and funding agencies which support them. However, the Supreme Court's Minimum Standards clearly state that for all supervised contact services provided by a program pursuant to a court order, **the primary obligation of the program shall be to the court.** Visitation monitors should remember this fundamental obligation when staffing cases, monitoring visits, and recording observation notes.

Communicating with the Court

Programs are required to have comprehensive written operating procedures regarding communication with the court, including how the program and the court will avoid impermissible communication. There are two kinds of communication that supervised visitation staff may have with the court: non-case specific and case specific. In some programs, the program director communicates with the court on a regular basis about all *non-case specific* program administration. However, in other programs, some staff members serve dual roles and assist directors with this communication while also monitoring visits.

The only time program directors and visitation monitors will communicate with the court regarding *case-specific* information – information about particular children, parents, and court cases – is in formal reports or letters to the court which are copied to the parties and their attorneys, and at formal court proceedings in which they have been called to testify.

Unlike guardians ad litem, who are appointed to protect the best interest of the child, supervised visitation staff are not parties to the cause in family court or juvenile court litigation. A party is a person having a direct interest in the outcome of a legal matter who is entitled to be present and to participate in all depositions, hearings, and other proceedings in the litigation. Because supervised visitation staff members are not parties, they must wait until the litigants (parents, DCF) or the judge set hearings. They cannot do so on their own.

Non-Case Specific Communication

Non-case specific information includes kinds of cases accepted, hours of operation, changes in services, reports of staff changes, program resource growth or shortages, waiting lists, and incidents such as floods,

fire, or other events not related to litigation. Communication from the program to the court regarding such information is generally accomplished through the trial court administrator or the chief judge. Even though it is usually the role of the director to discuss these issues, this information is not confidential, and visitation monitors are not legally prohibited from discussing it.

There may be, however, individual program policies regarding disclosure of such non-case specific information that can affect visitation monitors. For example, when there are interests in continuity and clarity at stake, program directors may identify one designated spokesperson to whom all questions regarding the program are referred. This avoids the possibility of confusion and miscommunication in information disclosure.

Case Specific Communication

Visit monitors should understand that it is only program directors or their staff designees who will communicate with the court regarding case specific information. Case specific information includes particular details about the parties and services in individual court cases. Such information is routinely included in administrative documents such as letters requesting information or declining cases, case progress reports, and critical incident and termination reports. In many programs, visitation staff members serve dual roles in assisting with creating these documents and monitoring the visits themselves.

Case specific information should be kept confidential by directors and staff/ volunteers/interns and should only be released as allowed by state law. In the case of information relating to domestic violence victims, for example, programs must keep location and address information confidential pursuant to Florida law.

Case-specific communication must be transmitted through established, routine channels, created and memorialized in the letter of agreement with the court. Depending on the preferences of the chief judge, this may include the program director or his/her staff designee sending documents to the following persons:

- the clerk of the court,
- the judicial assistant of the presiding judge, or
- to the judge him or herself.

Visitation monitors should be aware of the sensitive nature of confidential information and look to the program director for guidance on releasing any records.

Clearinghouse Publication Note

For more information on communication between the parties and the court, with expanded discussion of appropriate communication, see Chapter Five of *Referrals to Supervised Visitation Programs: A Manual for Florida's Judges*.

Prohibited Communication

Each time such case specific documentation is sent to the court, all parties should receive copies. Prohibited communication occurs when program directors or visitation monitors (staff/volunteers/interns) discuss particular cases with judges without having the parties or their attorneys present.

Exercise

Appropriate and Inappropriate Communication with the Court

Directions: For each example of communication with the court, check whether the case is case-specific or non-case specific and whether or not the communication is appropriate.

Example 1: Visitation monitor assigned to sit in the courtroom during the domestic violence docket reminds the judge that there is a waiting list for new cases at the program.

Case specific _____ Appropriate Communication _____

Non-case Specific _____ Inappropriate Communication _____

Example 2: Supervised visitation volunteer visit monitor calls the judge's judicial assistant to ask when the Jones case paperwork will be sent to the program so that intake can be scheduled.

Case specific _____ Appropriate Communication _____

Non-case Specific _____ Inappropriate Communication _____

Example 3: Visitation monitor sees Judge Harrison at the grocery store and mentions that the Smith case is "giving the program a lot of headaches."

Case specific _____ Appropriate Communication _____

Non-case Specific _____ Inappropriate Communication _____

Exercise (cont'd)

Example 4: Visitation monitor writes in her Observation Notes in the Brown case that the program does not have security personnel on-site and the case is a part of an Injunction Against Domestic Violence. The parties and their attorneys, as well as the court are sent copies of the Notes.

Case specific _____ Appropriate Communication _____

Non-case Specific _____ Inappropriate Communication _____

Example 5: Judge Greene sees a visitation program volunteer in the hallway of the courthouse and asks "Are you folks still open on Friday night?"

Case specific _____ Appropriate Communication _____

Non-case Specific _____ Inappropriate Communication _____

Case Example & Discussion Questions

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

Julie Smith volunteers several hours per week at the Sunshine Visitation Program. She assists with administrative duties such as scheduling visits as well as monitoring visits. She meets Judge Johnston at a dinner party and begins telling the judge about her work. Smith chats about some families in general, and then provides enough detail about one family in particular that Judge Johnston can identify them as one of his cases. Smith offers her opinion about the case, and ignores Judge Johnston's attempts to redirect the conversation. Finally, the judge asks Smith directly to stop discussing the case, and Smith is embarrassed.

Discussion Questions:

1. How might a family ordered to supervised visitation feel if they knew they were the topic of such a conversation?
2. How might a lawyer for one of the parents react, especially if he felt that his client had been treated unfairly in one of the court's decisions?
3. If Judge Smith decides to recuse himself from the case, how might a case delay affect the family?
4. What impact could such a situation have on the reputation of the program, especially if it is repeated by other staff or volunteers?

Reports to the Court

Each Program Agreement (discussed in Chapter 2) sets forth procedures for providing reports to the court. These Agreements address the frequency of reports to the court and the reporting method used by the supervised visitation program.

There are four types of reports listed in the Minimum Standards (discussed in Chapter Two) which visitation monitors may be asked to complete.

1) **Detailed Observation Reports**. Detailed observations offer a comprehensive account of events that took place between the noncustodial parent and child. Programs may use a checklist during the visit that records the level of adherence to visitation arrangements by the parent, for example, compliance with scheduling and program rules. Providers may also wish to include an objective account of all behaviors and actions observed between the parent and child as they occur.

2) **Summary Reports**. Summary reports provide an overview of the interaction that took place between the parent and child during a supervised visit. The summary report must be factual, objective, and absent of any professional recommendations and opinions. Unlike the detailed observation report, the summary report shall not contain a comprehensive list of all behaviors observed between the parent and child. Instead, this report provides the court with a brief synopsis of the visitation.

3) **Incident Reports/ Critical Incident Reports**. The Minimum Standards only describes *incident reports*, which must be completed when a visit monitor witnesses "potentially harmful behavior exhibited by a parent or child, either towards another client or program staff, during the supervised contact." The Clearinghouse uses a broader term, *critical incident*, which is "any incident that may endanger the physical or emotional health of participants or staff." This latter definition does not limit the incident to actions of the parent or child , but takes into account a wider variety of incidents in which parental agents, family members, staff, volunteers, and even natural disasters can endanger a visitation participant or staff.

Critical incidents include the following:

- A storm knocking out the power at a program, resulting in a momentary loss of control over the visit, or an inability to hear what was said between parent and child;
- A parent's grand mal seizure during a visit, and the subsequent arrival of emergency personnel;
- A parent's shouted threats to the other parent across a parking lot;
- A parent's use of corporal punishment contrary to program rules; and/or
- A parent's car vandalized during the visit.

The simple act of redirecting a parent is generally **not** considered a critical incident unless the behavior of the parent escalates. Thus, the following events, without escalation, are not considered critical incidents:

- Staff intervenes in a visit to teach a parent how to play a board game with a child;
- Parent scolds child for ignoring staff instructions; and
- Parent is angry with staff or expresses frustration at program rules.

If a visit monitor witnesses a critical incident, he or she should complete a detailed account of the incident after it has been resolved. This report would be provided to the program director, who is responsible for providing it to the court and to the parties. The account should include the following elements:

- Case Number or identifying information;
- Names of both parents or guardians;
- Names and birth dates or ages of children;
- List of all parties involved in the incident;
- List of all witnesses to the incident;
- Description of the incident (what initiated the behavior, how the incident occurred, and action taken);
- Name of the person completing the incident form;
- Time when the incident took place;
- Indication whether emergency personnel were called;
- Names of responding security personnel; and
- List of parties and service providers informed of the incident.

4) **Evaluative Reports**. Evaluative reports are different from observation, summary and critical incident reports. Evaluative reports provide assessments that offer professional opinions and recommendations as to the observed contact between the parent and child. Only visitation monitors who are qualified mental health professionals should complete such reports. Without prior approval from the chief judge, or from the court, **a program should not offer a report that provides recommendations or expresses opinions**, including opinions about appropriate future access between a parent and child who have been supervised by a program.

Observation, Summary, and Critical Incident reports must not offer a opinion as to what course of action the court should take regarding the incident.

Cautions on Use of Reports

All observation reports and summary reports should indicate that the contents of the notes reflect the various levels of training and experience of the different monitors; that the observations have occurred in a structured and protected setting; and that care should be exercised by any reader in making predictions about how the contacts might occur in a different setting.

Such a cautionary note is necessary for the following reasons:

Expertise: The majority of supervised visitation monitors in Florida are not licensed mental health professionals, and are unqualified to make recommendations as to placement of the child, or to decide whether or not the underlying allegations in the case are true.

Limited View of the Case: Even if the supervised visitation staff members collect extensive background information regarding the parties, they are not Guardians ad Litem, who interview the parties and child and spend time getting to know them in a natural setting.

Artificial Environment: Despite the best efforts of all staff to make the program child-friendly, visits are obviously controlled in an artificial setting by rules and policies. Staff may not be witnessing "natural" interaction between the parents and the child. Parents are put on notice as to what behavior is acceptable and may be more likely to act in an appropriate manner under such scrutiny.

Safety Assurances: Children and non-offending parents receive the message at the outset from staff and visitation monitors that safety is a priority of the program. Monitors go to great lengths to assuage children's fears and thus, children understand that they will not be harmed at visits. This may result in an artificially inflated level of comfort with the visiting parent that may not exist in an *unsupervised* setting.

Cultural Norms: When visitation monitors describe parent-child interaction, they are likely interpreting information based on their own cultural norms. Even when programs make good faith attempts to respect the dynamics and needs of people of other cultures at visits, they may not have a real understanding of minority cultures, and may err in interpreting behavior (See Chapter 13 on Working with Culturally Diverse Families).

Uses of Reports to the Court

Table 10.1 describes appropriate and inappropriate uses of observation, summary and critical incident reports.

Table 10.1
Appropriate and Inappropriate Uses of Observation, Summary and Critical Incident Reports

Inappropriate	Appropriate
To prove that the parent's rule-abiding behavior at visits means that the allegations in the case against him/her are untrue.	To factually document an incident which occurs at a supervised visit that may have endangered a monitor or participants.
To show that the child(ren) is not afraid of the noncustodial parent during visits, and therefore, no abuse occurred.	To demonstrate how a monitor redirects a parent's behavior to assist with building parenting skills.
To demonstrate that unsupervised visits would pose no danger to any party.	To verify that a parent complied with a court order to use a visitation program.
To show how the child would act without monitors present.	To analyze the incident and create program policies to avoid a re-occurrence of the critical incident.

Exercise

Look at actual observation, summary and critical incident reports used at the supervised visitation program. Using the two lists in Table 10.1, identify written comments that reflect inappropriate and appropriate uses of such documents.

Tape/DVD Recording of Visits

Another type of record produced for the court at some supervised visitation programs is a videotape/DVD recording of visits. Visitation monitors should be aware of the following with respect to the recording of visits:

- Videotaping/DVD recordings should only be created pursuant to written program policies and procedures that have been approved by the court.
- The duties of all staff, volunteers and interns involved in the making, circulation, storing and duplicating of recordings must be clearly outlined in program procedures.
- Visitation staff, volunteers, and interns must follow the formal instructions as to the making, storing, circulating, and duplicating of recordings.
- Visitation monitors must never attempt to modify or destroy any recordings of visits without specific directions from the program director. If the monitor believes that his or her behavior on the recording is embarrassing or otherwise reflects poorly on him or her or the program, the monitor should bring this to the attention of the director. There are legitimate steps that can be taken to lessen the impact of such recordings. For example, tapes/DVDs can be provided with an accompanying explanation that describes the context for a monitor's actions.
- Visitation monitors should be provided with clear instructions as to who else, besides staff and parties, is allowed to view the tapes/DVDs. This might include the Guardian ad Litem, a parenting coordinator, law enforcement, or a mental health professional involved in the case.

Case Example & Discussion Questions

Maria, a volunteer who is new to the program, monitors a visit that is being tape recorded. During the visit, the child shows Maria a bruise that he got when his mother beat him. Maria begins to cry. The program director comes into the room, allowing Maria to leave. Maria asks for the recorder to be turned off and the tape erased. The director refuses. Two weeks later, the judge asks to view the visit tape, and Maria is embarrassed. The program director asks the court for an *in camera* review of the tape, noting that the visit monitor was new, and had a strong emotional reaction to the visit.

Discussion Questions:

1. Why might Maria have such a reaction to the child's bruises?

2. How could Maria prepare for monitoring this case in the future?

3. Why is it always innappropriate for a monitor to erase a tape without administrative oversight?

Maintaining Records

Visitation monitors should understand that supervised visitation programs operating under the auspices of the court are mandated to maintain records pursuant to rule 2.075, Florida Rules of Judicial Administration. Independent programs must maintain records for a period of five years from the last recorded activity, or until the child reaches the age of majority, whichever occurs first. Monitors do not have authority to destroy records of visits; program directors are responsible for determining when records can be destroyed.

Courtesy Referrals

When a program receives a case referral from a court in another jurisdiction, several issues arise:

1. The supervised visitation program director has the sole discretion to accept or decline such a case.

2. A program director can limit the visitation monitor's obligation to appear in court. This occurs when a director conditions acceptance of the case on an agreement that communication equipment, not in-person testimony, will be used to elicit staff testimony in court proceedings.

3. Communication about the case must be directed to the referring court, not the local judiciary.

4. Rules of confidentiality apply in courtesy cases as in locally referred cases.

Visit monitors, volunteers, and interns should be very clear with program directors if they do not wish to travel to any other jurisdiction to testify as to what took place at visits.

Testifying in Court

Increasingly, visit monitors have been called to testify in court proceedings involving the families whose visits they observe. The advice below provides a step-by-step approach to prepare for providing such testimony.

1. **Review subpoenas.** Visitation monitors may be asked to review (with the program director) subpoenas served on the program to determine the following:
   a. which case is at issue;
   b. who has monitored visits in the case;
   c. who is being called to testify;
   d. the date and time of the hearing;
   e. whether a *duces tecum* is included, requiring the monitor to bring program documents to the hearing; and
   f. whether fees are included. Witnesses called to testify are generally paid nominal witness fees. In addition, many program agreements require that the parties pay for preparation time and staff time at hearings.

2. **Contact the attorneys.** When the parties are represented by counsel, it is the role of the program director to call those lawyers to ensure that the hearing is not cancelled or rescheduled, even up to the date of the hearing itself.

3. **Review the case file.** Before appearing in court, the program director and any subpoenaed visit monitor should review the case file for the following:
   a. Domestic violence – if a party is a victim of domestic violence, certain information, such as address, telephone number, and other location information is confidential and cannot be revealed. If a *duces tecum* is received, such information must be deleted from the copy of the record before it is brought to court.
   b. Service history – monitors should refresh their memories of the case, re-reading the visit or exchange notes to prepare for specific questions about the case.

4. **Testify.** There are several things visit monitors should know about testifying in court.
   a. The Rule of Sequestration. "The Rule," as it is commonly called, is invoked by a party's attorney to prohibit all witnesses from hearing each other's testimony or even speaking to one another, or discussing the case with anyone other than the lawyers. If the Rule is invoked, supervised visitation staff may not sit in the courtroom to wait for his or her turn on the witness stand.
   b. Testify only as to facts. Respond to questions with accounts of what actually took place at visits, instead of offering opinion and conjecture. Here's an example: Say "Mrs. Jones arrived thirty minutes after the visit was scheduled to start and called the monitor 'stupid and selfish' when he told her the visit had been cancelled." Do not say "Mrs. Jones was unreasonable and really mad at the staff."
   c. Objections: When one lawyer asks a question and the other lawyer objects to that question before it is answered, wait until the judge decides whether the objection is overruled or sustained before answering. "Overruled" means that the question is valid and can be answered. "Sustained" means that there is something wrong with the question itself. If the objection is sustained, witnesses will not be required to answer the question.

Dos and Don'ts of Testifying

Do

Ask the lawyer to repeat the question if you do not understand it.

Ask the judge or lawyer if you may review your records to refresh your memory.

Be polite.

Look to the judge and ask him or her if you can answer a question although a lawyer is trying to keep you from answering it.

Remain calm and professional.

Restrict your answer to the question asked.

Answer the question!

Don't

Do not answer a question with a question.

Do not guess or make up answers to questions.

Do not offer opinions.

Do not continue to talk about matters not covered by the question itself.

Do not yell or get angry.

Do not make faces at the questions.

Do not criticize the lawyers.

Support for Judicial System

Supervised visitation staff play an important role in the judicial system and should work to enhance the credibility and integrity of that system. This means that monitors, volunteers, and interns should be initially and periodically reminded to avoid comments critical of the court system in particular cases. Sometimes monitors second-guess a judge's order, especially in controversial cases. However, monitors should not express contrary views to the parties in the case. Such action only undermines the court's authority, and it is the court that has the ultimate responsibility of determining what is in the child's best interest in each case.

Case Example & Discussion Questions

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

Laura Reese is an intern and visit monitor at the Sunshine Visitation Program. She is extremely compassionate with the families, and sympathizes with them. When parents complain about the court system that ordered them to supervised visits, Laura nods and joins in, sometimes making statements such as "He (the judge) shouldn't have done that," or "What a terrible decision."

Discussion Questions:

1. What response should the program director have to these statements?
2. Is there a way to set a tone at the program that would deter this kind of statement being made in the first place?
3. What kind of behavior could result from the parents who hear these statements?

QUIZ

1. Discuss the difference between case-specific and non-case-specific case communication and provide examples of each.
2. Describe three things a visit monitor can do to prepare for appearing at a court proceeding.
3. List four types of reports to the court.
4. Define the role of the program director and visit monitor in deciding whether or not to accept an out-of-circuit case referral.
5. List four reasons why it is not appropriate for monitors to make recommendations regarding the long-term placement of the child.

CHAPTER 11

PRACTICE SKILLS FOR VISIT MONITORS

Introduction

Visit monitors need to use a range of skills in their roles monitoring visits between non-custodial parents and their children. These skills vary, depending on the type of supervised visitation services offered in a particular program, the cases assigned to a visit monitor, the availability of mental health professionals to work with cases, and other factors. For some visit monitors, the skills presented in this chapter will be a review of basic human service training received in previous academic or work settings; for others, the skills will be new. The chapter is not written to cover the entire range of skills that a visit monitor might need to address every possible kind of visit, but rather to present the *core skills* that most visit monitors will need to employ in order to fulfill their roles effectively.

Overview

This chapter presents material on the most common skills employed by visit monitors, including skills in communication (both verbal and non-verbal), crisis intervention skills, assertiveness, facilitation, observation, and recording. It is not uncommon for some visit monitors also to conduct parent education and family counseling pursuant to program resources. However, these skills are not covered in this manual, due to their complexity and the licensure restrictions in some settings.

Additional content is presented on ethical issues involved in the provision of supervised visitation services. These include ethical standards, ethical conflicts, setting of professional boundaries, and a suggested process for resolving ethical dilemmas that occur in visitation settings.

Objectives

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

1. Identify functions and responsibilities of visit monitors;
2. List effective practice skills for monitor visits;
3. Discuss components of effective communication;
4. Discuss components of a crisis intervention model;
5. Practice assertiveness skills;

9. Assess the range of skills needed to facilitate visits;
6. Distinguish between observation and inference;
7. Record observations of visits in an objective manner;
8. Practice effective intervention skills to employ when safety is compromised during a visit;
10. Recognize ethical standards and apply them to supervised visitation settings; and
11. Resolve ethical dilemmas.

Assessing Range of Skills

In order to better understand the range of skills that a visit monitor may need when facilitating visits, it is first important for a visit monitor to understand what his or her own responsibility is in observing visits. There may be variance in this range of skills, depending on the structure of the specific visitation program, the mission of the program, and the professional resources available within the program. The following exercise may help visit monitors better make these distinctions in their own roles.

Exercise

A Monitor's Role

The visit monitor should circle a number from one to six, indicating the degree to which he or she believes the statement describes a visit monitor's function or responsibility:

1=Primary, major responsibility
2=Very important
3=Moderate
4=Marginal
5=Optional
6=Not a responsibility

1. Evaluate the parenting skills of the visiting parent.	1	2	3	4	5	6
2. Assess the emotional attachment between a child and his/her visiting parent.	1	2	3	4	5	6
3. Teach parenting skills.	1	2	3	4	5	6
4. Provide a supportive relationship or setting for a visiting parent.	1	2	3	4	5	6
5. Facilitate the interaction.	1	2	3	4	5	6
6. Provide direct feedback to the parent(s).	1	2	3	4	5	6

7. Provide recommendations to the court to help decide issues of custody or placement.	1	2	3	4	5	6
8. Serve as a mediator between the foster parent, child and biological parent.	1	2	3	4	5	6
9. Serve as a mediator between the domestic violence victim, child, and perpetrator.	1	2	3	4	5	6
10. Serve as an advocate for a visiting parent.	1	2	3	4	5	6
11. Encourage positive interactions.	1	2	3	4	5	6
12. Determine or assess child's discomfort during visit.	1	2	3	4	5	6

After all responses are completed, the program director should discuss them with the monitor. This exercise is designed to help program directors clarify for staff the roles and responsibilities of monitors consistent with program policies.

Qualities of Effective Visit Monitors

Being an effective visit monitor means having the skills and knowledge necessary to observe visits and having the interpersonal characteristics that will assist in facilitating visits. These characteristics include:

- Self-awareness and understanding;
- Sound personal emotional/mental health;
- Sensitivity to cultural differences;
- Open-mindedness;
- Objectivity;
- Competence;
- Trustworthiness;
- Warmth; and
- Ethical standards.

A sample code of conduct is included in the Adminstrative Supplement.

Communication Skills

Effective communication in supervised visitation involves both verbal and non-verbal skills. A visit monitor must be able to communicate effectively with the custodial parent, non-custodial parent, child, and foster parent (if there is one) in a manner that is respectful, clear, assertive, and empathetic. To do so, a visit monitor needs to have what are referred to as "attending skills."

Attending skills include:

- Eye contact. Eye contact is culturally variable. Generally speaking, though, it is important to have some degree of eye contact when speaking in order to establish communication.
- Body posture. If a visit monitor's posture is free of indications of hostility (clenched fist, tense), then the family members will be more relaxed and respond accordingly.
- Verbal following. This simply means that the visit monitor is able to repeat information conveyed by the client in a manner that encourages him/her to continue to communicate.
- Encouraging attitude. Examples might be, "Tell me about your child." "When you have the children at home, how do you play?"
- Use of paraphrasing. Repeating in a different fashion what the client has told you to assure the client that you understand what is being conveyed: "What I hear you saying is _____."
- Open and closed questions. It is important for visit monitors to be able to use questions that require short answers as well as those types of questions that allow more information to be conveyed. For example, "Do you have toys at home?" Or, "Tell me what games you play at home."
- Ability to reflect feelings. Visit monitors need to be able to assess how a visiting parent is feeling: "You seem very upset today." Or, "I see that you are very happy."
- Being genuine, warm, professional, and respectful. It is critical for visit monitors to be respectful of cultural differences and family differences. It is also important to avoid being condescending or patronizing of families different from one's own.
- Being non-judgmental. This is sometimes quite difficult for inexperienced visit monitors to do when dealing with parents who have histories of child maltreatment or domestic violence. Try to separate the behavior from the person while at the same time being alert to signs of further risk.
- Being assertive. When program rules must be followed, visit monitors must be able to firmly, yet respectfully, direct participants to respond appropriately.
- Being able to use confrontation when appropriate. While it is generally better to be able to be assertive, there are times when it is appropriate to be able to be confrontational – such as when a child is put at risk during a visit: "Mr. Gandy, stop hitting that child immediately!"
- Giving directions by clearly stating specific outcomes and getting feedback so it is clear that the recipient understands the message.
- Non-verbal skills, such as head nods and silence. Non-verbal cues can be as effective when used appropriately as verbal communication. They can also be as ineffective as poor verbal communication can be.

Visit monitors need to be aware of how their everyday posture, gestures, and body-space may affect communication in a supervised visitation setting.

- It is imperative for monitors to remain respectful at all times, even if they are frustrated or angry with parents.

Verbal Responses to Avoid

There are a number of verbal responses which visit monitors should avoid – or at least use with extreme caution – in order to more effectively communicate and facilitate visits.

1. Avoid surprise exclamations: "That's awful! I never heard such a thing!"
2. Avoid expressions of over-concern: "I just don't know how you can manage."
3. Avoid moral judgments: "God would not be pleased with that behavior."
4. Avoid being punitive under all circumstances.
5. Avoid criticizing. Instead, if problem behavior is apparent, redirect the parent and suggest more positive ways of interacting. For example, if a parent is not interacting with his child during a visit, do not say, "You are just not acting like you care today at all." Instead, suggest a game or activity.
6. Avoid making false promises: "I'm sure you'll get your children back in the next month."
7. Avoid threatening or coercing a parent or a child: "If you don't go in that room and see your father, I am going right to the judge, and he won't be happy!"
8. Avoid burdening the parent with your own problems: "I am so tired today, my child was sick last night and my car broke down...."
9. Avoid displays of impatience. This can be hard sometimes when working with parents – watch for frustrating sighs, clinched jaws, and irritation.
10. Avoid political or religious discussions: "What church do you go to?"
11. Avoid arguing. Once a visit monitor begins to engage in arguing, the battle has begun. Use assertiveness in communication when signs of conflict arise. If the conflict escalates, use confrontation and then follow agency protocol. Engaging in arguments will only result in frustration on all sides.
12. Avoid ridiculing. Do not mock what family members say, how they say it, or their cultural differences, clothing, etc. This rule applies to monitors not only when they are interacting with families, but also when they are staffing cases or discussing program business with other staff.

Case Example & Discussion Questions

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

A judge has ordered Mrs. Sing to use the local supervised visitation program to see her child, Lucy, who has been placed in a foster home due to allegations of neglect. The intake worker at the visitation center tells Mrs. Sing that she is the only "authorized party" to visit. Mrs. Sing comes for her first visit and brings her mother and her sister with her. The visit supervisor tells the mother and sister that they will have to leave. Mrs. Sing doesn't understand and becomes upset. The visit supervisor becomes increasingly irritated and makes comments like "You people never" while clenching her jaw and throwing the court order on the table. The supervisor insists, "See, right here, it says **only authorized party!**" "I don't have time to teach you to read, too!"

Discussion Questions:

1. How could this exchange be avoided at supervised visitation? What did the supervisor do wrong?
2. How can a monitor describe what **authorized party** means without becoming impatient and demeaning?
3. How can the supervisor's verbal and non-verbal communication be changed so that it is patient and respectful, not ridiculing or intolerant?
4. Can the program work with the court and parents to allow other family members to attend visits?

Crisis Intervention

Before reading this section on conflict and crisis intervention, monitors should consider their own definitions of and reactions to a crisis.

Exercise

There is wide variation in what situations constitute a crisis. For some individuals, a minor inconvenience becomes a crisis, while other individuals experience a crisis only when there is a death or other major event. Use the following discussion questions to help monitors determine their personal definition of a crisis.

Discussion Questions:

1. What kinds of situations constitute a crisis for you?
2. How do you feel (physically and emotionally) when you are in a crisis situation?
3. When you are experiencing a crisis, what do you need for others to do to help you?
4. What kinds of crises do you think supervised visitation clients typically experience?

Continuum of Conflict

When understanding how to resolve a crisis, it is important to recognize that there is a continuum of conflict, and that if it is left unresolved, a crisis situation may result. The goal should not be to wait until a crisis situation emerges, but rather to assess levels of conflict that will result in a crisis if not addressed.

Discomfort Stage. In this stage, there is awareness that "something is not right" or a feeling of being uncomfortable about something. In a supervised visitation setting, a visiting parent may be a bit hesitant, confused, or annoyed about something. The skilled visit monitor will be able to assess the parent's discomfort and inquire about any problems or concerns at this initial stage.

Example: Mr. West is checked in for his scheduled visit with his children. He appears somewhat annoyed at having to sign the Rule Agreement but does so anyway. He asks the visit supervisor when his children will arrive. The visit supervisor responds, "I know you are excited about seeing them. They are scheduled to be here in fifteen minutes. I will come and get you as soon as they arrive."

Incident Stage. At this stage a sharp exchange occurs leaving one or both individuals upset, irritated, or confused. The visit monitor can still defuse the situation at this point by being able to use assertiveness skills, acknowledging feelings, providing information, redirecting, etc. Or, if the incident presents enough risk, staff may have to respond by being confrontational and utilizing security staff or other agency protocols.

Example: A visit monitor informs Mr. West that his wife has not yet arrived with the children. She is about

fifteen minutes late. Mr. West is visibly upset and expresses frustration over the delay to the visit monitor. She responds by acknowledging his frustration: "I know this delay is frustrating. I will let you know as soon as I can if there is a problem."

Misunderstanding Stage. At this stage, the motives of each side as well as the facts are often confused.

Example: "She is just trying to keep me from seeing my kids," Mr. West said when he learned that his wife had cancelled the visit when her car broke down. "She's a bitch and she'll pay for this."

Tension Stage. At this stage, existing attitudes and feelings toward the other person coupled with the outcomes of the incident and misunderstanding stages create a high level of tension.

Example: The visit monitor tries to calm Mr. West by acknowledging and redirecting him: "Mr. West, I understand that you are frustrated, but it's not appropriate for you to speak about Mrs. West like that. I'm sure she will show up next time." Mr. West shakes his head and begins to yell, ignoring the monitor. He paces back and forth in the presence of other parents, shouting.

Crisis Stage. At this stage, behavior is affected, normal functioning becomes difficult, and extreme actions are considered.

Example: Mr. West begins slamming doors, pushing staff out of his way and yelling obscenities. He says, "I'll find that whore and kill her today."

Crisis Intervention Skills

Once a crisis is identified a visit monitor needs to be able to employ crisis intervention skills. There are typically seven steps involved in effective crisis intervention. If these steps are employed, the impact of the crisis can be mediated.

Step 1: Identify risk

If the person in crisis is threatening harm to him/her self or to others, or if his/her behavior indicates this possibility, then it is imperative for the visit monitor to follow the center's protocol for emergencies. This may involve alerting on-site law enforcement, calling 911, using alarms, or other procedures.

There are a number of scales or other tools to use to identify risk in a more formal manner, but in a crisis situation one can assume that lethality or bodily harm is imminent if the person is verbally making these threats or acting to harm others or him/herself. Depending on the setting in which the supervised visitation program provides services, there may be mental health professionals who are routinely accessible to make assessments; in others, the expectation is that visit monitors (whether mental health professionals or not) and other staff will make the decisions about an appropriate course of action.

In the example given earlier, Mr. West is making a verbal threat to kill his wife; however, she is not present. Given the fact that he does not know where she is currently living, the danger may or may not be imminent. In this situation, the visit monitor would follow agency protocols for threats and also look to the following steps. It may be that Mr. West is merely venting, however, if there is a history of domestic violence, it may need to be taken as an actual threat. In any event, while the visit monitor may be taking other actions, he or she or other staff members can continue to follow the steps below to mitigate the situation.

Step 2: Establish Rapport

In this step, the visit monitors need to let the family members in crisis know that the staff care about them and their concerns. This can be done by acknowledging the person's anger, frustration, irritation, or sadness, calmly asking for their side of the story or complaint Using "I" statements, not "you" statements, can be of great help in this stage. Speaking calmly and quietly, being respectful of body space, trying to move the person away from others and from objects is also part of this effort. For example, "Mr. West, I know it is difficult for you not to see your children today. I can understand how frustrated you are. I am worried that you might do something you might regret. Let's sit down in my office and talk for a few minutes. I want to know what I can do to help you today."

Step 3: Identify the Problem

In this step, let the family member in crisis identify how they see the problem. Do not assume that you know what the problem is. In the above example, Mr. West may or may not identify the problem as not being able to see his children as scheduled. He might say the problem is his relationship with his wife, the court order, the fact that his work schedule prevents him from seeing the children more often, or any number of other problems.

Step 4: Deal with Feelings

Be supportive and empathetic and inquire about what feelings the family member is experiencing. Be prepared for expressions of anger, frustration, or sadness. Don't minimize the emotional reaction of what the person expresses. In our example, the visit monitor asks Mr. West how he is feeling. He responds, "How do you think I'm feeling? I'm pissed off. The f——ing judge orders me to come here and I come and I can't even see my kids because my wife is lying about her car. I'm getting screwed here. I want to see my kids – I went to a lot of trouble to get here today. I haven't seen them in weeks." He begins to tear up.

Step 5: Explore Alternatives and Past Coping Attempts

During this step the visit monitor should inquire about what the family member sees as alternatives to the problem(s) identified. The monitor can be helpful by restating or reframing some of the alternatives as they come up. If the visit monitor makes suggestions, they should be expressed as questions for consideration, not commands. The visit monitor should also assess what coping attempts the client has used previously and which worked and which did not.

Step 6: Develop an Action Plan

The visit monitor assists the family member in taking the steps necessary to get through the immediate future. It may be useful to write the steps down. The plan should be very simple and should include the person receiving help as well as others and their roles in the visitation center or other resource.

Step 7: Follow-Up

If the family member calms down and is able to focus on an action plan that does not involve harm to anyone, then the visit monitor would want to document the incident and follow agency procedures for a

follow-up. If the crisis situation escalates during any of the steps outlined above, then it would be appropriate to call law enforcement, ambulance, 911, or other emergency staff depending upon the nature of the crisis. Each agency has specific policies and procedures to follow when such a situation occurs and it is critical for each visit monitor to know what these are and how to follow them. Risk is an ever-present consideration in providing supervised visitation services but there is almost always a way to control the risk without discontinuing services.

Factors that Increase the Impact of Crisis

Whether or not a situation seems to be a "real" crisis to a visit monitor, certain factors may increase the impact of a situation for visitation participants.

1. Distortions in the way the parent/child views or experiences the event. For example, if the custodial parent does not bring the child to the first visit, the non-custodial parent could interpret that failure as "proof" that he or she will never see the child again. This distorted view would or could precipitate a crisis as in the preceding example.

2. Inadequate situational support. For example, some families have extended family members, friends, neighbors, or religious or social associations that will help them in crisis situations. Some have stable housing, financial resources, and educational attainment that they can rely upon in crisis – other families do not, due to mental health problems, substance abuse histories, social isolation, domestic violence, or other factors. Families without adequate situational support may experience events as crisis in a different manner than those with these supports.

3. Poor coping mechanisms. Some participants know that there are certain circumstances that they can do something about and some they cannot, so they devote energy into those situations that they can change. Others spend most of their time and energy worrying and feeling powerless, which makes any situation seem more serious.

Case Example & Discussion Questions

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

Mrs. Eastman is a custodial parent who was the victim of domestic violence. She brought her son to a scheduled visit with his father. She shared her concerns regarding "guns and other weapons" during the visit. She said she tries to keep her son away from all toys that encourage violence. The monitor stated that he would be sensitive to such conversation or play during the visit.

During a subsequent visit, Mr. Eastman brought a "laser gun" and a toy that made an explosive-like sound. He began playing with his son with these toys. At this time, the visit monitor explained that the toys were inappropriate and requested that he put the toys away. The father responded by asking for the supervisor, and when she came he expressed that he was a very gentle person and would never hurt anything and that the guns were "just toys." The father became tearful and stated that he was "afraid of something like this happening."

The son noticed his father's agitation and began to speak loudly to get his father's attention. It was suggested to the father that he speak outside of the child's presence but he refused and continued to speak in front of his son. He stated that he came a very long distance to visit his son and would never do anything to harm him. During this interaction, the father was defiant and he appeared angry and frustrated. His son tried to intervene and calm down his father. The supervisor again explained that the father was upsetting the child and asked the father to continue the conversation outside of the child's presence. The father then stated that he did not wish to talk further about the incident, put the toys away, and the visit continued.

Discussion Questions:

1. As a result of this encounter, is it likely that the son's behavior will carry over once he returns to his mother's home?
2. How might each step of the crisis intervention model be used in this case?
3. How should the monitor have handled the incident? What agency or program rules might have affected this situation? Should the visit monitor have removed the child from the situation to speak to the father alone?

Visit Facilitation Skills

Visit monitors must be able to perform a number of sometimes seemingly contradictory roles. They must remain neutral but also be constantly on alert for situations that might present risk to the children, a parent, or others. Visit monitors must remain in the "background" but be close enough to hear conversations or notice inappropriate nonverbal behavior. The primary responsibilities of visit monitors are as follows:

- Ensure that no physical or emotional harm is directed to the child during the visit, to the other parent, or to other program participants.
- Monitor conversations between a visiting parent and child to guard against inappropriate remarks or threats made toward the child or other parent.
- Facilitate the visit *when necessary* by suggesting age-appropriate games or activities. This entails being sensitive to the needs of the parent and the child.
- Monitor the length of visit in order to allow an opportunity for participants to prepare for the end of the visit.
- Remind parents of the role of the visit monitor and the rules of the program if necessary.
- Redirect inappropriate behavior, both physical and verbal, in a manner consistent with program rules.
- Avoid letting personal feelings about parents, child, or situation interfere with the monitor's objectivity in observing visits.
- Terminate the visit according to program policies if rules are violated.

Strategies for Managing Reactions

A key component of developing facilitation skills is the visit monitor's ability to manage reactions of participants during visits. This is accomplished by the following strategies:

- Prepare all participants prior to the first visit. Discuss emotions which they may feel in anticipation of scheduled visits.
- Set behavioral expectations. This means that the visit monitor needs to inform participants of what is expected of them during a visit and what will not be permitted.
- Help all participants focus on the needs of the child(ren) over their own needs.
- Respect the child's emotions.
- Be attentive and responsive to the child's post-visit reactions.
- Be attentive and responsive to the parents' ongoing reactions to visitation.
- Deal with the parents' emotions during visits.
- Deal with reactions over separation, changes in custody, or reunification.
- Deal with reactions to changes in visitation schedules.
- Deal with your own and other participants' reactions.

Exercise

Discuss the role of the visit monitor in each of the following situations:

1. Visit monitor observes a visiting mother trying to coax her daughter to discuss how she is getting along with her stepmother. When the daughter doesn't respond, the mother asks questions in a pointedly negative manner: "That bitch can't keep the house clean, can she?"
2. Visit monitor observes that a visiting 12-year old wants to play a board game that requires reading skills with her father. The visit monitor knows that the father cannot read.
3. A father recently released from prison after five years is visiting his six year old son for the first time.
4. A father plays chase with his 18-month old, throws him in the air and holds him upside down until the baby cries.
5. A mother visiting her children ignores the children and directs all conversation to the monitor.
6. A parent is using the visitation to say a final good-bye to his child subsequent to termination of parental rights. During the visit, the parent promises the child that they will be together again soon.

Activities for Visits

A number of activities can be employed to facilitate interaction between a visiting parent and a child ranging from doing a board game together, reading a book, listening to a tape of a story, singing, playing with toys, or using playground equipment.

Additionally, some visit monitors may choose to use more creative or therapeutic activities to engage the child and parent or to assess the impact of the visits on a child.

A list of such activities is included in the Administrative Supplement.

Intervening in Visits

Each visitation program has policies and procedures describing when a visit monitor should intervene in a visit. Below are some common situations in which monitors may need to intervene:

- If the visiting parent questions the children in detail about the activities of the custodial parent.
- If the visiting parent tells the children to convey a message to the custodial parent.

- If the visiting parent makes derogatory comments about the custodial parent, step-parent, foster parent, judge, etc.
- If the visiting parent falsely tells the children that he or she will be back soon – unless reunification really is imminent.
- If the visiting parent asks the children to choose which parent they want to live with.
- If the visiting parent promises trips, gifts, or privileges on the condition that the child does something. For example, if the parent tells the child, "I will bring you to Disney World if you tell me what school you are attending," a monitor must intervene.
- If the visiting parent actually harms or threatens to harm the child emotionally or physically during a visit.
- If the visiting parent threatens to harm other visitation participants, custodial parent dropping off children, or staff.
- If the visiting parent has significant impairments due to symptoms of mental illness, physical illness, or substance abuse that prevents the parent from engaging in an appropriate manner with the child. For example, if a monitor discovers that a parent is intoxicated during the visit, the monitor must intervene.

Case Example & Discussion Questions

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

A family with three children was referred for weekly supervised visits. The mother had been granted temporary custody after an order for protection had been filed against the father. During one of the visits, the youngest daughter was coloring and asked her father for help writing her mother's name on the bottom of the picture. The daughter asked what her father wrote and he said it was a "code word." When the daughter read the word "whore" out loud, he laughed loudly and told his daughter to give the picture to her mother. The child refused and colored over the word.

Discussion Questions:

1. How should the monitor hearing this exchange have intervened?
2. Should the father simply be warned, or should the visit be terminated?
3. Is any intervention necessary with the daughter?

Using Assertive Behavior to Intervene

Generally there are three ways in which a visit monitor might react to a parent's inappropriate behavior at visits: passively, aggressively, and assertively.

Passiveness occurs when a visit monitor ignores what is occurring and defers to the offending person. In the case on page 172, if the visit monitor simply looked away from the drawing or laughed nervously, then he or she would be said to be responding in a passive manner. Passive behavior in a visit monitor is ***not*** effective and can support escalation of inappropriate behavior.

Aggressiveness occurs when a visit monitor uses his or her position of authority to attack, dominate or inappropriately control a situation. Again, in the example above, if a visit monitor were aggressive in his response, he would angrily confront the father in a loud voice and attack him personally: "Mr. Goodman, you are such a jerk – how dare you do that! I can make you lose any chance to see your children for that. You better do what I say!" Aggressivenes is not effective and can escalate inappropriate behavior.

Assertiveness occurs when the visit monitor communicates what is desired in an open, courteous, and firm manner. Assertive communication can be very effective, even in hostile situations, by defusing hostility and anger and allowing the offending party to "save face." In the example given, a visit monitor using assertive communication might say, "Mr. Goodman, I would like to speak to you away from the children for a moment." (Visit monitor and father go to another area.) "I can tell you have anger toward your wife, but it is not appropriate to involve the children in this manner. I will have to terminate the visit if you continue to do this."

Practice Skills on Homelesssness

Homelessness impacts families affected by substance abuse, domestic violence, parental mental illness and disability, and a host of other problems that may result in a referral to supervised visitation. Thus, the intake process at supervised visitation programs should include ways to explore the extent to which families who are referred to Supervised Visitation are stably housed. It is important to remember that the likelihood of families who are either homeless or precariously housed will self-disclose this fact is very slim. The barrier to disclosure is fear that children will be taken away because of homelessness. But, in the event that this information is not volunteered by the parties nor is it available in case files, visit monitors can heighten their awareness of signs of homelessness. Observations of the following behaviors and/or physical status can be instructive in these cases:

- Child and/or parent falls asleep during visitation;
- Child and/or parent wearing clothes that are unclean;
- Parent brings inappropriate personal possessions to visitation session;
- Parent and child arrive and leave on foot;
- Parent and/or child are vague about where they are staying; and/or
- Parent is difficult to contact by telephone when arranging visit sessions (phone calls require call-backs).

A final point about children who are homeless is that they must attend school, and school districts are required by law to provide free and appropriate educations to all homeless children. The McKinney-Vento Act (42 USC 11432 et seq.) requires schools to transport homeless children from where they are staying to the school district of their choice; this can be in their home district or the district to which they have moved. It is especially important to identify the need for school referrals for families that have dissolved due to domestic violence so that the child's safety is assured. Visit monitors should be familiar with the local school district's Homeless Liaison.

Observing & Recording

There is variation across supervised visitation programs in terms of how observation reports are written. Some programs use narrative reports written by visitation monitors and others use checklists. Other programs only record whether the parties came to the program as scheduled. Because programs vary so much on the type of records maintained, the information here may or may not apply to any specific program but will be useful in making monitors familiar with the issues involved in observation and recording of visits.

Uses of Records

Records maintained by supervised visitation programs have a number of uses:

- Records help to identify the client system and the need for services.
- Records are used to document the range and duration of visitation services.
- Records document critical incidents that cause services to be terminated.
- Records allow the case to have continuity if monitors change or different visitation services are provided.
- Records help facilitate inter-professional communication with the court of child welfare agencies.
- Records are also maintained in order to have a statistical record of the need for certain interventions.
- Supervisors may use records to ensure that workers are providing services appropriately.
- Data contained in records are also used in formal research studies to assess the outcome of services.
- Records are also important in legal actions programs may encounter as they can provide documentation of services.

Guidelines for Recording Observations

Below are general guidelines for writing visit observation notes:

1. Record only what is directly observed, not what someone else says about the visit.
2. Be objective and do not make inferences.
3. Do not assign diagnostic labels to family members (e.g. paranoid, schizophrenic) without the qualifications to do so.

4. Be careful when recording observations to be sensitive to cultural differences which may affect observations. As noted previously, eye contact and hugging and kissing are culturally variable. (See Chapter 13 for material on Culturally Diverse Families.)

Exercise
Objectivity Versus Inference

Indicate by using an "O" which of these statements are objective and an "I" by those statements,which are inferences.

1. Mrs. Young was very anxious during the visit.
2. Mr. Gandy slapped his son, Marc, when he started crying.
3. Mr. Foster is affectionate towards his children during visits.
4. During her scheduled visit, Mrs. Crockett held her three year old on her lap and read her a story.
5. Molly exhibited no attachment or affection toward her father today during the visit.
6. Because Mr. West has attended all of his scheduled visits with his children, he should be able to have unsupervised visits with them.
7. Mr. Wong, a Chinese-American father, is not affectionate with his children – he does not hug or kiss them during visits.

Ethical Practice Considerations

The process of providing supervised visitation services should be guided by ethical practice principles that promote client welfare while guiding the visit monitor's relationship with the family. Often these ethical principles are embedded within professional codes of ethics such as those of social workers (National Association of Social Workers), counselors (American Counseling Association), psychologists (American Psychological Association), and marriage and family therapists (American Association of Marriage & Family Therapists.

Additionally, groups such as the Supervised Visitation Network and the Office on Violence Against Women have developed standards and principles for supervised visitation practice. Finally, Florida law provides some parameters regarding how supervised visitation services should be provided.

Sometimes an ethical dilemma arises because of a difference between what a client feels should be provided, what the court has ordered, what visitation staff feel is appropriate, and what services can safely be provided with limited resources. The role of the visit monitor may involve trying to resolve these dilemmas. Researchers who examine ethical decision-making recommend a variety of criteria to assist human service workers in

resolving these situations. Listed below in descending order of priority are some ethical principles that may serve as a guide to this process:

Principle of the Protection of Life. Program staff must ensure the safety of all clients using the supervised visitation program as well as the safety of staff and volunteers. This means that staff must act to terminate any behavior that threatens harm. For example, if a domestic violence perpetrator leaves a threatening note on his partner's car, staff must intervene to protect the safety of the non-offending parent and the children, even if this results in termination of visits for perpetrator.

Principle of Equality and Inequality. This principle addresses the right of persons of equal status to be treated equally and non-equal persons to be treated in a different fashion ***if*** their inequality is related to the issue in question. For example, if a mother is visiting a child whom she has abused and she abuses the child again during the visit, the visit monitor must protect the child rather than the mother's court-ordered "right" to visit the child.

Principle of Autonomy and Freedom. Programs strive to provide supervised visitation services in a safe and neutral setting. However, if a parent refuses to abide by program rules and presents a safety threat to others, visitation staff must intervene, even though this limits the parent's autonomy.

Principle of Least Harm. Here the guideline maintains that given alternatives, a provider should choose the option that presents the least harm to those involved, the least permanent harm/disruption, and/or the most easily reversible harm or disruption. For example, if a visiting parent briefly whispers to his/her child despite program rules prohibiting whispering, the visit monitor might (depending on the circumstances) first redirect the parent's behavior instead of immediately ending the visit.

Principle of Privacy and Confidentiality. Most supervised visitation programs have policies and procedures in place addressing privacy and confidentiality concerns. These are designed not only to protect a client's need for privacy but also for safety. A seemingly benign request for information about a child by a non-custodial parent or information about a custodial parent's whereabouts can endanger the life of both. Nonetheless, in some circumstances this information may be requested by either parent's attorney or by the child's GAL or the caseworker. It is imperative that there be clear understanding of what information can and cannot be revealed.

Principle of Truthfulness and Full Disclosure In practice, this principle means that visitation staff should fully inform family members about program rules, services, reporting requirements, and court communication.

Exercise

Consider the following situations. In each example determine where the ethical dilemma lies. How should the visit monitor in each case resolve the conflict?

1. A nine-year old child tells her visit monitor details of her father's sexual abuse. The visit monitor has reported this to the Child Abuse Registry and the allegations are being investigated. While the investigation is being conducted, the court has ordered visits to continue between the child and her father.

2. A visit monitor notices that the on-site law enforcement officer has become very friendly with a particular parent, offering to give her a ride home, and lending her money. Should the visit monitor intervene? Does it make any difference if the parent is the custodial or non-custodial?

3. A father who has custody tells the visit monitor that his wife, the visiting parent, has had her driver's license suspended for nonpayment of child support. The mother is observed by the visit monitor driving to and from the scheduled visits. Should the visit monitor say anything to the mother? If her license has been revoked because of a DUI, should the visit monitor do anything differently?

4. A visit monitor knows that a visiting mother is on probation and that, as a condition of probation, is not supposed to consume alcohol. The mother arrives for a visit smelling like stale beer, but she is not impaired and denies drinking. What should the visit monitor do?

5. A teen-age girl refuses to visit her father as the court has ordered. She sits in the intake office crying, saying she hates her father and is frightened of him because he abused her mother. Her father has a court order and he insists that the visit monitor force his daughter to see him.

QUIZ

1. List five qualities of effective visit monitors.

2. Describe the seven steps of crisis intervention.

3. List five appropriate uses for supervised visitation recrsds.

4. Describe four general guidelines for writing visit observation notes.

CHAPTER 12

GUIDELINES FOR VISIT MONITORS: INTAKE, MONITORING & TERMINATING VISITS

Introduction

Previous chapters in this manual have provided information about specific problems that families who are referred to supervised visitation programs may be experiencing and about the skills needed to facilitate safe visits. This chapter offers visit monitors guidelines that integrate the skills, knowledge, and policy issues presented previously.

Overview

Guidelines presented in this chapter offer a decision protocol by which visit monitors can determine how to prepare family members for visits, identify safety considerations, address children's concerns during visits, intervene when necessary in visits, and report critical incidents.

Objectives

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

1. Describe best practice guidelines for preparing families for supervised visits;
2. Review appropriate criminal, child welfare, and psychosocial histories of family members, when available;
3. Identify risk factors in providing supervised visits;
4. Employ a decision protocol to conduct intake, prepare families for visits, provide visits, and terminate visits when necessary;
5. Give necessary information regarding the program and rules for visits to the custodial and non-custodial parents, the caregivers, the child, and others;
6. Recognize safety concerns during visits;
7. Intervene when the safety of the child, staff, or others are compromised during visit; and
8. Document critical incidents.

Practice Guidelines for Preparing Families for Visits

Practice guidelines require that each party be informed of the order for visitation, its parameters, the program rules, the role of the visit monitor, and safety protocols. Supervised visitation program staff routinely prepare family members for visits when scheduling services according to their program policies and procedures. The program should have sufficient information about each family member as indicated in the following charts. This is critical in order to assist providers in conducting on-going risk identification which will help prevent revictimization of children during supervised visitation.

This chapter presents a logical decision-making sequence that we call a **Decision Protocol**. It should be used when a new case is referred to the program. Presented in three steps, the Decision Protocol begins with **Step 1: Intake and Preparation**, on this page. On page 187 the Protocol continues with **Step 2: Provide the Visit**. The final step, on page 189, is **Step 3: Intervention, Termination, and Reporting of Critical Incidents**.

Decision Protocol: Step One
Intake and Preparation

Decision process:

1. Gather identified background information from each family member party (children, parents) to the extent possible.

2. Emphasize respect and fairness.

3. Inform each family member of program rules and parameters of visit. This must be done in a respectful way, encouraging the support of the parents for the rules. Remind parents that the rules were not developed for them, but for every program participant.

4. Develop safety-plan with child(ren) prior to the first visit.

5. Identify the risk factors for each family member.

6. Schedule visit *or* decline referral due to risks identified (safety or training) *or* request modification of court order (e.g. for therapeutic supervision or other modification).

Preparing Family Members for Scheduled Visitation: Information Needed from Each Parent

The most effective, safe visits are ones in which staff fully understand the family dynamics, the risks, and the problems that face the family. Table 12.1 represents information that would fully inform a visit monitor of critical family dynamics and history prior to providing visits. This list is comprehensive and it may be beyond the ability of supervised visitation programs to access this background information on a routine basis. However, it is important for visit monitors to review this list even if the information cannot be fully obtained, so that they understand as much as possible about the nature of the problems each family is experiencing.

Table 12.1
Parent & Child Information

About Child(ren):
Past history of abuse (physical, sexual, neglect)
Current abuse experience
Current living arrangements
Age
Educational level or developmental stage
Relationship between abuser and child
Mental status (emotional problems, developmental delays)
Juvenile justice system involvement, including juvenile sexual offenses
Characteristics of abusive situation
Number of offenders
Reaction of non-offending parent
Other problems in family function
Reaction of offender

Custodial Parent/Caretaker:
Past history of childhood maltreatment including child sexual abuse
Current living situation
Education and employment
Parenting concerns
Discipline concerns
Partner relationship
Domestic violence history
Substance abuse history
Mental health history
Mental retardation history
Criminal history
Reactions to disclosure of child's sexual abuse

Non-Custodial Parent:
Past history of child maltreatment including child sexual abuse
Current living situation
Education and employment
Domestic violence history
Parenting concerns
Discipline concerns
Partner relationship
Substance abuse history
Mental illness history
Mental retardation history
Criminal history
Reactions to child's disclosure

Rationale for Obtaining Background Information

Supervised visitation program staff may not always be able to access background case information on families. However, Table 12.2 demonstrates the rationale for being able to use this information (if it is available) to better prepare for scheduled visits.

Table 12.2
Rationale for Background Information

Background Case Information Needed	Rationale
Any Past History of Physical Abuse, Neglect	This information helps supervised visitation staff identify other problems in the family which may affect the visiting party's interaction with the child during visits, including lack of empathy for the sexual abuse victims, victim-blaming, etc.
Any Past History of Sexual Abuse in Family	This information can assist supervised visitation staff in better understanding variables which might put a child at greater risk for being sexually abused. For example, has either parent been sexually abused?
Information on Family's Current Living and Housing Situation	This information can assist staff in assessing the safety of the child; and identifying availability of social supports for the family, such as foster care workers, community support agencies family and supportive friends.
Information on Parent's Educational Level and Employment History	This information provides visitation staff with an indication of the parents' overall functioning level. For example, do they have steady employment, and is the non-offending parent able to support the family without the offending parent's support? This information may also reveal intellectual deficits in parents (e.g. illiteracy) which may detrimentally affect their parenting skills or require special skills during scheduled visitation services.

Table 12.2 (cont'd)
Rationale for Background Information

Background Case Information Needed	Rationale
Background on Parenting Skills and Understanding of Parenting Role	Case information obtained on parenting skills can be useful in assessing how well the scheduled visits will go, whether visit monitors should be aware of parent's inability to discipline, over-reliance upon physical discipline, distortions in their thinking about what is appropriate and inappropriate behavior for children to exhibit.
Relationship Between Parents	Supervised visitation staff must be aware of any domestic violence currently in the relationship which might put the child or non-offending parent at increased risk during scheduled services.
Sexual History of Family Members	Although this information may seen difficult at first to obtain, it is important for staff, if at all possible, to have case information pertaining to any other sexually inappropriate behavior engaged in by family members, and level of knowledge that parents have about the sexual development of children. For example, do other family members have "open marriages" where it is accepted to have multiple sexual partners; do any family members routinely watch pornography or adult movies?
Substance Abuse Histories	Case information that addresses parents' substance abuse histories or early abuse of substances by children can be an important tool in determining risk. Often abusers "blame" their abuse upon substance use or rely on substance use/abuse to cope with impact of child's disclosure of his/her abuse. Latency-aged or teen-aged children who have been abused are at greater risk of substance abuse themselves. Many supervised visitation programs routinely screen visiting parents for substance use prior to visits. It may be helpful to know as much as possible about a parent's substance abuse history prior to visits to enhance this screening.

Table 12.2 (cont'd)
Rationale for Background Information

Background Case Information Needed	Rationale
Mental Health Histories of Family Members	Having background information on any significant mental health problems can greatly enhance a program's ability to provide a safe visit. For example, is there a history of suicide threats or attempts? Does a visiting parent exhibit delusional thinking? Does failure to take psychotropic medication present potential threats to the child during visits? Do the parent's mental health problems prevent appropriate understanding of the needs of the child during visits?
Mental Retardation/Developmental Delays	Information about each parent's intellectual functioning can provide a context for understanding how they might interpret the abuse, how they function on a daily basis, and their ability to protect the child from abuse. Having information about any developmental delays in the child can assist supervised visitation staff in better facilitating visits. Further, some research on childhood abuse indicates that children who are developmentally delayed are at greater risk for abuse.
Criminal History of Family Members	As discussed in previous materials, supervised visitation staff must request copies of any current court orders, such as orders for protection, visitation, or custody. It is also good practice to have information on the criminal histories of parents to prevent or reduce possible risk during provision of services.
Information about Parent's Reaction to Child's Disclosure of Sexual Abuse	Intake with each parent may reveal information about responses to the child's disclosure of his/her sexual abuse. This can be critical to staff in conducting risk assessments and preparing the child and family for visits. For example, is one parent denying the abuse or blaming the child? Is the offending parent taking responsibility for the abuse?

Sharing Program Information with Children & Parents

Prior to scheduling visits, each party should be told specific information about the protocols employed by the supervised visitation program. This includes visit rules, the location of visits, the role of visit monitors, and the mission of the program. How extensively this information is conveyed to the child(ren) will depend on the child's developmental age or emotional status.

Table 12.3
Preparing Parties for Scheduled Supervised Visitation: Information to be Conveyed

Child(ren)	Residential Parent or Caregiver	Non-Residential Parent (alleged or confirmed abuser)
Location and schedule for visits. What degree of physical contact child wants or will be permitted. Signals for child to use to indicate need for help. Conversation topics child wants or doesn't want to occur. Other program rules.	Location and schedule for visits. Program rules. Role of visit monitor. Security measures in place. "Checking in" with the victim parent before each visit, to ascertain safety between visits.	Location and schedule for visits. Program rules. Role of visit monitor. Degree of physical contact. Toilet rules. Items brought to visits. Conversation topics allowed or disallowed. Emphasis on respect, fairness. Intervention techniques to be used by visit monitor during visits.

Identification of Safety Concerns of Child Victim

After a child has been told the basic information about his/her scheduled visit outlined above (and after any further risk assessment is made subsequent to reviewing case information from parents), staff should engage the child in making a safety-plan for his/her scheduled visit or assist the child in an identification of his/her safety concerns about the visit. Again, the extent to which this is done will depend upon the developmental level of the child and the allegations or findings in the case. This step can assist the child in feeling less anxious about the visit and also help reassure the child that his or her safety will be addressed. The following questions can be used by visitation intake or visit monitors to assist in identification of concerns throughout

the period of time the family receives services at the program, not just prior to the first visit. (Note: Not all questions need to be asked of each child. These are examples that can be modified by each program.)

- Do you feel safe right now?
- What makes you feel safe?
- What do you keep with you that makes you feel safe or loved? (e.g., Teddy Bear? Blanket? Picture?)
- What kinds of games or toys do you like to play with?
- What would be fun for you to do while you are here?
- Did you bring something with you today (or can you bring something) that would make you feel safe?
- What makes you feel upset, nervous or sad?
- How can I help you feel safe during your visit?
- Does anything frighten you about being here at this program?
- Does anyone here frighten you?
- Is there anyone here who you fear will hurt you while you're here? Be mad at you? Be sad at you?
- Sometimes certain smells, music, or clothes remind us of frightening things, does anything in particular like that frighten you?
- Where would you like your visiting parent to be in the room during your visit?
- Is there anything you don't want him to say to you during the visit?
- If you become frightened, upset or sad during the visit, how can I help you?
- Is there a signal (raised hand, certain word, song) that you can use during a visit to let me know you don't feel safe or are upset.

Decision Protocol: Step 2
Provide the Visit

Decision process:

1. Consider whether a safe visit can be provided in the case.

2. Schedule visit.

3. Conduct routine pre-visit screening following program policies.

4. Cancel visit because of visiting parent's behavior during pre-visit screening, *or* cancel visit because of child's emotional state during pre-visit screening indicating need for more skilled visit monitor.

5. Facilitate visit while monitoring using program policies and procedures for ensuring safe visit.

6. Document interaction.

Maladaptive Behaviors

Visits may proceed without problems, but it is imperative that in every case visit monitors attend to the interaction, be alert to both verbal and nonverbal messages, and watch for indications that the child is demonstrating maladaptive reaction as described below. These behaviors may appear during a visit, but they may also appear subsequent to a visit and be reported to the supervised visitation program by the custodial parent. If these behaviors appear, a formal mental health evaluation conducted by a mental health professional is indicated prior to the scheduling of any further visits between the offending parent and the child. It is imperative that the program's letter of agreement with the court provide for this. To allow subsequent visits while having knowledge of these behaviors can result in serious harm to the child. The maladaptive behaviors are:

- Rage including suicidal or homicidal threats, aggressive play, (e.g. destroying toys, furniture), or severe temper tantrums;
- Excessive aggression including physical or verbal attacks on visiting parent, custodial parent or caregiver, supervised visitation staff, siblings or others;
- Depression manifested by flat affect, slowed body movements, excessive crying, mood swings, lack of interest in school or in play subsequent to visits, suicide threats or self-injurious behaviors;
- Numbing illustrated by memory loss (e.g., can't remember coming to see offending parent week before), depersonalization, excessive fantasizing, high-risk play, compulsive behaviors (picking at skin or pulling out hair);
- Panic attacks brought on by stressors or triggers of the sexual abuse experience (e.g., child has panic attack after smelling father's aftershave or being shown photograph of where abuse took place);
- Severe distrust of others;

- Sexualized behaviors such as masturbating during scheduled visits, molesting other children during visits, behaving in a sexual manner toward program staff or toward other parents;
- Flashbacks of the sexual abuse which may occur during the visit triggered by certain smells, actions, sights, or sounds;
- Sleep disturbances such as nightmares following or prior to visits, inability to sleep soundly, or falling asleep during visits;
- Somatic complaints such as severe headaches, stomach aches, nausea, vomiting without physical cause; and,
- Elimination disorders in children who have been toilet trained, such as soiling or wetting during scheduled visits or immediately following visit or prior to next visit.

Exercise

Many children who have been abused experience what are diagnosed as phobic reactions when confronted with sensory stimuli which remind them of either their abuse experience or their abuser. These stimuli are called "triggers." It is therapeutic for children to be able to identify triggering stimuli in order to then be able to adopt safe coping mechanisms to these triggers. Triggers may well be present during a scheduled visit between a parent and child and may go unidentified unless staff work with the child to help identify them. Sometimes triggers can be identified from information in the case record, or from interviews with the offending parent and custodial parent; often, however, they may not be identified until the child has a reaction to them.

Monitors should be asked to identify potential sounds, smells, sights and tastes or other sensory events that might "trigger" a phobic or fearful reaction in a child who has been abused. To get started, list the following triggers on a piece of newsprint with a marker and then have the group identify other triggers a child may experience. For example, some possible triggers are: perfume or cologne, other smells (e.g., beer or smoke on clothing), certain kinds of candy used in grooming, or child's nickname used only by his abuser.

Addressing a Child's Discomfort During Scheduled Visits

In cases where the abuse has been confirmed, as well as in cases where there is "some indication" of child abuse, the child should be allowed to signal when the visit needs to end or break for a period of time. During preparation of the child for the visit, staff can suggest certain signals or statements the child can make to indicate that this needs to occur. What signal or statement is used will depend upon the age or developmental level of the child. If the child leaves the visit for a break or asks that the visit be terminated, staff should conduct a risk assessment to determine how the child is being affected by the contact.

When child abuse has been alleged or proven, a child should be reassured that the supervised visitation staff wants to make sure he or she is safe at visits. It may be confusing for a child victim if staff remains silent about what happened or may have happened to the child. On the other hand, a program must not begin advocating for one parent, or treating a parent with disdain or contempt.

Supervised visitation staff does not need to be specific about the allegations with a child. The following example is a statements that can be said to alleviate a child's fears prior to visits. These assurances let the child know that staff will be vigilant: "*You are here because the judge cares about you. We care about you, too. You have not done anything wrong. We are here so you can have a safe visit. Tell us if there is anything we can do to make your time here better. Tell us how we can help you feel more comfortable."*

More information about this topic is included in the Administrative Supplement.

Decision Protocol: Step 3
Intervention, Termination, and Reporting of Critical Incidents

Decision process:

1. Use program policies for intervening in cases where program rules are violated or in cases where the visit is causing harm to the child.

2. Remind parent of the rule violation.

3. Redirect parent.

4. Verbally insist that behavior cease.

5. Physically intervene and remove child from visit room or proximity to parent with assistance from program security as needed.

6. Terminate visit.

7. Complete critical incident report.

8. Disseminate critical incident report to parties, attorneys, DCF/CBC staff, GAL, and mental health professionals involved with family.

Intervention Examples

Table 12.4 lists a few ways of dealing with parent misbehavior on-site. Each program should decide whether it will focus on removing the child or the parent from the visit room in order to redirect or terminate visits. An advantage of removing the child is to avoid having the child react angrily to perceived parental criticism by staff. It is ***not*** advisable to inform the parent that the visit is ended with the child in the room. Programs have created innovative ways to remove the child without incident. Some programs inform parents that monitors must always stay with the child, so if the monitor needs to use the rest room, the child must also leave the room. The monitor's tone should be respectful and calm at all times.

Table 12.4
Intervention Examples

Parent Behavior	Staff Action	Suggestioned Communication
Parent begins to speak in a foreign language, staff feels parent "forgot" restrictions.	After subtle reminders, use overt reminders, but try to remove child first.	Subtle: "Oh, let's speak in English for a while…" Overt: remove child from room under guise of using the bathroom. Then: "Please, sir, remember to speak only English unless we need a translator at all visits." Document incident.
Parent ignores reminder, continues to speak to child in foreign language.	Verbal insistence that parent stop.	Remove child from room. "I need you to stop that immediately or the visit will end." Document incident.
Parent refuses to stop.	Visit terminated – Report filed.	Child is removed from room. "I'm sorry, but the visit is over, Mrs. Jones." Call for assistance in terminating visit, if necessary. File incident report.
Parent says to visit monitor in child's presence, "I did not abuse my kid, my ex-wife is making this up."	Immediate calm redirection and verbal direction for parent to stop. Verbal direction can be simple and respectful but firm.	"Mr. Tims please step out in the hallway." Then: "Sir, we will not discuss this case in Johnny's presence. If you continue to discuss it, I will be forced to end the visit. Now, let's see about a game or activity that the two of you can play." File report.
Parent holds baby in lap and strokes him between the legs.	Physical intervention and termination of visit.	"Ma'm, please let me take Charmaine now." Then: "The visit is over."

Immediate Intervention

There will be many instances when intervention must be immediate, and therefore, will take place within hearing or sight of child. For this reason, we recommend that the visit monitor or director do the following:

- Stay calm and focused on the behavior.
- Express redirection and verbal warnings in a clear, controlled manner.
- Use "I" statements as much as possible.

If the intervention is more than a quick statement or is not acted on by the parent immediately, the director or staff should ask the parent to accompany her to a nearby or adjacent office to explore in more depth or at greater length the need for the behavior to stop. The child should not be present for (and should not be able to hear) the conversation.

If the parent wants to respond, explain, or to offer any more discussion about the incident, staff should immediately bring that parent to the nearby office so that the statement(s) can be made away from the child.

If staff feels threatened, the child should be removed from the visit immediately.

Exercise

Role-play the following behaviors and reactions:

Actors	Scenario
Parent/10-year-old girl/director	Parent arrives for visit, tells daughter, "You're making up lies about me again, aren't you?"
Parent/monitor	Parent says, "You're going to rot in hell for believing the lies they've told you."
Parent/monitor/other parent	Parent pays too much attention to other parents and their children and wants to interact with them.
Mother/two children/monitor	Child stares at chest of monitor, tries to look down shirt. Wants to accompany brother to bathroom.

Discretionary Considerations for Termination

There is a great deal of discretion left to directors in deciding the most appropriate course of action in interventions. The following considerations should be taken into account when making intervention decisions that may warrant termination of program services:

- How severe is the action or statement by the parent?
  - If the action endangers the child, the visit should be suspended or terminated.
- Has the parent directed the statements directly to the staff or to the child?
  - If the parent expressed anger or displeasure at the staff, the child may or may not be alarmed.
  - If the parent expresses anger at the child, the child may be unable to continue to participate in the visit.
- What are the child's reactions to the statements or behavior?
  - If the child is upset by the statement or behavior, even if he/she is not physically harmed, the visit may need to be suspended.
- Is the statement a "first offense" or has the parent has repeatedly engaged in such conduct during the same visit or in other visits?
  - A parent's continuous violations of a program's rules despite repeated interventions may warrant suspension or termination of visits, even if such violations do not endanger or upset the child.

Critical Incident Reports & Termination Reports

Whenever an intervention is necessary in a supervised visit of a child sexual abuse case, staff should complete a critical incident report and mail it to the court and all parties in accordance with program policies.

A critical incident report should include:

- A list of staff members or security personnel who witnessed the incident,
- A description of the rule violation reported as a narrative (describing the event as it occurred), and
- A list of parties/attorneys to whom the report was sent.

If the visit is **terminated** because of a critical incident, staff must file a written Termination Report within 72 hours. Termination Reports must state the reasons for the termination and should include:

- A description of the incident or incidents necessitating termination, and
- A list of sources to whom copies of the report will be sent, including

- The parties
- Their lawyers
- Social services caseworkers, and
- Guardians ad litem assigned to the case.

In addition, if the court has ordered that mental health professionals/therapists receive such information, the program should also mail copies of the reports to these participants.

The best practice would be for programs to include a Notice of Suspension of Future Visits in Termination Reports. This provides the parties with an opportunity to return to court to discuss the incident. Any suspensions of visits must be reported to the court within 72 hours.

A sample Critical Incident Report is included in the Administrative Supplement.

QUIZ

1. List important sources of background information that a visit monitor should review prior to facilitating a visit.
2. List the rationale for collecting such information in question number one.
3. Identify common safety concerns of a child victim who is scheduled to visit an abusive parent.
4. Describe ways in which a visit monitor can address a child's discomfort during a visit.
5. Describe the process for intervening in visits when a parent or child engages in inappropriate behavior.
6. Describe when a critical incident report should be made.

CHAPTER 13

WORKING WITH CULTURALLY DIVERSE FAMILIES AT SUPERVISED VISITATION

Introduction

Families who are referred to supervised visitation programs represent the diversity of race, ethnicity and sexual orientation in our culture. There is evidence that families of color and/or poor families may be over-represented in social service agencies and the judicial system. Thus, visitation programs may encounter a higher percentage of these families than might normally appear within the surrounding community.

It is critical for visit monitors to be aware of their own perceptions and biases about cultural or ethnic groups different than their own. To gain awareness, visit monitors must learn as much as they can about differences in families and recognize that each culture or ethnic group – while different from that of the visit monitor – has strengths.

Only when they are sensitive to the needs of culturally diverse families can visits monitors fully understand and apply the issues identified in the previous chapters of this manual.

Overview

This chapter presents information about culturally diverse families. It challenges visit monitors to recognize their own prejudices in order to more effectively and objectively interact with families at visits. It emphasizes the importance of respecting diversity and gaining confidence in working with families from different backgrounds.

Strategies for facilitating visits with culturally diverse families are presented. Suggestions are also made for accommodating families who may have different language needs.

Objectives

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

1. State data on the prevalence of racial and ethnic groups in the U.S. as well as data on the prevalence of gay or lesbian parents;
2. Define terminology relevant to discussing cultural diverse families;
3. Discuss common stereotypes about different cultural groups and societal reactions to them;

4. Understand other cultural views of family structure and child-rearing practices;
5. Demonstrate effective strategies for working with culturally diverse families;
6. Identify how cultural misunderstandings of families may detrimentally impact supervised visitation services; and
7. Discuss effective techniques to employ when monitoring visits with culturally diverse families.

Snapshots

- Florida's population is becoming increasing Hispanic: in 2000 Hispanics represented 16.8% of the population in the state. This represents an increase of 70.4% between the censuses of 1990 and 2000.
- Data from the 2000 Census reflect that about 67% of the US population is identified as being White –either as White alone or biracial. Of the remaining 33%, 13% indicated that they were African-American; 4.55% Asian/Pacific Islander; 13% Hispanic; 1.5% Native American or Alaskan Native; and 7% other racial identity.
- In some parts of the U.S., white European-Americans no longer represent a majority of the population.
- According to the FBI, in 2003 there were 2000 hate crimes reported. Of these, 51.4% were motivated by racial bias; 17.9% were caused by religious intolerance; 16.6% were the result of a sexual orientation and 13.7% were triggered by an ethnicity/national origin bias.
- In 1990, the National Adoption Information Clearinghouse reported that between six and ten million children in the U.S. were living in gay/lesbian households.
- Children with gay/lesbian parents have the same incidence of homosexuality as in the general population, about 10%.

Terminology

While differences in cultures or ethnicity are too varied to cover in this manual, it is important for visit monitors to understand the terminology generally used in discussing culture, race and ethnicity.

Bisexual: A person who is sexually attracted to males and females.

Blended families: Families created when adults with children from previous relationships marry and/or live together.

Co-parent adoption or second-parent adoption: The legal process through which a nonbiological or non-adoptive parent in the original adoption procedure gains shared legal custody.

Diversity: The term "diversity" refers to the ways that groups differ from one another – groups may differ by the following characteristics:

- Cultural or ethnic identity (Haitian, Seminole Tribe, gay/lesbian, Hispanic, African-American).
- Socioeconomic class (upper class, working class, lower income, etc.).
- Gender (male, female, or transsexual)
- Sexual orientation (heterosexual, gay, lesbian, or bisexual).
- Physical ability (sight or hearing impaired, paraplegia or other physical challenges that make an individual differently-abled).
- Other affiliations of individuals such as religious (Muslim, Jewish, Protestant, Hindu).

Homophobia: Pathological fear of homosexuals and/or homosexuality.

Race: Group identified based on inherited physical characteristics: Asian, Black, Hispanic/Latino, Caucasian/White, Native American.

Ethnicity: Group identity based upon common history, tradition, language, geography, or religion.

Culture: Group identify based on the learned rules, traditions, or expectations of interacting that a particular group condones or practices – such as the role of women or how parenting is practiced.

Multicultural competence: Includes the visit monitor's own awareness of culture, his/her knowledge of culturally diverse families, and the ability to engage in culturally appropriate skills when working with diverse families.

Multiculturalism: The recognition of the scope of race, ethnicity, language, sexual orientation, gender, age, disability, class, status, education, religious/spiritual orientation, and other cultural dimensions.

Oppression: The systematic denial of rights or access to resources as part of the social structure.

"Out": A term used to describe either a lesbian or gay person who is open about his/her sexual identity.

Racism: Prejudice or bias against a person because of his/her race or ethnicity.

Sexism: Prejudice or bias against a person because of his/her gender.

Stereotype: Oversimplified picture or understanding of a person or group that generalizes to the extent that their individualism is lost. For example, *all Asian-American children are well-behaved and bright* is a stereotype.

Transgendered: A person whose gender identification, expression or behaviors are not traditionally associated with their birth sex.

Ethnocentrism: The human tendency to assume that one's own culture is superior to all others and to judge other cultures using one's own background as the standard.

Xenophobia: An unrealistic fear of other cultures.

Preferred Terminology

When addressing families of different backgrounds, certain terms are preferred over others because they are more accurate and/or recognize the families' strengths rather than their weaknesses. Examples include the following:

Ethnicity or ethnic background is preferred over race.

Culture or reference to a specific cultural background is preferred over minority.

Differently-abled is preferred over disabled or handicapped.

Sexual orientation is preferred over sexual preference, as some believe that sexual orientation is not a choice they have made but a genetic predisposition.

Exercise

Instructions: Discuss the preferred terms in the list above. Why is each preferred term better than its alternative? Explore the negative connotations of the following words: race, minority, disabled, gay.

Cultural Identification

Families referred to a supervised visitation program grow up, like other families, in a primary culture. They are thus shaped and affected by that culture's traditions, beliefs, and values. Like other families, they are also part of many subcultures which leads to infinite familial experiences. For example, monitors may have a referral of a black family, but if they make certain assumptions about the culture of an average African-American family in preparing to facilitate a visit, they may find themselves unprepared when the family is black *and* of Haitian-immigrant background. Likewise, Hispanics, the second largest ethnic group in Florida, may be Latinos (from Latin America) or from Spain or South America. Beyond that distinction, Hispanic or Latino families vary in customs and beliefs depending upon whether they come from the cultural traditions of Cuba, Puerto Rico, Mexico, Costa Rica, or a multitude of other countries.

Some two million Native Americans were identified in the 2000 U.S. Census – less than one percent of the population in the United States. Within this single ethnic group exist some 546 tribes, each with its own cultural heritage, recognized by the U.S. Bureau of Indian Affairs. Tribes native to Florida include the Seminoles and Miccosukees, both of which are part of the Creek Tribal Nation.

Stereotypes

Stereotypes are prejudged perceptions of how certain ethnic families behave. These perceptions can detrimentally impact the ability of a visit monitor to effectively observe interactions between a parent and child. The following exercise will help illustrate this.

Exercise

Instructions: Read the following vignettes and write down the name(s) of the ethnic group(s) that come to mind in each. After reading all the vignettes, discuss your responses and then consider whether your response are stereotypes. Then read aloud the actual circumstances that follow.

Vignettes:

1. While I was stopped for gas in the country, a pick-up truck also stopped at a gas tank near mine. I noticed a Confederate flag sticker on the truck, and a gun rack in the back. A man with a large belly and a tattoo on his right arm got out of the pick-up and yelled, "Hey boy, fill-er up!"
2. I'm sitting in the family room of a home. The children are polite and well-behaved, bowing when the grandfather enters the room and treating him with considerable respect. The children indicate that they're having fried rice for dinner, and when they set the table, they ask whether I want a fork or chopsticks.
3. While walking down an inner-city street, I observe some individuals sitting in front of a housing project listening to loud music while performing some fancy dance moves. A large SUV with chrome accessories drives up, and an attractive woman gets out. I hear someone say to her, "What's happening, Momma?"
4. I'm sitting in the dining room at a table. Several other people are seated around the table having a great time: drinking wine, eating spaghetti and laughing loudly. There is opera music playing softly in the background.

Actual Circumstances:

1. The pick-up driver is a Native American who borrowed his friend's truck to pick up his daughter returning from college at the airport. She's studying to be an engineer. The gas attendant is the man's nephew, an honor student in high school. He is working at the gas station to earn money for college. The man loves his nephew and the greeting "Hey, boy, fill'er up" is his way of relating to his nephew in a loving, joking manner.
2. The grand-father entering the room is attending his 75th birthday party. He is a person of German descent who happens to love Chinese food. He worked as an engineer in Taiwan for a number of years and is adept at using chopsticks.
3. The individuals sitting on the steps are of Hispanic descent and are preparing for a neighborhood block party. Some of the young individuals dancing belong to a folk dance group that will be performing at the block party. The attractive woman is the mayor, a White woman who has been invited to the party. The person who says, "What's happening, Momma?" does so as a friendly joke.
4. The family is an African-American family that loves pasta and wine. This is a close-knit, three generation family. Members enjoy each other and laugh at each other's jokes. The hostess hates loud music while visiting with her relatives, so she keeps the volume on the CD player low.

Cultural Sensitivities

For many parents, involvement with a supervised visitation program is involuntary and entirely unwanted; that is, they want to see their children but do not want to do so in a supervised visitation setting. Nevertheless, if these parents want to see their children, they must do so in a supervised setting and comply with program rules and limitations. Ethnic groups whose history has included being discriminated against may well have a culturally-ingrained sensitivity to being told what to do by members of a dominant class or culture. Thus, some culturally diverse family members may respond more negatively to the visits than would someone from another cultural background. The following case example illustrates this sensitivity.

Case Example & Discussion Questions

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

Ms. Jones and Mr. Harrison's children are in foster care due to findings of child maltreatment. When the visit monitor met with the parents prior to the first visit, she explained the program rules and the rationale behind some of the rules. During this process, done in each instance when a new family is referred, Ms. Jones said, "Just because I'm black doesn't mean I can't read. I'm sick of you people assuming I am stupid." The visit monitor told Ms. Jones that it was not her intent to imply that Jones was either stupid or illiterate. She said that as part of her role as visit monitor, she had to ensure that parents understood the rules since visits would be terminated if the rules were not followed. The visit monitor then let Jones read the rest of the agreement and ask questions. Ms. Jones had questions about many of the rules, and the visit monitor responded to her questions.

Ms. Jones appears to have a quick temper. During subsequent visits, Ms. Jones has been quick to become angry if something happens that she feels is unfair.

Discussion Questions:

1. What reasons can you think of for Ms. Jones' reactions?
2. Do you think it is likely that Ms. Jones' responses have anything to do with the history of African-Americans in our country?
3. Would it be helpful for the visit monitor to assume that Ms. Jones' is personally angry with her?

Cultural Views of Family Structure

Child-rearing philosophies and practices vary greatly between cultures. Some ethnic groups hold that children should be seen and not heard, while others are more child-centered. Some cultures view children as property of their parents, while others believe that children belong to the entire community. The important point for visit monitors to keep in mind is that culturally diverse families need to be treated with the same level of dignity and respect that the monitors themselves would desire in interactions with others. Visit monitors should not view all families with the same "lens." Effective child-rearing practices may well differ among cultures.

The list below highlights some of differences in culture which impact family structure or parenting and thus impact the observations of a visit monitor:

- Concept of time: In some cultures, arriving early or right on time is considered disrespectful as the person appears too eager to get on with a scheduled activity. A visit monitor not knowing this may become angry when a parent repeatedly shows up late for a visit or when a foster parent brings a child late to visits.

- Eye contact: In some cultures it is not considered respectful to look directly in another person's eyes. In other cultures it is considered a sign of respect to do so. Some parents encourage their children to look them in the eyes, while others consider it disrespectful for a child to engage in eye contact with a parent or older adult.

- Respect for elders: In some cultures, it is extremely important to express respect for elders by deferring to them, using certain forms of address (Mr., Mrs., Auntie) or other means.

- Expressing emotions: Some cultures condone public expression of a range of emotions, while others reserve expressing emotions to very private places. A visit monitor who is not aware of this may misconstrue the lack of emotion and infer that a parent is not happy at seeing his child, even though that parent is merely being consistent with his cultural habits.

- Self-disclosure: Some groups that have experienced historic discrimination may have learned that self-disclosure can be risky. Thus, they are quite reserved in answering questions unless they are among others they know to be trustworthy. In contrast, members of dominant social groups may seem more open and revealing.

- Role and discipline of children: In some cultures, children are expected to adopt "adult roles," such as caring for younger children at a very young age. In other cultures, children are not expected to engage in caring for other children until adolescence. Corporal punishment is seen as good and necessary in some cultures, while others view physical punishment of any kind as unnecessary and abusive.

- Use of physical affection: Culturally, the use of physical affection (hugging, kissing, hand-holding) may vary. In some cultures, it is common for parents to show physical affection, while in others it is not. Additionally, in some cultures parents may show affection differently to male and to female children.

Working with Culturally Diverse Families

Visit monitors must be able to develop cultural competences in order to effectively facilitate visits with families. In order to have cultural competencies, a visit monitor must:

- Respect the unique culturally-defined needs of various families.
- Acknowledge culture as a primary force in shaping a family's behaviors, values and institutions.
- Believe that families as defined within their specific culture are the primary and preferred point of intervention.
- Acknowledge that minority families are served in varying degrees by their natural cultural systems.
- Recognize that the concepts of family and community will differ among cultures and subgroups within cultures.
- Understand that culturally diverse clients are usually best served by persons who are either part of their culture or in tune with their culture.
- Accept that cultural differences exist and have an impact on the delivery of supervised visitation services.
- Acknowledge that some values of culturally diverse families may be in conflict with dominant societal values.

Exercise

Supervised visitation staff should reflect upon their own belief systems and be willing to develop cultural self-awareness in order to more effectively work with families. To do so, staff might want to reflect on the following questions, and discuss their answers in a group setting:

a. What is your primary cultural identification?

b. Describe at least two family structures that may be different than your own.

c. Within your cultural background, how is a "good" parent described?

d. Is it important for parents to play with their children?

e. Should parents spend a lot of time interacting with their children?

f. What are your feelings about the use of physical discipline?

g. Is it important for parents to show patience when interacting with their children?

h. Should children's respect for their parents be the most important consideration in a good parent-child relationship?

i. Do you believe that "children should be seen and not heard?"

j. Should children be the focus of the family unit?

k. Should the father be viewed as the head of the family unit?

l. Should the mother be viewed as the head of the family unit?

m. Should parents be partners in parenting?

n. Can same-sex couples be good parents?

Coming From Where I'm From

My name is Byron and I'm an African-American social work intern at a visitation program. I can understand why some visitation monitors may misunderstand or misinterpret parent-child behaviors when observing visits with families from different backgrounds from their own. I grew up in an urban neighborhood with many different family members, mainly because my mom was incarcerated. In one of my families, my oldest cousin, who was 15, was responsible for all the cooking and regulations of the house when the adults were away. I lived in the type of environment that one would have to live in to be able to understand it. That is why if we had to choose out of a line-up of possible supervised visitation workers to observe us, we would have most likely chosen the worker from our ethnic background. We would assume that he or she would be able to relate to us more. If you were to see some of my family in a visitation center, one should not expect to see kissing and hugging for the duration of the visit. The first five minutes would consist of greetings – we may not express too much because of our background as African-Americans and our concern over others watching us too much. We may feel a little uncomfortable expressing ourselves in public places – it may be insulting for workers to "stare" at us during the whole visit. Do not get it twisted though – just because we do not show enough affection to some visitation monitors' expectations does not mean that we do not love and care for each other. We just do things differently.

The bottom line is for visitation monitors not to judge others' culture based upon their own. Be open-minded about things that take place during a visit that may be completely different from what you are used to seeing. ***That does not mean we tolerate physical abuse.*** But try to understand why different cultures may act a certain way and see it as interesting instead of deviant behavior.

Strategies for Visit Monitors

Certain strategies and techniques can be incorporated by visit monitors to reflect cultural competencies:

- If the visiting family does not speak English and the visit monitor does not have verbal competencies in the language they do speak, a translator should be provided. Visit monitors should avoid having a family member serve as a translator. Court staff or hospital social workers can often help in identifying translators.

- Likewise, if a parent needs to use sign language to communicate, make sure that the visit monitor can employ sign language as well, or make arrangements to have someone present who can sign when visits are scheduled.

- Visit monitors must not assume that how they parent or expect children to behave is how all families act.

- Visit monitors should learn more about cultures different than their own. If, for example, their supervised visitation program has a number of Haitian families, then the visit monitor should become familiar with aspects of that culture. It is important for monitors to remember, though, that there are always differences within cultures, not all Haitian families act the same as other Haitian families.

- Visit monitors should be respectfully inquisitive of differences. They should let parents inform them about how parenting or other issues are handled in their culture.
- Special care should be taken not to interpret culturally-different parenting practices as "bad" or "wrong" unless such practices are clearly harming children or putting children in imminent danger.
- Visit monitors need to be informed about different religious practices and how families' participation in religious activities may impact their supervised visits. For example, observation of religious holy days varies from one religion to another and can affect a parent's ability to visit on a specific date. Such observance may also affect whether participants can eat or need to pray during a scheduled visit.
- Visit monitors should treat all families and their traditions with dignity and respect unless specific harm is threatened.
- Visit monitors should encourage families to discuss their family's traditions and to inform others of their customs if they so desire.
- Visit monitors might also ask families who they would like to include in discussions about their families – e.g. a second mother or father or an "auntie" who is not a blood relative but who holds special status for family members.
- Visit monitors need to determine what names a child uses to refer to family members. In same-sex families, some children refer to both parents as Mother ("Mama Jane/Mama Sally").
- In cases of gay families, visit monitors need to assess how open the parent is about sexual orientation. (That is, does the child know; is the parent's sexual orientation an issue in custody and visitation?)
- Visit monitor can ask if the family has resources (toys, food) that would help reduce cultural differences between the home and the setting of the visitation center? (Visit monitors would have to assess whether any of these resources might present harm or violate program rules prior to agreeing that the parent bring them.)

Case Examples

Instructions: Read the following case examples and then discuss both the cultural backgrounds of the parents and how their respective backgrounds may impact observations during visits. Identify ways in which monitors can make their interactions with a visitation participant more responsive.

Case One: Janel Baker is a 28 year old African-American mother of three sons ages 15, 11 and five. Due to her substance abuse problem, Janel's children were removed from her home and she is ordered to have supervised visitation as part of her case plan. She is working two minimum wage jobs to support her family and is caring for her mother, who is disabled and lives with them. During the first visit, Janel sits on a sofa and just stares at the boys. The older boy ignores her and sits in a corner closing his eyes. The eleven-year-old bosses the five-year-old around. When first seeing the boys, Janel kisses them and greets them but does not interact otherwise. A visit monitor offers her a book to read to the five year old, but Jane declines. During a second visit, a monitor tries to get Janel and her sons to play a board game. After five minutes, no one seems interested in pursuing the game. The monitor notes minimal interaction.

(Note: the monitor is a married white woman who is 42 and raised her own three children while being married to a physician. She has never worked outside of the home. Her children were taught to read before kindergarten and she believes all good parents should consider home schooling their children).

Case Two: Mickey and Rick are gay men in their 30s who have had a civil commitment ceremony. Mickey was formerly married and had two children, a daughter age six and a son age four. When his former wife found out that Mickey was gay, she asked the court to order only supervised visitation. Mickey shows pictures of Rick during the visit and refers to him as his "partner." The children tell Mickey that he is bad and that all gays will go to hell. Mickey wants to bring age-appropriate children's books to the center which discuss same-sex parents in a more positive light.

Case Three: The Juarez family: father, Roberto (25); mother, Rachel (age 22) and their children Juan (7) and Maria (5) are ordered to use a visitation program. The children have been living in a foster home while allegations of abuse are being investigated. The visitation program has a translator, but she is not available on the days when the Juarez family uses the program. The family uses limited English. Rachel asks the staff if she can bring food to cook for the children during visits, but is told she cannot. She becomes upset and says that food is one way she shows love to her children. During the visit, the monitor reminds the parents constantly to speak English. The children seem embarrassed by their parents' accents and don't interact much.

QUIZ

1. Define the following terms:
   - Ethnicity
   - Cultural competence
   - Homophobia
   - Stereotype
   - Sexual orientation
   - Disabled
   - Second-parent adoption
   - Prejudice
2. What are the preferred terms for the following: disabled, sexual preference?
3. Describe ways in which a visit monitor can better meet the needs of culturally diverse families.
4. Discuss what is meant by being culturally competent.
5. List recommended training topics on cultural diversity that you have had and those that you still need.
6. Identify ways in which your visitation program can better meet the needs of culturally diverse families.

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