A Training Manual for Florida's Supervised Visitation Programs

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CHAPTER 1

FLORIDA'S FRAMEWORK FOR SUPERVISED VISITATION

Introduction

This Chapter explains Florida's current standards, best practices, and statutory mandates for supervised visitation programs. It includes commonly asked questions for new programs. In order to understand Florida's framework for supervised visitation, there are three documents which must be considered:

Florida Statutes Chapter 753	Florida Supreme Court's Minimum Standards	2008 Report to the Florida Legislature: Best Practices for Programs

The state of Florida has one of the most structured and transparent systems for the service of supervised visitation in the U.S. However, the state's goal of a formal certification process and stable funding for programs has not yet been realized. Even without a certification and funding structure, there are still many training resources for programs funded by the Department of Children and Families.

In 2017, programs still use a skeletal set of Florida Supreme Court Standards (called the "Interim Minimum Standards" in Florida Statutes Chapter 753) written in the late 1990's. In addition, the Clearinghouse encourages programs to follow a more updated set of

Recommended Standards, commonly referred to as "best practices," from the 2008 Report to the Florida Legislature. Both are discussed below.

Note

Note: Programs must work closely with the Courts, but this chapter does not include information on that topic. Instead please see chapter 4 entitled "Working with the Court."

What will I learn in this chapter?

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

- Understand the elements of Florida Statute 753
- List the purposes of supervised visitation mandated by the Supreme Court's Minimum Standards for Supervised Visitation Programs
- Understand the scope and limitations of the best practices in the 2008 Report to the Florida Legislature
- List the elements of a Client's Agreement with the Program
- Describe the requirements of an Agreement for accepting child sexual abuse referrals
- Identify the Clearinghouse's set of training materials and tools on the web

"The Mission of Florida's Supervised Visitation Programs is to use well-trained staff to provide safe and respectful Supervised Visitation and Monitored Exchange services and to coordinate these services within each community. Programs accomplish this mission by adhering to four principles: safety, training, dignity and diversity, and community."
(From the Report to the Florida Legislature, See Appendix)

Snapshots and Facts

- There are currently approximately 100 programs offering supervised visitation in Florida.

- Most judicial circuits in Florida are home to at least one supervised visitation program.

- Over the last decade, six programs in Florida have received federal funding from the US Office on Violence Against Women to provide supervised visitation in domestic violence cases.

- Approximately 28 programs receive federal Access and Visitation funding annually from the U.S. Office on Child Support Enforcement through the Florida Department of Children and Families.

- There are three important documents that guide supervised visitation services in Florida: Florida Statutes Chapter 753, The 1999 Florida Supreme Court's Minimum Standards for Supervised Visitation Program Agreements; and the 2008 Report to the Florida Legislature. All can be found on the Clearinghouse website familyvio.csw.fsu.edu.

- Programs may take a variety of cases. These may include dependency cases, divorce and post-divorce related cases, paternity cases, and criminal cases.

Definitions

The following definitions were created by the Supervised Visitation Standards Committee and appear in the Report to the Florida Legislature.

Supervised visitation is contact between a parent and a child overseen by a trained third party in a controlled environment which enhances the safety of all vulnerable parties. The contact between the parent and the child is structured so that program personnel may actively encourage the parent-child relationship by providing age-appropriate activities, helping parents develop or enhance parenting skills when necessary, modeling appropriate interactions with the child and discouraging inappropriate parental conduct. Although Supervised Visitation program staff facilitate and support the parent and the child relationship, facilitation and support should not be construed to mean therapeutic intervention rising to the level of therapist-client relationship.

A **supervised visitation program** is an entity that has as its core function the provision of supervised visitation and/or monitored exchange services, and has entered into an agreement with the Chief Judge of the circuit in which the Program is located to provide services pursuant to the program agreement and court order. A Program may operate under the auspices of the court, or be a not-for-profit corporation or association, or be a component of a larger not- for-profit corporation or association. Some private for-profit programs also exist in Florida.

Types of Supervised Visitation

- Group supervision: supervision of parent/child contact in which more than one family is supervised by one or more visit supervisors simultaneously; also referred to as "multiple-family" supervision
- Individual/"one to one" supervised visitation: one visitation monitor for one family
- Therapeutic Supervision: the provision of therapeutic evaluation or therapeutic intervention to help improve the parent-child interactions; may only be provided by order of the court and only by licensed mental health professionals who are also specifically trained to provide supervised visitation
- Facilitation or supportive/educational visitation: the means by which program personnel actively encourages the parent- child relationship, and should not be construed to mean therapeutic intervention rising to the level of a therapist-client relationship.

The Purposes of Supervised Visitation

According to the Minimum Standards, the purposes of supervised visits are:

(1) To assure the safety and welfare of the child, adults, and program staff during supervised contact.

(2) To enable an ongoing relationship between the noncustodial parent and child by impartially observing their contact in a safe and structured environment and to facilitate appropriate child/parent interaction during supervised contact.

(3) Where appropriate, to provide written information to the court regarding the supervised contacts.

(4) Programs may also provide other services, including parenting education, mediation, assistance with parenting plans, and others, listed at: http://familyvio.csw.fsu.edu/clearinghouse/fl-programs/

Florida Law

The Florida law that deals directly with supervised visitation program function is Florida Statutes Chapter 753. This statute outlines definitions and terms of supervised visitation services, describes the functions of the Clearinghouse on Supervised Visitation within Florida State University's College of Social Work (in the Institute for Family Violence Studies), and creates the requirement for supervised visitation programs to have Agreements with the Court. It also provides additional rules for programs that accept cases involving child sexual abuse.

§753.03, Fla. Stat. requires the Clearinghouse to develop a new set of standards that will ensure the safety of children and families for supervised visitation programs. These were created and published in 2008, but they have not been approved by the legislature or "fully implemented." They are only considered Best Practices, and are located at http://familyvio.csw.fsu.edu/clearinghouse/standards-best-practices/

§753.03, Fla. Stat. mandates that until the standards for supervised visitation and supervised exchange programs are completed and a certification and monitoring process is fully implemented, supervised visitation programs must comply with the Minimum Standards for Supervised Visitation Programs Agreement adopted by the Supreme Court in 1999. These Standards require a supervised visitation program to form an agreement with the circuit court(s) within the geographic jurisdiction of the program which will confirm the willingness of the program to comply with the Supreme Court's standards.

Under §753.04, programs cannot receive federal funding through the Department of Children and Families under 42 U.S.C. §669b, unless the program provides documentation to the state agency administering the grant that verifies an agreement between the program and the circuit court.

§753.05: Referrals involving child sexual abuse

This section of the statute mandates that in order to accept referrals involving child sexual abuse, a visitation program must have an agreement with court and current affidavit of compliance on file. Additionally, the chief judge of the circuit in which the program is located must affirm that the program has agreed to comply with the minimum standards.

- The program must also have a written an agreement with the court and with the department that contains policies specifically related to child sexual abuse that include provisions for the following:
  - Staff who supervise visits must have specific training on child sexual abuse by the Clearinghouse and that training must be documented in personnel files
  - The program must have protocols on how to obtain background material on the family prior to starting services
  - The program can only accept referrals for which the staff already has background material, training, and security in place to safely monitor visits.
  - The program cannot accept referrals when staff lacks the education, training, background material, and the security necessary to ensure safety of the child.
  - The program must cease visits if the child appears to be traumatized by the visits or when the visitor engages in inappropriate behavior or violates the program rules.

Use Your Resources

A copy of the Department of Children and Families' agreement for supervised visitation programs in sexual abuses appears as an appendix to this chapter.

REMINDER

Agreements with the Court are described in the chapter entitled "Working with the Court."

Important Roles under the Supreme Court's Minimum Standards

The chief judge in each judicial circuit has responsibility for:

a. the oversight of a program operating under the auspices of the court; and

b. entering into a Program Agreement with independent programs that are in compliance with minimum standards for providers of supervised contact services. (See Chapter 4 on **Working with the Court**.)

The role of the referring judge is to determine when supervised contact is appropriate and to ensure that referrals for supervised contact are comprehensive and specific as to the conditions under which the supervised contact is to occur, including the party responsible for the payment of fees for the supervised contact services. The judge shall also ensure that referrals are appropriate for the level of service available in a program.

The role of a program is to provide a safe, independent site at which supervised contact between the noncustodial parent and child may occur; to ensure that program staff have adequate training to observe the contact; and where appropriate, provide written information about such contact to the court.

The role of a program director/coordinator is to ensure the overall quality of services provided and he/she will also be able to assume roles associated with that of visitation supervisor.

The role of the visitation supervisor is to:

c. maintain independence from parties;

d. ensure that contact between parties proceeds pursuant the visitation agreement and court order;

e. relay relevant information relating to the child's welfare between the custodial and noncustodial parent at the commencement and conclusion of supervised contact (e.g. special needs, medication, diet, etc.);

f. intervene, where necessary or appropriate, to ensure the welfare of the child or parent;

g. if necessary, facilitate child/parent interaction during the supervised contact;

h. terminate the visit if the child's safety or that of other parties or staff cannot be maintained;

i. provide constructive feedback, correction, or redirection;

j. document the visits consistent with the program agreement.

Program Policies and Procedures

Under the Minimum Standards, Programs must have comprehensive written operating policies and procedures, which shall include, at a minimum:

- types of services and manner in which they are provided;
- case acceptance and discharge policies;
- procedures for communication with the court, including how the program and the court will avoid impermissible ex parte communication;
- procedures for providing reports to the court;
- the visitation agreement;
- payment of fees;
- hours of operation that are accessible to use;
- restrictions for transportation of children;
- security measures and emergency protocol and/or procedures;
- grievance procedures;
- policies and procedures regarding release of information;
- employment policies and policies governing the acceptance and discharge of volunteers, including: non-discrimination policies regarding the employee or volunteer's race, religion, gender, sexual orientation, national origin, age, disability, marital status; and policies that comply with the laws and regulations governing fair employment practices.

The Best Practices call for additional operating policies on the following:

- Risk and danger assessments for all referral types;
- Intake, documenting observed behavior;
- Record retention;
- Sexual abuse allegations;
- Photography;
- Gift-giving.

Visitation Agreements Between Programs and Adult Clients

Adult Clients of Supervised Visitation Programs should enter into Visitation Agreements with the program to ensure compliance with program policies and procedures.

A Visitation Agreement is a written agreement between the program and each custodian and visitor 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 the program's records, except as provided by the law or order of the court. (Best Practices: Report to the Florida Legislature)

Elements of a Visitation Agreement with Adult Clients

In all cases, visiting parents and the custodian in non-dependency cases must sign an Agreement that states they will comply with the requirements of the Program.

A Program's Standard Agreement must contain at least the following, but may contain additional information as well.

1. General Program usage information, such as:

- The primary purpose of the visit center
- Hours of operation of the Program and holidays
- A "hold harmless" clause
- Prohibitions on firearms and weapons of any kind.
- Building access information (arrival and departure time)
- Names of all participants authorized to visit
- Specific security protocols and conditions of the Parties; including separation of the parties
- Supervision model/level
- Information regarding records access
- Fee and fine information
- Process of forms, reports, and court correspondence

- Scheduling and cancelling visits, including the Program's discretion to cancel any visit.

2. Participants must have an understanding and agreement with the Program rules: this understanding and agreement must be documented in a provision within the Agreement.

3. Additional rules must be included in the Agreement as well as commonly relevant issues including at least:

For the visitor:

- Policies regarding suspicion of drug or alcohol use prior to or during visit
- Policies regarding sexual abuse allegation cases
- Policies related to physical space where visit occurs
- Policies regarding smoking, pets, cell phones, and cameras
- Policies on gifts
- A section for special conditions

For both the visitor and custodian:

- Policies designed to keep visual, auditory, and physical separation of the parents
- Policies regarding food
- Policies regarding corporal punishment
- Policies about speaking foreign languages
- Policies about any topics or remarks that should not be discussed in the presence of the child
- A section for special conditions
- Signature and date of visitor, custodian, and program representative

Frequently Asked Questions

Starting a new program? New to supervised visitation as a concept? Let these frequently asked questions give you some clarity on the basics, and guide you as you do further research.

I would like to know about supervised visitation. What is it?
Supervised visitation is contact between a parent and a child which is overseen by a trained third party. The supervision is in a controlled environment, which enhances the safety of all vulnerable parties. The contact between the parent and the child is structured so that program personnel may actively encourage the parent-child relationship by providing age-appropriate activities, helping parents develop or enhance parenting skills when necessary, modeling appropriate interactions with the child, and discouraging inappropriate parental conduct.

What is a supervised visitation program?
A supervised visitation program is an entity that has as its core function the provision of supervised visitation services in a family-centered manner. Programs enter into an agreement with the Department of Children and Families and the Chief Judge of the circuit in which the Program is located to provide services pursuant to the program agreement and court order. A Program may operate under the auspices of the court, or be a not-for-profit corporation or association, or be a component of a larger not-for- profit corporation or association. Private entities may also operate supervised visitation programs, but there is no local, state, or federal funding available to such entities.

What does Family-Centered mean?
The Department of Children and Families has a strategic mission of ensuring that all assistance to families in Florida is consistent with Family-Centered Practice. The purpose of such a practice includes ensuring that families have an active,

leading role in reaching a resolution to their problems. Those who use a Family-Centered approach are respectful of the family's ethnic background, always focus on working with a family's strengths to help it meet its goals, and take the time to understand what the family needs to help it reach those goals.

Is there a need for more supervised visitation programs?
Currently, over 60 supervised visitation programs exist in Florida. There is a need for more programs, especially for cases that involve parents whose child has been removed from the home by child protective services such as the Department of Children and Families. However, funding for more programs is scarce.

Who funds supervised visitation programs?
Currently, programs in Florida are funded by several sources, including federal Access and Visitation grants which (partially) fund 28 programs, federal Safe Havens grants, which have funded (at different times) six programs in the state, and a variety of municipal, state, and private funding sources. Programs are constantly seeking new sources of funding, and overall funding for programs is considered unstable. Many programs have suffered cutbacks during the economic downturn. In addition, many of the Community Based Care agencies in the state use their own staff to supervise visits.

How do supervised visitation programs obtain clients?
In most cases, the courts and child protective services agencies refer families to supervised visitation programs. Sometimes programs accept self-referred families, but only under certain circumstances and after a thorough safety review. Parents in divorce/custody cases also often pay a sliding fee for services. Visits in family court cases, which typically originate from judicial referrals, are never paid for by the court. Visits in dependency cases, in which the child has been removed from the home by a child protective services agency, are usually paid for by the agency pursuant to an agency contract with the program.

How does a program obtain a contract from a Child Protective Services Agency?

The Florida Department of Children and Families (DCF) has partnered with child protection Community-Based Care organizations across the state. Sometimes the CBC will decide to keep the supervised visits "in house" and dedicate staff to supervise visits. However, when the CBC seeks to contract with a supervised visitation provider, it will issue a request for proposals (RFP). Programs that apply for state dollars under such an RFP engage in a competitive grant process which ultimately determines who will receive the contract. RFPs are usually on a state fiscal year calendar, from July 1 until June 30, and can be awarded for annual or multi-year terms.

Can SV programs use volunteers?

Yes, but no program staffed by volunteers alone has survived more than a year. Volunteers, although crucial to many programs, should only supplement the paid staff at programs. They do play an important role in an otherwise stable program, though, and the Clearinghouse encourages programs to find ways to maximize their use.

How much does it cost to operate a supervised visitation program?

That depends on many factors, including hours of operation, rent and operating costs, number of staff, staff-to-client ratio during visits, salary of staff, etc. Budgets at Florida programs have ranged from $80,000 per year for a small program with weekend-only hours, to $750,000+ per year for programs operating five to seven days a week. Other typical expenses include criminal history checks on volunteers and staff, salaries and benefits for employees, insurance costs, utilities, office equipment and supplies, furniture, toys, pest control, security, and site maintenance.

Are there any rules or regulations I should know about?
Yes. There is a set of standards created by the Florida Supreme Court in 1999 that are still in effect. Florida Statute 753 also discusses supervised visitation. In addition, there are Best Practices created by a legislatively-mandated Supervised Visitation Standards Committee in 2008 that are used throughout the state. All programs that receive referrals from the court aspire to meet the best practices. In addition, programs are required to conduct criminal background checks on all staff and volunteers. The extensive best practices can be found online at http://familyvio.csw.fsu.

Is there any certification for Programs or Providers?
No, the Florida Legislature has not yet mandated a certification process for programs or providers. DCF does not certify programs, but it does require that all programs receiving state funds enter into an agreement with the court in the jurisdiction of the program and DCF. The agreement must state that the Program will abide by the Supreme Court Standards. The Clearinghouse supports a certification process, but does not currently have the authority or capacity to certify programs.

Is there any specific training or knowledge necessary for supervised visitation staff?
Yes, program directors and staff of programs are required to have extensive training. Program directors should also have college degrees and experience in working with families in crisis. A lack of proper training can result in the revictimization of children and vulnerable parents on-site. The Clearinghouse on Supervised Visitation provides a great deal of training on its website: familyvio.csw.fsu.edu.

What kinds of problems do the families at supervised visitation have?
The families referred to supervised visitation may have a variety of problems, including allegations of parental substance abuse, domestic violence, parental mental illness, parental kidnapping, child abuse and neglect, parental criminal activity, and/or other potentially detrimental parental behavior. Thus, working with

these families requires a great deal of training, skill, patience, respect, and attention on behalf of staff.

Are there any risks associated with supervised visitation?
Yes. Although the majority of cases proceed with supervised visitation without incident, every program has experienced a variety of safety issues. These range from parents who arrive under the influence of drugs and alcohol to parental revictimization of children on-site, parental attempts at kidnapping, one parents' stalking of the other parent, and physical assaults on staff. Because the dynamics of supervised visitation are unique, intensive training is necessary for all staff. The Clearinghouse publishes training material that describes the risks in the service, and all prospective providers must be aware of the potential risks involved in supervised visitation. All cases must be screened by staff for safety issues, and programs are encouraged to have a working relationship with the local law enforcement agency so that the agency understands the program's mission, goals, and structure. In addition, law enforcement agencies can advise programs about safety issues such as site safety and emergency response protocols.

What kinds of safety measures are used at supervised visitation programs?
Programs must be designed, developed, and administered with safety in mind. All cases must be thoroughly assessed for risks, and programs must only accept cases in which they have considered and can reasonably address the safety needs of vulnerable parents and children. In addition, programs are required to have safety measures and protocols in place because of the high level of family violence that often exists in supervised visitation referrals. (Referring judges typically do not screen for such risks before making referrals.) All cases must be screened by trained program staff using a danger assessment, and many programs use security personnel to enhance safety. Special and distinct protections exist for cases involving child sexual abuse. Having on site security personnel (usually off-duty law enforcement officers) is best practice at supervised visitation programs, especially for cases that involve violence.

Can I refer clients to other services?
Yes. Supervised visitation programs are part of communities' efforts to serve families in crisis. Program directors should ensure that the program is part of a community community's coordinated response to the holistic problems of troubled families. Each supervised visitation program must be informed about the diverse identities and needs of the local population. Community groups can serve to educate and support each other in a coordinated response to child abuse, domestic violence, substance abuse, economic problems and the related problems experienced in families in crisis. All program directors should be knowledgeable about existing community resources in order to make culturally appropriate, informed referrals to community agencies.

I think I can help! How do I get started?
First, don't open a program until you are sure that the community can support it. (Information about forming a non-profit organization can be found on the internet.)

Far too many well-intentioned people have started the service of supervised visitation before developing a strong foundation for it. Thus, many programs have failed shortly after opening because of poor preparation. Traditionally, successful programs get their start after a community collaborative has ensured that the service is needed, and has created the framework for a safe program with stakeholder buy-in.

What is a community collaborative?
A community collaborative is a core group of community members who have a stake in the availability, competency, and outcomes of a successful supervised visitation program providing quality services. This group may eventually form the program's community advisory board, or may only be brought together to help initially form the program. Judges are typically consulted to ensure that they believe that there may be cases to refer to a new program. (Even if judges agree in principle that a program is needed in a community, this does not create an obligation on the part of the judges to send cases to the program.) If the program intends to accept dependency cases that originate from child protective services agencies (Florida Statutes, Chapter 39), it is essential for representatives from the child protective services agency to communicate and correspond with the program.

Other members of the core community collaborative include the following:

- A member of the mental health community who specializes in child or family counseling and can help the program enhance the program environment for children;
- A family law attorney who can help advise the program about court orders;
- A representative from a local law enforcement agency, so that the agency understands the mission and goals of a program and can advise the program as to safety risks, issues, and potential security measures;
- A representative of the Guardian Ad Litem office, especially if the program plans to take dependency cases;
- A representative of the local domestic violence victim advocacy community to assist with cross training and informing about domestic violence dynamics and victim services.

These people can help determine whether or not the community can support a supervised visitation program. They may also be able to assist you with conducting a community Needs Assessment. Contact the Clearinghouse for a sample Needs Assessment.

What if I don't have a building for my program? Can I go into people's homes, or meet them in public places for visits?

Many entrepreneurs ask this question, and the Clearinghouse strongly cautions them to avoid off-site visits because of safety risks involved. We reiterate here what the Best Practices say about off-site visits:

Any Off-Site Visitation is subject to increased safety measures and training.

A. **Off-Site Visitation:** In non-dependency cases, courts sometimes ask Programs to provide supervision of parent-child contact in a setting such as a mall, restaurant, park, or any other location not on the Program's physical site. These visits are called "off-site" visits because, by definition, they are not conducted in a Program site/location. They have the disadvantage of less control, fewer safety precautions, and increased risk of intervening persons and circumstances. For these reasons, most programs do not offer "off-site" visits.

B. **General Considerations for Off-Site Decisions**: The following considerations apply to off-site decisions:

1. Programs may not be compelled to conduct off-site visits by any referring source, including the courts.
2. Program directors retain the discretion to reject any off-site referral for safety reasons. This includes a history of parental threats of abduction, and risk of flight. It also includes parental history of or threats of violence.
3. Cases where there is currently entered a temporary or final order of injunction for protection against domestic violence or where there has been a criminal no-contact order or criminal conviction for domestic violence are not appropriate for off-site visits.

4. Cases in which there are allegations of sexual abuse are not appropriate for off-site visits.
5. Programs must demonstrate that they have considered the risks involved before agreeing to supervise off-site visits.
6. Referring judges must issue written orders for off-site visits and must consider any potential safety risks, including allegations of domestic violence. The order must contain specific findings that off-site visitation is safe for the parties and the child and is in the child's best interest.

C. **Risks Involved**: The following is a partial list of risks inherent in off-site visits. The Clearinghouse training materials address these risks more thoroughly.

- *Risks of child abduction.* An unsecured location with many entrances/ exits, open spaces, public access, and /or crowds increases the ability of a parent or his/her cohorts to abduct the child.
- *Risks of child abuse.* The ability to be vigilant – hear and see everything going on in a visit – is an essential component of supervised visitation, but is severely reduced in off-site visits.
- *Slow responses in emergency.* Programs have on-site security plans and work closely with local law enforcement to augment safety. The ability to get help quickly off-site may be reduced by the very nature of off-site visits. Staff simply have less control over the setting, intervening factors, and surrounding circumstances.
- *Multiple child complications.* Having more than one child present increases the possibility that the children will not be appropriately monitored off-site; that if something such as an illness affects one child, all of the staff 's attention must go to that child; that children can distract the monitor's attention easily, and that there is no backup to assist the monitor as there is on-site.
- *Transportation risks.* Visit monitors are not permitted to transport children in their own cars unless the Program provides adequate and specific liability insurance for such transportation. This makes off-site visitation much more likely to involve the transporting parents (who are involved in the dispute) to have an opportunity to negatively interact in the presence of the children. It also increases the risks to non-offending victim parents.
- *Concealed weapons risk.* On-site, programs choose between prohibiting visitors from bringing packages or parcels to visits, or searching any such parcels brought on-site. This helps avoid the presence and dangers of unauthorized concealed weapons. Off-site visits offer no such control, as there is no way to secure a public park, mall, or other similar location.
- *Intervening emergencies and circumstances.* Power outages, storms, intervening adults who show up unannounced (parent's friends, family, etc.), all decrease the monitor's ability to control the visit.

D. **Off-Site Prerequisites**: For those communities and Programs that have considered the risks yet have decided to offer off-site visits, the following apply:

1. Off-site visitation can only be conducted by staff who have at least three years of experience working with families at an on-site Program.
2. Each off-site referral must be pursuant to a court order which specifically states that off-site visitation is in the child's best interest.
3. Any Program offering off-site visits must have liability insurance that specifically includes coverage of off-site visits.

4. Separate policies and procedures dealing with off-site security issues must be developed by the Program.
5. The Program's Agreement with the court and DCF must include references to all of the above prerequisites (numbers 1-5 of this section).
6. Programs may not circumvent these requirements by referring off-site cases to current volunteers or staff acting as "independent contractors." All current volunteers and staff must agree not to take cases independently. This must be part of the Code of Conduct. (The Code of Conduct is part of Principle Two: Training in the Best Practices.)

Appendix A

The Minimum Standards and the Report to the Florida Legislature.

STANDARDS & BEST PRACTICES

You can access the Final Report to the Florida Legislature with the link below. In addition, you will find multiple resources on best practices, minimum standards, and compliance.

http://familyvio.csw.fsu.edu/clearinghouse/standards-best-practices/

Appendix B

AGREEMENT FOR SUPERVISED VISITATION PROGRAMS

Pursuant to S.39.0139 and S.753.05, F.S., this Letter of Agreement outlines specific requirements in the provision of supervised visitation services administered by the (Name):_____Supervised Visitation Program in accordance with the agreement on file with the_____Judicial Circuit.

The Florida Department of Children and Families (DCF) agrees:

1. To acknowledge the authority of the staff of the above-named Supervised Visitation Program to accept or decline referrals. Programs shall decline to accept a case for which they cannot reasonably ensure the safety of all clients, program staff and volunteers, for reasons including, but not necessarily limited to the following:

a. The volatile nature of the case or client;
b. Inadequate training of program staff and/or volunteers;
c. Inadequate facility security;
d. Insufficient resources;
e. Insufficient case background information;
f. Conflict of interest.

The (Name):_____Supervised Visitation Program agrees that:

1. The program has an agreement with the court and a current affidavit of compliance on file with the chief judge of the_____Judicial Circuit affirming that the program has agreed to comply with the minimum standards contained in the administrative order issued by the Chief Justice of the Supreme Court on November 18, 1999.

2. The program will ensure that all program staff monitoring supervised visitation and other contact will have previously received special training in the dynamics of child sexual abuse provided through the Clearinghouse on Supervised Visitation; same training will be clearly documented in staff personnel files.

3. The program will have protocols established for obtaining background information on the family/case, prior to the initiation of supervised visitation services.

4. The program will accept only those referrals for which staff members have the requisite case background information, training, and security in place to safely monitor visitation and other contact.

5. The program will decline referrals of child sexual abuse cases when staff lacks the necessary training or education, when background information has not been received, or when lack of security may enable re-victimization of the child.

6. The program will establish and train staff on procedures for staff to follow when supervising visitation and other contact, particularly in cases involving child sexual abuse.

7. The program will develop and follow policies for the handling and reporting of critical incidents.

8. The program will develop and enforce rules for appropriate interaction between the child(ren) and the parent(s)/individual(s) visiting during supervised visitation and other contact.

9. The program will suspend visits and subsequently notify the court in cases when the child appears to be traumatized by the visits, or when the parent/individual visiting or having other contact with the child engages in inappropriate behavior or otherwise violates program rules.

_____ _____

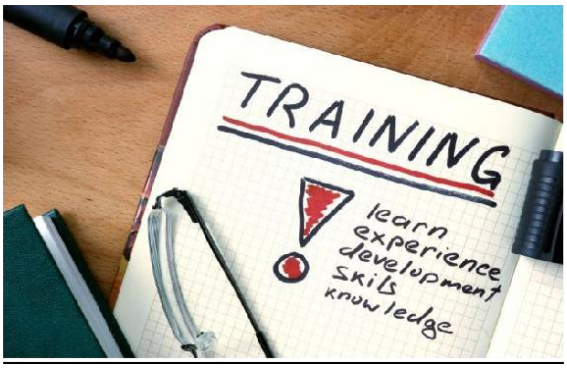
(DCF Representative Signature, Title, Date) (SV Director, Title, Date)

CHAPTER 2

TRAIN-THE-TRAINER: INFORMATION AND RESOURCES FOR SUPERVISED VISITATION PROGRAMS

Introduction

This instruction guide will help directors learn the basics of being an effective trainer. The Clearinghouse has produced a large collection of training material and continually releases new material online.
However, even though some of the manuals can be self-taught, it is extremely important for program directors to offer in-person trainings for new staff, using our materials. Each program director should learn how to train his or her staff on Clearinghouse materials. Ongoing training helps keep monitors updated with new research and skills.



What will I learn in this chapter?

Part 1: Facts/research about training in supervised visitation

- Designating a trainer
- Barriers to training
- Adult learning theory
- Components of memory and retention

Part 2: Training Skills

- How to be an effective trainer
- Minimizing stage fright
- Components of effective training Part

3: Evaluation

- Sample trainer/training evaluation forms

Designating a Trainer

When selecting a staff member to train others, there are a few things that should be taken into consideration:

- Knowledge related to proposed training
- Experience in public speaking
- Relatability
- Prior training successes

Since the quality and effectiveness of the training depends on the trainer, it is vital to select a trainer wisely and take all of these things into consideration.

Barriers to Training

There are several barriers to effective trainings that exist on multiple levels. Being aware of them helps directors, trainers and trainees to overcome them. Barriers may exist in the following areas:

- Organizational Barriers
- Personal Barriers of Trainer
- Barriers to Retention

Organizational Barriers

Some organizational barriers that may arise when attempting to facilitate a train-the-trainer session include limited funding to carry out the training(s), staff/managerial resistance, scheduling issues, and high turnover rates. Each of these factors present some impediment to successful trainings, but they may be overcome if they are addressed in a timely fashion in preparation for proposed training.

Personal Barriers of Trainer

In addition to organizational hurdles, there may also be several individual barriers for chosen trainers. These may include lack of confidence in speaking/training, stage fright, time/scheduling limitations, personal relationship barriers among staff, and credibility. Most of these barriers can be overcome by selecting the right staff member to carry out trainings and allocating time/funding for them.

Barriers to Retention

The final area in which effective training and learning may be hindered has to do with engagement of trainees and their capacity for memory retention. As will be discussed in more detail, adults retain information more readily when they are able to engage in the material. Information about adult memory retention and tips for how best to train them will follow. Armed with this information, trainers can present the material in such a way that participants retain the majority of the information they acquire through the training.

Adult Learning Theory

Adult learners are a unique group who learn in unique ways. As such, it is crucial that program directors understand the basics of adult learning, or **andragogy,** so that they can facilitate successful learning to their adult cohort. Here are the fundamentals:

(1) Adults need to know **why** they need to learn something

(2) Adults need to learn **experientially**

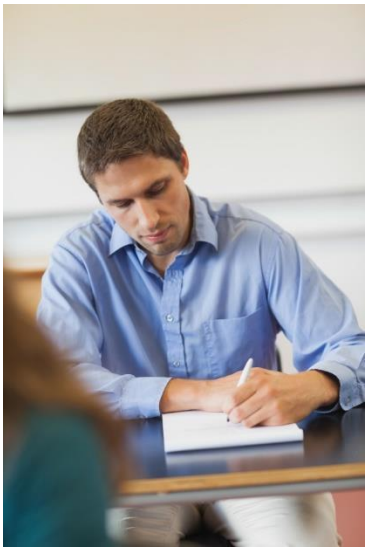
(3) Adults approach learning as **problem-solving**

(4) Adults learn best when the topic is of **immediate value**

(5) Adults have a need to be **self-directing**

Keeping these basic principles in mind, here are some tips for would-be trainers charged with training adults:

Mix it up: Employ a combination of learning strategies (auditory, visual, tactile, participatory) to keep your audience engaged, help them retain information, and appeal to different learning styles.



Define your Purpose: Adults respond best to a program that is clearly defined. Knowing why the training is needed, and how they can apply it, is crucial.

Be organized and well-paced: Information should be presented in an organized, concise manner, so the learner can create their own flow of understanding. Optimal pacing should challenge adult learners just beyond their current ability or knowledge to avoid boredom and create an intellectual challenge.

Material: Adults prefer information that will focus heavily on the application of the concept to relevant problems.

Be relatable: Adults need to learn experientially. Anchor information to existing knowledge.
Adults should be encouraged to voice their opinions, and relate the material to past experiences and knowledge. The use of open-ended questions helps foster open discussions and draw out relevant knowledge and experiences.

Create a comfortable learning environment: The learning environment should be comfortable enough to encourage engagement. Be sure to avoid long lectures and periods of interminable sitting with the absence of practice opportunities.

Motivate:
If the participant does not recognize the need for the information it will not be of value to them. You can motivate participants by enhancing their reasons for learning.

Challenge: Adult learners prefer to be self-directed. Allow them the opportunity to break into groups or work through the material on their own to engage in problem-solving.

Components of Memory

There are *six components* of memory. Each component means different things to a trainer. Adults tend to remember things that:

1. **Stand Out** – Make your information dynamic!
2. **Link to the known** – "Anchor" the information. Provide information that builds on what the learner already knows.

3. **Are written down or recorded** – Use handouts. Make it easy for participants to take notes.

4. **Are reviewed** – Periodically reviewing information will increase learner retention. Quizzes at the end of each unit, group activities, and closing exercises will help you review information with participants, thereby increasing retention.

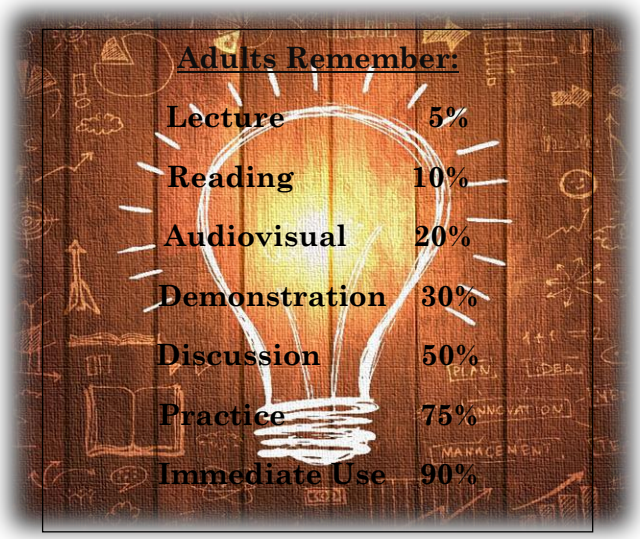
5. **Use primacy** – People tend to remember beginnings and endings and are more likely to forget what happens in the middle. Information heard in the early stages or towards the end will be more easily remembered. Make your key points early and in the end of the presentation. The training manuals written by the Clearinghouse are structured in this fashion.

6. **Are recent** – Remember that newly gained information, such as that at the end of the training, will be more easily recalled than earlier information.

Memory Retention

How do you help adults retain the information you are giving them? The graphic shown demonstrates the average retention rates for various learning methods.

When adults are able to teach others the skills they have learned, or otherwise use them immediately, they retain 90% of the information!



Part 2: Training Skills

The trainer's goal is for participants to not only learn the material, but be able to use it effectively. Below you will find some tips about how to be a successful trainer.

Becoming an Effective Trainer

Take the time. The recommended preparation time is three hours for every hour of training.

Attend trainings. Be knowledgeable about the subjects you plan to teach. What was effective about the training you took? Incorporate these things into your own sessions and develop your own style! What would you have done differently? Avoid things that were unappealing to you. This will lend the impression that you are a competent and confident trainer. It will also facilitate effective instructional delivery, and will increase your ability to answer questions correctly that the adult learner might pose.

Be current. Have up-to-date resources and references on the subject(s) you plan to teach.

Use online training courses. There are many free training materials online. Go to "YouTube" and watch video trainings. Here is a short helpful one: https://www.youtube.com/watch?v=CCcMSiJmSg0

Attend monthly meetings. The Clearinghouse hosts meetings every month. You will pick up pointers and valuable information each time.

Stay informed. Changes occur all the time. Be familiar with new developments. Read all of the E-Presses and the Director Memos. http://familyvio.csw.fsu.edu

Minimizing Stage Fright

Stage fright, or fear of public speaking, is a common phenomenon experienced by many. After all, not everyone can confidently and effectively speak in front of others. With this in mind, we have provided some useful tips for the trainer to overcome their stage fright and effectively train others.

They are as follows:

Remember, you know the materials. Remind yourself that you are well prepared. Read through the materials, and discuss them with other trainers.

Release the tension. Take deep breaths. Breathe from your diaphragm and remember to exhale all the way. It also helps to exercise regularly to relieve stress.

Rehearse. Practice, practice, practice, until you feel comfortable.

Know the training room and your equipment. Test your audio and visual equipment in advance. Make sure that instructional aides (paper, pens, flip charts, tape, etc.) are on hand and sufficient in number.

Know your audience. Greet and talk with participants as they arrive.

Re-frame. Harness your nervous energy and turn it into enthusiasm.

Use your own style. Be natural and relaxed.

Know your first line and the transition to the main point. Memorizing the introduction can lower anxiety and help you begin with confidence.

Concentrate on the message, not yourself. Focus on what you are there to do. Engage the future trainers in the material, not on you.

Rest up and eat well. Get plenty of rest beforehand and eat well so that you are physically and psychologically alert.

Components of Effective Training

Once trainers have overcome their own impediments to training, they can then focus on how best to train others. Below are some things they must keep in mind in order to put together an effective training:

First time presenting. Choose a subject that can be taught in an hour or less. Present with enthusiasm and dedication!

Condense. Be sure not to overwhelm people with too much information. Never speak for more than 10-15 minutes at a time without a break/activity.

Use your own words. The training will be better received and more interesting for adult learners, and you will be more confident, if you know the important points well enough to be able to express them in your own unique style.

Incorporate experiential learning. Make connections between your own experiences and some of the main points. Make sure to also inquire about the trainee's experiences. Personalizing information with your own anecdotes will assist in both stressing and expanding points.

Model and demonstrate. Be sure to provide enough materials so that adult

REMINDER

Effective Training Phases:

Inquire

Gather

Process

Apply

learners can experience age–appropriate curriculum instruction and delivery (e.g., hands-on learning, discovery learning)

Foster discussion. Discussion extends learning and introduces other perspectives. It allows for reciprocity between learner and learner, and learner and trainer. Asking questions can foster discussion.

Listen reflectively. This provides an opportunity to process information introduced by the future trainer. Active listening skills are essential for effective discussion facilitation. It builds understanding and consensus in a group. Active listening skills include: encouraging, paraphrasing, clarifying, reflecting, summarizing, and validating.

Provide consistent feedback. Candid and compassionate feedback can be a powerful stimulus for learning. It addresses the adult learners need for immediate application.

Set the Tone

Another important component of successful training is the ability of the trainer to set the tone for an exciting and engaging learning environment. Below are some tips for setting a positive tone:

- Complete setting up before participants arrive.
- Greet the adult learners as they enter the room.
- Ask adults to print their own name tags.
- Introduce yourself.
- Allow adults to help themselves to refreshments/food.

Breaking the Ice

Ice breakers are short activities that help participants feel energized and more comfortable among each other. They also establish an enthusiastic tone for the training and can help ensure that everyone is actively engaged.

- **Smile** As you do introductions, ask each person to share one thing that made them smile that day.

- **Birthday Game** Have the group stand and line up in a straight line. After they are in line, tell them to rearrange the line so that they are organized by their birthdays. (Jan 1 on one end, Dec 31 at the other end)

- **The Pocket/Purse Game** Everyone selects one or two items from their pocket or purse that has some personal significance to them. They introduce themselves and do a show and tell for the selected item and why it is important to them.

- **Story Time Game.** The facilitator starts a story with a sentence, and each person follows suit and adds a

REMINDER

Encourage, but do not force participation. Everyone has different learning styles.

sentence onto the story-after repeating each sentence that's already been added.

Workshop Management

Sound management makes for an effective training session. Be sure to set rules at the beginning of the training that establish the way participants interact with you and each other during the training. Doing so can serve as a model for future trainers, and also be useful in defusing or redirecting difficult participants and/or situations.

Sample Rules:

♦ Be a good listener. ♦ It is okay to disagree, but not to be disagreeable. ♦ Respect the opinions of others. ♦ Listen to and think about what others are attempting to say. ♦ Be honest and open.

Demonstrate Your Credibility

- **Be honest.** If you do not know the answer to a question, don't make one up. Do some research and get back to them with an answer.
- **Be unbiased**. Make your presentation balanced and as free from bias as possible.
- **Raise questions** about the information. For example, is the information cross-cultural?
- **Cite authorities** that are accepted by your audience, the adult learner.

Evaluation

Following any training session or lecture, and to ensure its efficacy, some form of evaluation should be employed. We suggest distributing evaluation forms to participants. Doing so will help the trainer:

- Determine how participants responded to the training
- Identify areas of strengths/weaknesses of the training
- Gauge whether participants enhanced their job skills
- Gather information to help improve the trainer's presentation.

Remember to:

- Give participants time to fill out the form
- Collect the form in a manner that allows anonymity to the participants
- Review every form. You can and should learn to be a better trainer over time.

We have attached two sample evaluation forms below which can be used as a guide for trainers to create their own. The forms below may be amended to meet specific program needs.

Sample Training Evaluation Form

Please circle the score that most closely represents your views.

1. To what extent have the objectives of the training been achieved?

Fully	Adequately	A little	Not at all	Not sure
4	3	2	1	0

2. To what extent have your personal objectives for attending the training been achieved?

Fully	Adequately	A little	Not at all	Not sure
4	3	2	1	0

3. To what extent has your understanding of the subject improved or increased as a result of the training?

Fully	Adequately	A little	Not at all	Not sure
4	3	2	1	0

4. To what extent have your skills in the subject of the training improved or increased as a result of the training?

Fully	Adequately	A little	Not at all	Not sure
4	3	2	1	0

5. To what extent has the training helped to enhance your appreciation and understanding of your job as a whole?

Fully	Adequately	A little	Not at all	Not sure
4	3	2	1	0

6. What is your overall rating of this training?

Excellent	Good	Fair	Poor	Not sure
4	3	2	1	0

7. To what extent would you recommend others, with similar needs to your own, to attend this training?

Would Highly Recommend	Might Recommend	Would Probably Not Recommend	Would Definitely Not Recommend	Not Sure
4	3	2	1	0

Trainer Evaluation

8. Please rate each trainer by circling the relevant score for each:

Trainer 1: _____

a) Knowledge of Subject	4	3	2	1	0
b) Organization of sessions	4	3	2	1	0
c) Obvious Preparation	4	3	2	1	0
d) Style and Delivery	4	3	2	1	0
e) Responsiveness to Group	4	3	2	1	0
f) Producing a good learning climate	4	3	2	1	0

Optional Additional Questions: (leave room for free responses)

What did you like most about the training?

How can we improve this training?

Are there any additional topics/issues you think we should add to this training?

Quiz Yourself!

1. Which of the following can be considered a barrier to training?

A. high turnover rate
B. staff/managerial resistance
C. stage fright
D. all of the above

2. TRUE or FALSE: Adults approach learning as problem-solving.

3. Which of the following helps to minimize stage fright?

A. taking a power nap before a training
B. know your first line and the transition to the main point.
C. drinking coffee
D. None of the above

4. TRUE or FALSE: Effective training incorporates experiential learning and fosters open discussion.

5. Evaluation of training helps the trainer for all of the following reasons *except*:

A. Determine participants' personalities
B. Identify areas of strengths/weaknesses of the training
C. Gauge whether participants enhanced their job skills
D. Gather information to help improve the trainer's presentation.

6. TRUE or FALSE: Adult learners have long attention spans and are able to retain the majority of information provided in a lecture easily.

Answers: 1. D, 2. True, 3. B, 4. True, 5. A, 6. False

1. **Train-the-Trainer Videos:** These videos provide helpful tips for presenting/training effectively and engaging your audience.
   - https://www.youtube.com/watch?v=FncJgNaUwT4
   - https://www.youtube.com/watch?v=CCcMSiJmSg0

2. **Training the Trainer Resource Pack:** The training pack provides helpful tips about getting organized and conducting trainings.
   - http://www.ica-sae.org/trainer/english/training%20the%20trainer%20resource%20pack.pdf

3. **Adult Learning:** Basic information about adult learning from the Occupational Safety and Health Administration
   - https://www.osha.gov/dte/grant_materials/fy11/sh-22240-11/HowAdultsLearn.pdf

4. **Train the Trainer Manual:** This manual provides detailed information about mentoring adult learners, which can be adapted to fit a program's needs
   - http://www.csu.edu/TLMP/documents/TLMPTraining-the-TrainerManual2.pdf

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Training Manual for Florida's Supervised Visitation Programs

CHAPTER 3

CRUCIAL SAFETY COMPONENTS: SITE SAFETY, INTAKE, MONITORING, AND TERMINATING VISITS

Case Scenario

Jeff Kuehn is a 31-year-old father of one daughter, Alyse, age 8. As a result of concerns with substance use, Jeff's is ordered to have supervised visitation. He arrives to his first visit late and hurries the visit monitor through an intake session so he can see his daughter. The monitor asked only a few questions about background information. The monitor saw Jeff as charming and polite, and assumed that the intake information wasn't necessary for this substance abuse case. Throughout the visit, Alyse does not smile or talk, and refuses to play. Later in the visit, Jeff and Alyse are reading a book together on the floor. Jeff starts whispering to her about her mother. "Your mom has been accusing me of drinking around you. You're making up lies about me again, aren't you?" Jeff whispers just loud enough for the visit monitor to hear. The monitor steps in between the two and says to Jeff, "That behavior is not appropriate during visits. Please stop." Jeff quickly turns angry and picks up a letter opener that had been sitting on the desk next to him, saying, "I came here to get answers!" Turning to Alyse, he says, "Now tell me what you told her!" Alyse starts to cry, barely getting out the words, "I didn't mean to…" The visit monitor moves between Alyse and Jeff and he backs down and puts the letter opener down, quickly running out of the room.

After completion of this chapter, you will be able to answer the following questions:

- How could an assessment of background information and safety risks change this situation?
- What information should the monitor have provided before the visit began?
- What questions could the visit monitor have asked Alyse to create a safety plan?
- What maladaptive behaviors was Alyse showing that the monitor missed?
- What assertive behaviors did the monitor use to intervene? How did it help reduce the conflict?
- Would this constitute a critical incident? What about termination of visitation?
- What workplace safety hazard existed in the situation that could have led to grave harm for the child or monitor?

Introduction

The most crucial goal in supervised visitation is safety: safety for the children, the vulnerable parent, both parties, the program staff, and the community. It is essential for visit monitors to know how to prepare both the site and their clients for visits. It is also important to know how to conduct a visit effectively and how to terminate visits while keeping safety in mind. This knowledge provides the basis for a visit monitor's day-to-day work. At each step of the process, monitors should feel confident about options for intervening when needed. This can lay the groundwork for a successful supervised visit that meets the family's needs while maintaining a safe environment for everyone.

DID YOU KNOW?

A survey completed by the Supervised Visitation Network revealed that over 80% of all supervised visitation providers agree or strongly agree on three goals. They want:

- recognition as being well-trained,
- an increase in professionalism in the field, and
- more accountability.

To accomplish this, visit monitors need to be well aware of the safety needs in supervised visitation and the steps for intake, monitoring and terminating visits in a safe way.

What will I learn in this chapter?

Upon completion of this chapter, participants will be able to:

- Identify workplace safety considerations and threats
- Conduct a worksite analysis
- Safely prepare self and clients for visits
- Develop a safety plan with children prior to the first visit
- Identify risk factors for each family member
- Safely and effectively provide visits
- Identify the primary responsibilities of visit monitors
- Understand your responsibility in child abuse reporting
- Employ strategies for managing reactions during visitation
- Identify safety concerns during visits
- Identify maladaptive behaviors in children
- Address children's concerns during visits
- Engage in activities that foster positive parent-child interaction
- Use assertive behavior to intervene in visits
- Prepare clients for visits and terminate visits safely

Workplace Safety

A supervised visit can only be safe when a visit monitor is prepared, creates a comfortable space, takes into consideration all safety precautions, has adequate information about the case, and knows how to intervene appropriately when necessary. A threshold question is the safety of the space the visit takes place in. Child safety, family safety, and employee safety should all be of importance to every agency. Safety precautions should be considered and implemented throughout the system. Many supervised visitation programs are part of larger agencies. Some, however, are stand-alone programs. Thus, we will refer to agencies/programs below.

Each agency/program should consider:

- Has the agency conducted a worksite analysis to determine risks associated with supervised visitation?
- Is management committed to safety, developing safety policies and protocols, and involving employees in safety analysis and feedback?
- Do all employees have safety training on critical incidents, including how to deal with clients who are violent or use intimidation on-site; or who are injured or experience health crises on-site (including injuries, diabetic shock, epileptic seizures, or other health issues)?
- Does the agency/program have a recordkeeping system for risk management issues, training records, employee feedback/concerns, and program evaluation?

For more information, read **Basic Safety Issues in Supervised Parent- Child Contact: An E-Book for the Child Welfare Community**

by visiting http://familyvio.csw.fsu.edu/wp-content/uploads/2010/05/Safety_eBook.pdf

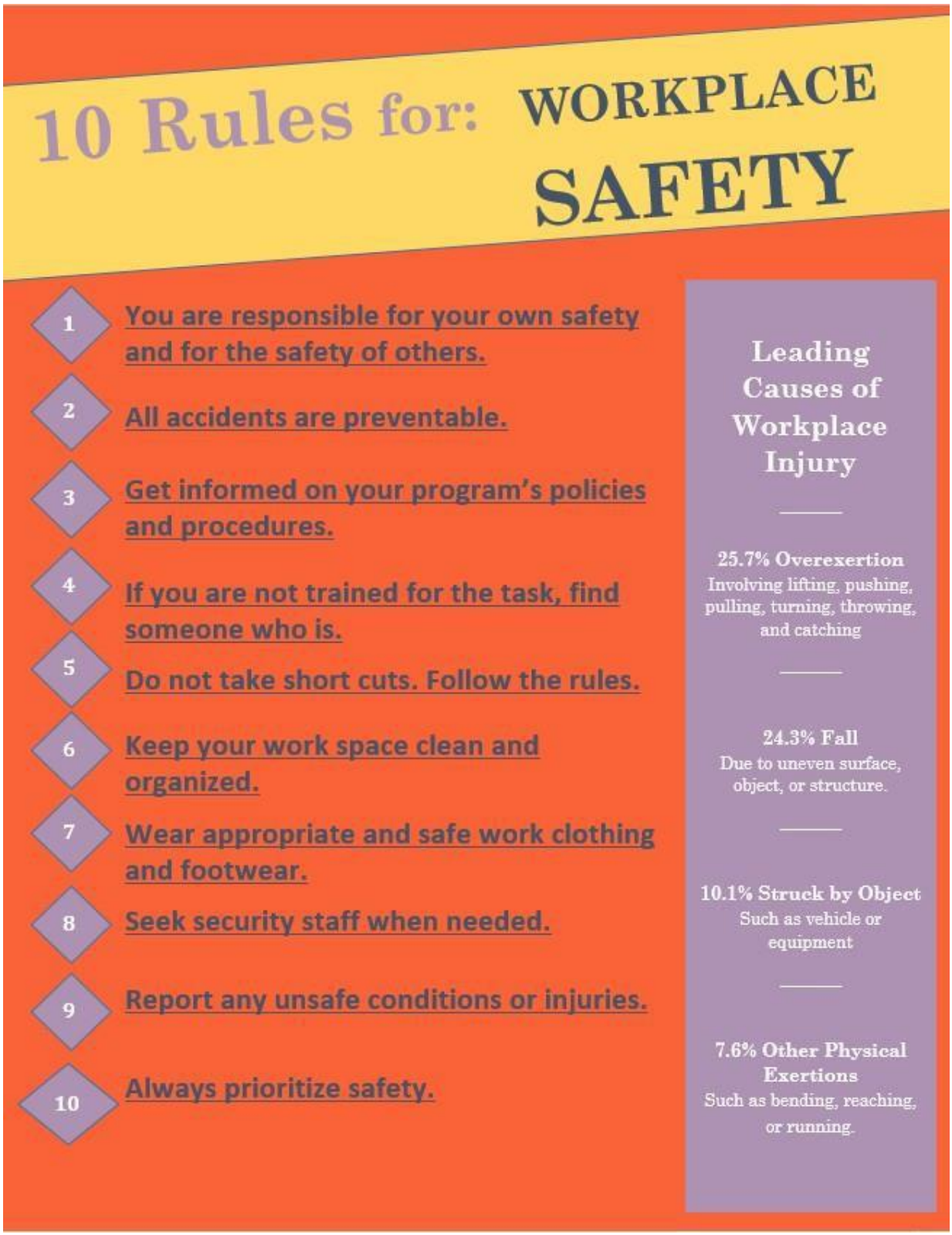
Worksite Analysis

Each agency/program should conduct a worksite safety analysis. This analysis often involves a walk-through of the visitation site to look for potential safety concerns.
The physical layout of an agency should meet the safety needs of parents and children who receive services, as well as agency staff. Asking local law enforcement to assist in this process is crucial.

The following are some typical considerations regarding safety:

- **Working with law enforcement**
  - Does the local law enforcement agency understand the nature of the agency's work and the risks involved in case management onsite? Has law enforcement been consulted to help assess risks and contribute to risk management? If an employee called 911 from the office, would law enforcement understand that the emergency from that agency could involve vulnerable children and adults?
- **Parking**
  - Are parking areas well lit?
  - Are the parking lots littered with debris?
  - Are there any unexpected cars parked or people loitering?
- **Lighting**
  - Are parking areas well lit?
  - Are rooms and stairwells well lit (both inside and outside)?
- **Checkpoints**
  - Has the agency considered metal detectors to check for weapons or checkpoints at which staff check bags and parcels for weapons or disallowed items? (This should be operated by security staff.)
- **Alarm System**
  - Does the agency have an alarm system, panic buttons, or some other method of emergency alerts?
- **Monitors**
  - Have your monitors all been trained thoroughly?
  - Does the agency use video surveillance?
- **Objects**
  - Does the agency keep any objects that may be used as weapons out of reach from clients? This includes items such as large desk items, lanyards, and sharp objects, like letter openers.
  - If the program has a kitchen, are knives locked up?
- **Training**
  - Has management trained employees on safety measures, such as understanding the risks of each case, agency protocols, and de-escalation techniques?

You can provide the following handout on **10 Rules for Workplace Safety** to staff at your program as a starting point while discussing workplace safety. It is important that all staff are aware of safety rules and feel comfortable implementing them.



Model Emergency Plan

Agencies should utilize training to reduce the chance of violence to staff, children, parents, or other people. Through training, staff will be able to identify potential risks. This process includes learning the agency safety plan. One component of the safety plan is knowing how to respond to an emergency if one occurs, aptly called an emergency plan. FEMA offers a sample emergency plan. For the purposes of this e-book, some of the main points are outlined here in order to help social service agencies create their own.

For more information or to access the full sample plan, see here: http://training.fema.gov/EMIWeb/emischool/EL361Toolkit/assets/SamplePlan.pdf

What Kinds of Threats Exist?

Building an emergency plan, like the one outlined above, allows an agency to plan for emergency situations that it may not be able to control. A chart is listed here with some safety threats an agency may experience and can utilize the emergency plan to respond to.

Client Threats --- A disgruntled parent; a relative or friend of a disgruntled parent; a parent who becomes upset during parenting time; a parent who uses substances at the agency; a parent displaying disruptive symptoms from a mental illness during a visit; a parent who tries to harm the case manager or the child; a parent who uses the agency to stalk the child or the other parent; a parent taking a hostage during a visit.

External Threats --- Someone coming in to the agency from outside who wants to inflict harm; a car accident that hits the agency; an unrelated robbery happening near the agency; an abusive partner of an employee who stalks the employee at the agency; a former employee who is disgruntled at management or at other workers.

Natural Disaster Threats --- A tornado; a fire; an earthquake; a bad thunderstorm; fallen trees; and power outages that affect the program.

Medical Threats --- A parent, child or staff member who has a medical problem while at the agency.

Tips to Reduce Safety Threats

- **Staff Training**
  - It is essential that staff are trained regularly on topics that relate to supervised visitation and its clients, including safety risks at visits (particularly off-site visits), how to intervene safely, and updated information and research on topics like child welfare and domestic violence. Visit monitors need this information to meet the needs of clients effectively!

- **Keep "Supervising" in Supervised Visits**
  - Visit monitors need to be vigilant in supervising all statements, behaviors, and interactions of both parents and children during visits. Simply observing parent-child interactions from afar without vigilance does not further the goal of supervised visitation: safety.

- **Recordkeeping**
  - Visit monitors should keep clear records of any concerns about safety of anyone involved in the visit in accordance with the program's policies. Visit monitors are then able to track progress and effectively respond to safety threats that exist.

- **Creating a Safety Plan**
  - The purpose of this emergency plan is to provide the agency with a plan to train staff members on how to deal with an emergency. In the case of an emergency, agency management and staff will be able to respond to the emergency quickly and appropriately to ensure the safety of all involved.
  - Scope of the Plan: This emergency plan outlines the roles of different staff in an emergency including the following: communication plans, training plans, and safety procedures.

STOP and Think

After reading this section, you should be able to answer the following question regarding the case scenario from the start of the chapter.

What workplace safety hazard existed in the situation that could have led to grave harm for the child or monitor?

Preparing Self & Clients for Visit

Being informed thoroughly about the history of a client and providing safe, effective visits can be difficult and even emotionally draining at times. To make sure you are prepared to provide effective supervised visitation, prepare yourself mentally and physically before a visit with the following steps.

Preparing Yourself for Visits

1. Have a clear understanding of the agency's protocols for client and employee safety.

2. Receive and/or review agency training on defusing aggression and recognizing escalating behaviors and warning signs that lead to assaults.

3. Receive and/or review agency training in the dynamics of parental behavior that results in supervised visitation, such as mental illness, domestic violence, and substance abuse.

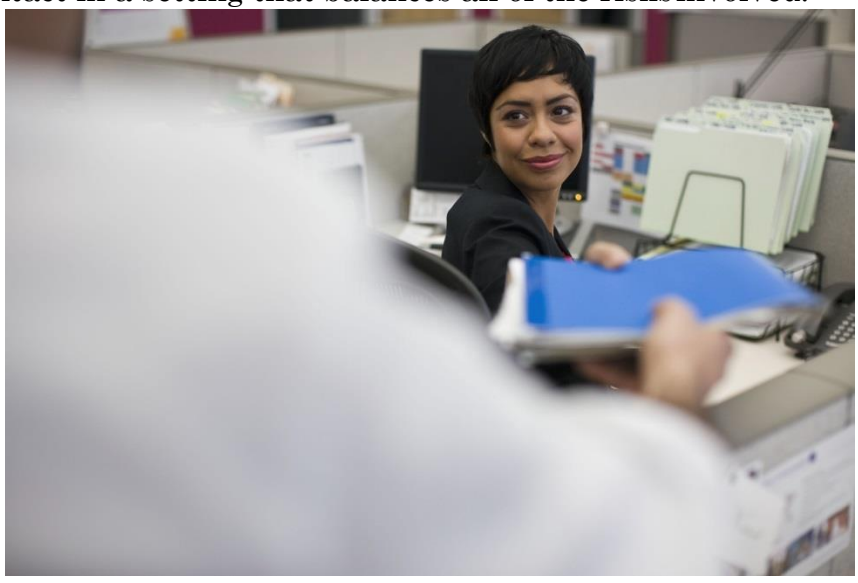
4. Be sure that you have considered safety issues in the visit setting and know how to help parents and children move through the process of visitation, from welcome to the end of the visit.

5. Be ready to approach clients in a helpful, non-authoritarian manner.

6. Know how to alert management and emergency personnel of safety violations and incidents.

7. Understand how to recognize escalating risk.

8. Plan for parent-child contact in a setting that balances all of the risks involved. The higher the risk, the more restrictive the setting, including having security in the room with the parent and child.



Preparing for Visits – Intake and Preparation are Crucial for Safety

Safety is not just about a program safety plan. It

is also crucial that your program has sufficient information to understand what the risks are in each and every case. This happens through a process called intake. Thorough intake helps programs plan specifically for each case. Intake provides you with information upon which to create a safe visit. It also helps family members feel prepared for visits to ensure an open environment that supports communication and progress. Intake should be done in every case -- even in dependency cases where a case manager has already conducted a separate intake.

<u>Step One:</u> Conduct a thorough case history. Gather identified background information from caseworker, guardians ad litem, the parents, and sometimes, the child. The most effective, safe visits are ones in which staff fully understand the family dynamics, the risks, and the problems that face the family.

- In dependency cases, before meeting with clients to complete an intake, speak with the caseworker and/or guardians ad litem involved in the referral of the case to supervised visitation. They may have already assessed violence and abuse history that you can use as a foundation for intake in these areas.

- According to the 2014 Annual Report on Supervised Visitation Database Case and Client Statistical Analysis, 36.2% of cases were referred to Florida supervised visitation programs due to domestic violence. To help manage the risks for domestic violence victims, staff should understand that a referral to a local domestic violence center is essential so that the vulnerable parent has resources and advocacy.

- Refer to the following tables for important information that can help supervised visitation program staff manage risks.

Table 3.1
Intake Issues

A complete understanding of the dynamics of the case will require that you obtain the following information. Both parents should be asked about these issues. Keep in mind that the dependency case manager will likely have already obtained this information in dependency cases.

About the Child(ren) *Note: You may have to ask these questions more than once if there are multiple children in the case to assess the full family dynamics.*	
Current living arrangements	- Where does the child currently reside? - Who resides there with the child? - How long has the child lived there?
Age	- How old is the child?
Educational level or developmental stage	- Is the child in school? - What grade is the child in? - Do you feel that the child has any developmental setbacks or advantages?
Mental status (emotional problems, developmental delays)	- Does the child have any emotional or mental health issues that may affect the visit? - Does the child have any physical challenges, developmental delays, areas of concern, medications or special needs that may affect the visit?
Juvenile justice system involvement, including juvenile sexual offenses	- Has the child ever been involved in the Juvenile Justice (DJJ) system? - Does the child have any gang affiliation or criminal history/record?
Past history of abuse (physical, sexual, neglect)	- Is there a history of allegations of physical, sexual, or emotional abuse or neglect?
Current abuse experience	- What are the current allegations related to physical, sexual, or emotional abuse or neglect?
Relationship between alleged perpetrator and child	- Who is the alleged perpetrator of the alleged physical, sexual, or emotional abuse or neglect? - What is the child's relationship to the alleged abuser?
Characteristics of abusive situation	- What other details can you tell me about the alleged abuse?
Reaction of non-perpetrator parent	- Did you believe the child when they disclosed? - What support are you providing to the child?
Reaction of alleged perpetrator	- What was the alleged perpetrator's reaction to the child's disclosure of abuse?

Table 3.2
Information to Obtain About Custodial and Visiting Parents During Intake

In dependency cases, the case manager is likely to have conducted a thorough intake and is likely to have provided the family with a broad spectrum of resources. Especially in family court cases, though, you will also want to gather as much background information as you can to determine what the risks are in each case.

About the Custodial/Visiting Parent	
Current living situation	- Is your current housing affordable? - Is your current housing safe and stable? - What adults currently live with you? - What children currently live with you?
Education	- What is the highest level of formal education that you have completed? - Are you interested in going back to school?

Employment	- Are you currently working?
	  o If yes, is it full-time, part-time, or temporary? Where do you work?
	  o If no, are you interested in assistance finding employment?

Concerns	- Do you have any concerns about your child(ren)?
Parenting Skills	- What do you think are your strengths as a parent? - Do you feel that you have a good relationship with your child? - Do you feel there are areas of your relationship that you could potentially work on improving? *Note: It is important to assess parenting skills at intake, but sometimes you will be unable to tell the true level of parenting skills until the first visit.*
Discipline concerns	- Do you have any concerns about disciplining your child(ren)? - Do you have any concerns about your partner's discipline of your child(ren)?
Partner relationship	- Is there a person you can count on to care about you regardless of what is happening to you? - Do you have a significant other? What is your relationship like?
Domestic violence history	- Does this case have a history of domestic violence?
Substance abuse history	- Have you ever been in a detox program? - What about a residential treatment facility for drug or alcohol use? - Have others ever raised concern about how often you drink or use drugs?

Mental health history	- Have you ever received or are you currently receiving mental health treatment or counseling? - Are you currently taking any medications to treat a mental health condition? - How do you manage difficult feelings or emotions?
Mental status (emotional problems, developmental disabilities, etc.)	- How often do you feel anxious, depressed, or confused? - How often do you find yourself feeling sad or hopeless? - Do you ever think about hurting yourself or others?
Criminal history	- Have you ever been arrested and charged with a crime? - Were you ever convicted of a crime? Have you ever been incarcerated?
Past history of childhood maltreatment, including child sexual abuse	- Did you ever experience maltreatment or abuse in your childhood?

STOP and Think

After reading this section, you should be able to answer the following question regarding the case scenario from the start of the chapter.

How could an assessment of background information and safety risks change this situation?

Step Two: Discuss with each family member the program rules and parameters for the visit in an encouraging, respectful tone, particularly noting that rules apply to all program participants.

It is important for clients to feel well-informed when entering into a visit, as well as feel respected and encouraged for an open dialogue and overall successful visit to occur. When clients have the information needed to make them feel comfortable during visits, a positive parent-monitor relationship can be developed more efficiently and families can begin making progress sooner. Make sure you readily prepare clients by utilizing the items listed in Table 3.3 in your preparation of clients for visits.

Table 3.3

Information to be Conveyed/Assessed in Preparation for Visits

Children	Custodial Parent or Care-Giver	Non-Custodial Parent
Location and schedules for visits	Location and schedules for visits	Location and schedules for visits
What degree of physical contact child wants or will be permitted	Program rules	Program rules
Signals for child to use to indicate need for help	Role of visit monitor	Role of visit monitor
Conversation topics child wants or doesn't want to occur	Security measures in place	Degree of physical contact
Other program rules	"Checking in" with the victim parent before each visit, to ascertain safety between visits	Toilet rules
Any other concerns child has regarding visits.	Any concerns residential parent has regarding visits	Rules on items brought to visits Conversation topics allowed or disallowed Emphasis on respect, fairness Intervention techniques to be used by visit monitor during visits

Information given to children will depend on your assessment of the child's developmental age and emotional status

Child Orientation

If a child is of sufficient age and capacity, the program should include him or her in some structured orientation meeting. Child orientation is the process by which staff familiarize the child with the program, program staff, safety protocols, and facilities in an age-appropriate and child-friendly manner. The child should also be assured that the involvement of the program is not the child's fault. This is not an intake session; the child should not be questioned about the case during orientation.

Any orientation should be presented to the child in a manner appropriate to the child's developmental stage. Children of a sufficient age and maturity should attend at least part of the orientation without the custodial parent; this will help the child understand that the parent will not be present with the child during the visits.

STOP and Think

After reading this section, you should be able to answer the following question regarding the case scenario from the start of the chapter.

What information should the monitor have provided before the visit began?

Step Three: Develop a safety-plan with children prior to their first visit.

After a child has been given 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.)

Creating a Safety Signal

When you develop a safety plan with a child, it is also a good idea to establish a safety signal the child feels comfortable using during visits that indicates he /she feels sad, upset, or unsafe. Encourage the child to use the safety signal you decide on together at any point the child needs to during the session.

Simply ask the child:
"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 you are upset?"

Some possible signals you can use are:

- **Raised hand**
- **Certain word or phrase**
- **Song**
- **Crossing arms across chest**
- **Two hands forward, as if to say "Stop"**
- **Putting both hands in lap**

Make sure that the signal is not anything too obvious like tapping the left foot or any movement that is frequently used like shaking the head from side-to-side.

- What makes you feel safe? (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 makes you feel safe?
- What makes you feel upset, nervous or sad?
- How can I help you feel safe during your visit?
- Sometimes certain smells, music, or clothes remind us of scary things, does anything in particular like that scare you?
- Where would you like your visiting parent to be in the room during your visit?
- Is there anything you don't want him/her to say to you during the visit?
- If you become frightened, upset or sad during the visit, how can I help you?

STOP and Think

After reading this section, you should be able to answer the following question regarding the case scenario from the start of the chapter.

What questions could the visit monitor have asked Alyse to create a safety plan?

Step Four: Identify the risk factors for each family member from the background information you receive.

Based on the background information for each family member, along with the child(ren)'s discussion of safety and risks, determine the risk factors for each family member. These risk factors can include past experience with neglect or abuse, substance abuse history, mental health, behavioral issues, specific needs, or a variety of other issues identified in your initial assessment of the family. For any risks you find in each case, decide on parameters that will address any safety concerns you may have. These may include limitations on the site used for visitation, set-up of the room used for visitation, extra preparation on your part before visits, or extra security personnel. Parameters should also include the names and relationship to the child of other individuals who are allowed to participate in the visit (per court order).

Step Five: Schedule visit, decline referral, or modify court order.

According to the Florida Supreme Court Standards, programs have the discretion to decline cases. Consider whether a safe visit can be provided in the case based on safety assessment, background information, and risk factors identified.
If a safe visit can be provided, schedule a visit. Otherwise, you have two options. You can:
1. Decline the referral due to risks identified (in client safety or staff training); Or
2. Request a modification of the court order (e.g. for therapeutic supervision or other modification).

Step Six: Conduct the pre-visit screening and assess children, parents/caregivers, and the visitation monitor.

If you decide to schedule the visit, move forward in the visit process by conducting a pre-visit screening following program policies. At this stage, you may still cancel the visit due to the visiting parent's behavior or an indication of a need for a more skilled visit monitor due to the child's emotional state. Make sure you are able to facilitate the visit while monitoring using program policies and procedures for ensuring a safe visit.

Providing the Visit

Visit monitors must be able to fulfill a variety of roles that sometimes may seem contradictory, such as remaining neutral while being on constant alert for safety risks. Visit monitors must remain close enough to hear conversations and notice

inappropriate behavior, yet allow the parent and child to take center stage of the visit.

The primary responsibilities of visit monitors include:

- Ensure that no physical or emotional harm is directed at the child during the visit, at the other parent, or at other program participants.
- Directly observe all interaction between the parent and the child. Be able to hear and see what is said and done. Document the interaction according to program rules.
- 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.
- Model healthy parenting behaviors and communication skills for parents.
- Teach parents skills they can adapt for use with their children.

- Coach parents on how to achieve their goals and improve their parenting capacity and strengthen the parent-child bonds that exist within the family.
- 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 or bias about parents, children, or situations interfere with the monitor's objectivity in observing visits.
- Terminate the visit according to program policies if rules are violated.

Identifying Safety Concerns during the Visit

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 reactions as described below. These behaviors may appear during a visit, but they may also appear after 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 recommended 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.

Maladaptive behaviors include:

- 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 reduced expression of emotion, 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 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 a visit.

Strategies for Managing Reactions

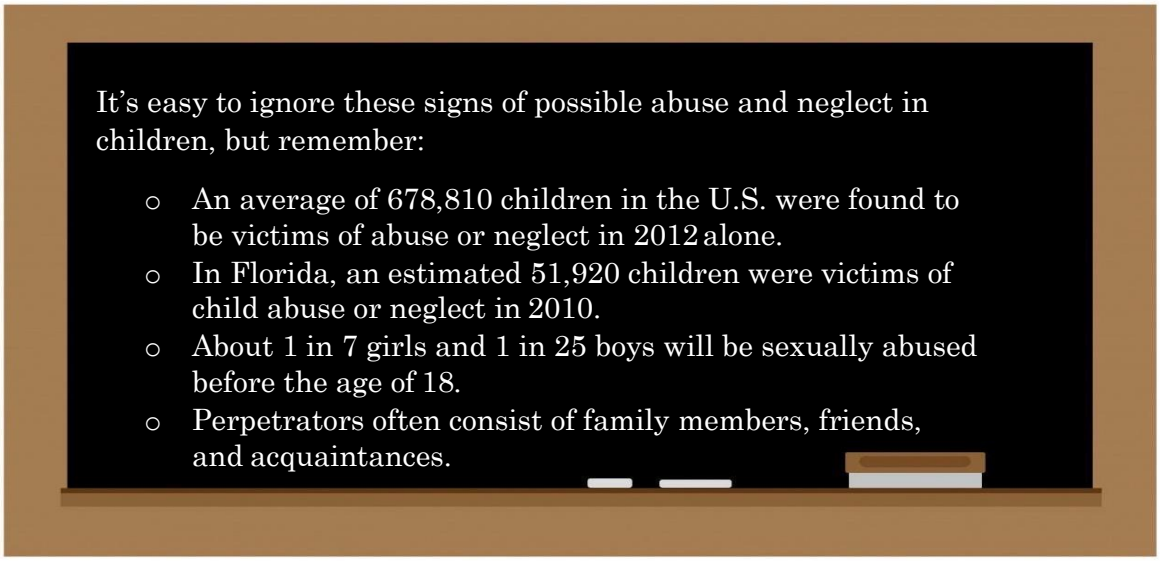
A key component of conducting supervised visits is the visit monitor's ability to manage reactions of participants as they arise. This can be necessary in a variety of situations, from a child becoming anxious around certain topics to a parent raising his voice at his child. The following strategies can aid you in managing client reactions effectively while maintaining respect and fairness:

1. Prepare all participants prior to the first visit, by discussing any emotions they feel in anticipation of scheduled visits.
2. Set behavioral expectations for clients, specifying exactly what appropriate and inappropriate behavior is during visits.
3. Aid all participants in prioritizing children's needs over their own.
4. Be attentive and responsive to the child's reactions.
5. Be attentive and responsive to the parents' ongoing reactions before, during, and following visitation sessions.
6. Respond to parents' emotions during visits, especially revolving anger.
7. Help clients communicate and process their emotions regarding issues of separation, changes in custody or reunification (e.g., frustration due to custody, changes in visitation).
8. Process your own emotions and reactions throughout the visit. Make sure to practice self-care to ensure your emotions and personal experiences don't affect visits or clients negatively.

STOP and Think

After reading this section, you should be able to answer the following question regarding the case scenario at the start of the chapter.

What maladaptive behaviors was Alyse exhibiting that the monitor missed?



Child Abuse Reporting

Another factor in safety at visits is prohibiting child abuse. Part of a visitation monitor's work is to ensure the safety of all children involved in visitation. In order to ensure safety, visit monitors must have an understanding of child abuse and how to report when cases may arise.

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.

Note

To learn more about the types, prevalence, and risk factors of child abuse, keep reading this manual!

Chapter 11 of this manual addresses the impact of child physical and sexual abuse on supervised visitation.
Keep Reading!

The law states that **you report when you have a suspicion**. You **do not need proof.** You **must report** when you have **reasonable cause** to believe that a child or adolescent has been abused or neglected or is in danger of being abused.

In Florida, **the reporting requirement is not limited to the first person reporting.** In other words, you cannot assume that the report has already been made. **You must always make a report if you suspect that a child is or has been abused.**

It is important to note that all calls to DCF will remain anonymous (if requested, you do not even need to provide your name) and it is up to DCF on whether a case will be opened or not. However, the Clearinghouse recommends that programs provide their full name and the names of staff.

Addressing Children's Concerns During Visits

Many children in supervised visitation may have experienced trauma, such as abuse or neglect. It is essential that you keep this in mind while communicating and interacting with children at visits. Children may experience trauma due to:

- The death of a parent, friend, or pet
- Physical, sexual, or verbal abuse
- Neglect or maltreatment
- An unstable or unsafe environment
- Bullying
- Surviving a natural disaster (fire, hurricane, etc.)
- Separation from a parent
- Witnessing domestic violence

Children who have experienced trauma will have unique needs, which you can help meet by practicing trauma-informed care to best promote empowerment and effective treatment. These can include ethnic or cultural differences, mental or physical disabilities, or language barriers.

"Trauma-informed care" involves the provision of care that, borrowing from the field of cultural competence, is "trauma competent."

Children and Safety

Trauma-informed care must begin with the provision of safety, both physical and emotional, by adult caregivers to the child facing trauma.

In the absence of safety, the child will be unable and often unwilling to alter behavior, consider new ideas, or accept help. Children concerned about their survival cannot broaden their focus, engage in self-reflection, or allow themselves to be emotionally vulnerable.

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. This is a perfect time to remind children of the **safety signal** you chose together during your initial safety planning. 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 do not need to be specific about the allegations with a child. The following examples are statements that monitors can use to alleviate a child's fears prior to visits. Make sure to give the child assurances that let the child know that staff will be vigilant, such as:

- "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."

Always remember the trauma the child may have experienced when interacting with them at visits. If a child starts to become upset or overly withdrawn, stop the visit and talk with them one-on-one to make sure everything is okay before moving forward with the visit. Make a note of any child behaviors or statements that may indicate past trauma in your case notes, and make sure to address these concerns in your safety plan.

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:

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

- The visiting parent makes derogatory comments about the custodial parent, step-parent, foster parent, judge, etc.
- The visiting parent falsely tells the children that he or she will be back soon- unless reunification really is imminent.
- The visiting parent asks the children to choose which parent they want to live with.

- 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", the monitor must intervene.
- The visiting parent harms or threatens to harm the child emotionally or physically during a visit.
- The visiting parent threatens to harm other visitation participants, custodial parent dropping off children, or staff.
- The visiting parent begins to speak in a foreign language, following a staff member has informed of the restrictions on language use in visitation.
- 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.

Immediate Intervention

In many cases, visit monitors will have to intervene immediately in a situation, many times within earshot or presence of the child. For this reason, we recommend that the visit monitor or director use the following steps when intervening in front of children:

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

If the intervention requires more than a quick statement or the parent does not respond in a positive manner, ask the parent to accompany you to a nearby office to discuss the problem at hand in a lengthier manner. The child should not be present for the conversation. Find a supervisor or other trusted member of the staff to stay with the child during this time.

REMINDER

If you feel or any staff member feels threatened, the child should be removed from the visit immediately.

Using Assertive Behavior to Intervene

There are three ways a visit monitor can react to a parent's inappropriate behavior at visits: passively, aggressively, or assertively.

A visit monitor is reacting **passively** when he or she ignores what is occurring and defers to the offending person. Passive behavior such as looking away or laughing nervously is not effective and can encourage escalation of inappropriate behavior.

A visit monitor is reacting **aggressively** when he or she uses authority to attack, dominate, or inappropriately control the situation. Aggressive behavior such as angrily confronting the parent or attacking the parent personally is not effective and can support escalation of inappropriate behavior.

A visit monitor is reacting **assertively** when he or she communicates what is desired in an open, courteous, and firm manner. Assertive communication that incorporates clear, direct communication about the inappropriate behavior occurring can be very effective and help to defuse hostility and anger.

Assertive body language involves:

- Maintaining direct eye contact
- Sitting/standing up straight
- Speaking clearly
- Using a firm, audible tone
- Adding emphasis with facial expressions and gestures

Examples of Assertive Behavior:

1. In reaction to Mr. Goodman, a visiting father, talking negatively to his children about their mother, the visit monitor could say, "Mr. Goodman, I would like to speak to you away from your children for a moment." The visit monitor can then guide the father into another area and calmly say, "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."

2. In response to a visiting mother, Camilla Rodriguez, bringing her son Jaelyn a small gift bag for his birthday during a visit, the visit monitor could say, "Ms. Rodriguez, "We need to screen all gifts for safety reasons. Let's take the bag into the office first so that we are following our program policies."

Assertiveness Assessment

Do you have difficulty with any of the following behaviors?

- ❖ Asking for help
- ❖ Stating a difference of opinion
- ❖ Receiving and expressing emotions, particularly negative ones
- ❖ Saying "no"
- ❖ Responding to criticism
- ❖ Negotiating
- ❖ Taking charge
- ❖ Asking questions
- ❖ Dealing with someone who refuses to cooperate
- ❖ Making speeches in front of audiences

If so, you may need to work on your assertiveness with clients. Assertive behavior can allow you to:

- ⇒ Gain help when needed
- ⇒ Be listened to and understood
- ⇒ Foster cooperation in clients
- ⇒ Improve your self-confidence
- ⇒ Feel more comfortable in negative situations
- ⇒ Guide conversations effectively
- ⇒ Gain leadership roles in the workplace

STOP and Think

After reading this section, you should be able to answer the following questions regarding the case scenario at the start of the chapter.

What assertive behaviors did the monitor use to intervene? How did it help reduce the conflict?

Would this constitute a critical incident? What about termination of visitation?

Preparing for Visit's End

Make sure to keep track of time during visits so that you are able to prepare parents and children for a session's end. Let parents and children know when there are 10 and 5 minutes left in the session so they are able to say goodbye and feel the visit come to a natural end. This can help the visit go smoothly and allow for children to feel safe, secure, and expect the end to come.

Children have specific needs at supervised visits. One of the most important is to have support in preparing for the end of a session. While some children may be okay without added guidance, many children require emotional support in order to deal with the transition. For some children, the end of a supervised visit may seem traumatic. With education and support, children can better understand what to expect and will react in a non-traumatic way.

Developing Rituals

Children can be comforted by a routine for the end of a session they can learn to trust in. Some ways to incorporate rituals into a session include:

- Identify what will happen ahead of time and allow for questions.
- Allow children the opportunity to be involved in developing rituals.
- Minimize changes made to the routine, unless necessary.
- Define rules for the session and explain them in detail to the child. This can include what physical touch is allowed, what can be discussed, and how long visits will last.
- Create an agreed upon signal for ending the visit, such as a specific phrase or a song that is played.
- Determine a ritual for the end of the session, such as hugging the visiting parent, shaking hands, or waving goodbye.

As the supervisor, ask routine check-in questions following the departure of the visiting parent, such as what specific things the child liked or disliked about the session. This can allow the child to have a sense of purpose after the end of the visit.

Age-appropriate Rituals

Infants & Toddlers (Birth to 5 years): Children under the age of five have yet to fully develop their sense of time, causing confusion and frustration over when they will see their parent again. Professionals can help by providing color-coded calendars or describing how long until they see the visiting parent in terms they would understand, such as the number of school days or meals. Children of this age also have higher needs for consistency and routines than others.

Elementary School (5-12 years): Children of this age develop stronger sense of awareness and feelings, such as sadness and anger, requiring stronger emotional support at the end of sessions. Be prepared for discussions of emotions and assure children it is okay to feel this way.

Adolescents (12-18 years): This age group desires more self-autonomy, so allowing them to help create routines can be positive for them. Adolescents also try to break rules just to see how adults react. Remain concrete in your enforcement of rules and routines, relaying that you care about their behaviors. Encourage discussions of emotions, but do not expect sharing with this age group. Adolescents' needs can range vastly depending on personality and upbringing.

If setting limits and routines fails to reduce anxiety, consider making changes to the arrangement and look out for signs of bigger issues that could be causing the anxiety.

Termination

In the case of severely inappropriate behavior or statements by either party, suspension or termination of visitation may be considered. We review termination of visits due to critical incidents in Chapter 15, but suspension and termination can occur due to actions and statements that may not be deemed critical incidents.

There is a great deal of discretion left to directors in deciding the most appropriate course of action to take regarding inappropriate behaviors and statements. When making intervention decisions that may lead to suspension and termination, consider the following:

- **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 or behaviors 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 or behavior a "first offense" or has the parent repeatedly engaged in such conduct during the same visit or in past 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.

PRACTICE EXAMPLES

Case Scenario 1

Derrick Morlen regularly attends supervised visits with his 6-year-old son Ethan. Derrick was originally referred to supervised visitation for domestic violence allegations. During his most recent session, Derrick and Ethan are putting together a puzzle on the floor when Derrick starts to ask inappropriate questions, such as, "Where do you and your mom stay at now?" and "Where are you going to be tomorrow in the afternoon?" The visit monitor tries to change the subject, but doesn't address the issue directly or note it in the file. The next day, she hears that Ethan's mother said that Derrick stalked her and Ethan at the baseball park.

Discussion Questions:

1. What safety concerns exist in this family?
2. Why should the visit monitor have been more concerned about the questions?
3. What could the visit monitor have done to intervene immediately in the situation?
4. What could the visit monitor have done to address the situation fully post-visit?

Case Scenario 2

Eddie LaRosa was recently assigned to supervised visitation with his 8-year-old son Demetri. During intake, the visit monitor addresses substance abuse and domestic violence history, but thinks it's best to spend the rest of the time playing an introduction game to relax the father and son. During the first session, the visit monitor notices Demetri becoming frustrated and withdrawing during activities that should be appropriate for his age. Near the end of the visit, Demetri says, "I hate this. I don't ever want to come back." Eddie says, "Your mother made you hate me." After the visit, the monitor speaks to Demetri's mother, and notes Demetri's behavior and lack of effort in the visit. Demetri's mother responds by saying, "Don't you know he has a developmental disability? Those activities were much too hard for him. And that made him feel left out. Of course he doesn't want to come back."

Discussion Questions:

1. What key questions did the visit monitor skip during intake?
2. What could the monitor have done differently if she had the full background information?
3. How did the monitor's lack of knowledge harm the visit?
4. How did the monitor's lack of knowledge harm the family's engagement and interaction?

Quiz Yourself!

1. As a visitation monitor, which of the following is not one of the ways to prepare yourself for visits as a visit monitor?
a) Consider the safety issues present.
b) Review the agency's protocols for safety.
c) Be confident in your abilities to monitor the visit, regardless of your experience or the risks involved.
d) Receive agency training on defusing aggression.

2. Developing a safety signal for children during visits helps to:
a) Scare them of the safety risks present.
b) Give children a way to communication when they feel upset or unsafe during visits.
c) Give one, universal signal that all children use to designate feeling unsafe.
d) Make sure children never feel unsafe during visits.

3. True or False: Maladaptive behavior in children during visits may show a need for a mental health evaluation conducted by a mental health professional before proceeding to future visits.

4. When intervening in visits, it's best for the visit monitor to use:
a) Passive behavior
b) Aggressive behavior
c) Assertive behavior
d) Introverted behavior

5. What should you do if you noticed a light in the parking lot at your center to be out?
a) Ignore it, it's not important.
b) Hope that a co-worker spots it.
c) Inform a supervisor of the light.
d) Fill out a purchase request for a new lightbulb.
e) Either C or D.

6. True or False: In order to make a child abuse report you MUST have proof of abuse occurring including but not limited to photos, statements from the child, or personal witness to the abuse.

7. To fully understand the safety risks and because of the high prevalence in dependency and family law cases, it is important to discuss any history of_____with both parties.

a) Violence
b) Cigarette smoking
c) Relocation
d) None of the above

8. True or False: It is every monitor's job to be specifically trained on important safety considerations for each case.

9. List three ways monitors can work with children to enhance safety in any case.

_____
_____
_____

10. When terminating or suspending a visit due to a non-critical incident, what are some important factors in the determination?

_____
_____
_____

Answers: 1. C; 2. B; 3. True; 4. C; 5. C; 6. False; 7. A; 8. True; 9. Develop a safety plan, transparency about process of visitation, reassuring statements of care and safety; 10. The severity of the incident, the child's reaction to the incident, has the parent directly threatened a child or staff, and if the incident a first-time incident.

- **Causes & Symptoms of Sexually Maladaptive Behaviors.** *http://www.resolutetreatmentcenter.com/behavioral/sexually-maladaptive/symptoms-effects.* This resource outlines the causes, risk factors, signs and symptoms, effects, and co-occurring disorders of sexually maladaptive behaviors in children.

- **Assertive Versus Aggressive Behavior.** *http://www.etfo.ca/SupportingMembers/Employees/PDF%20Versions/Assertive%20Versus%20Aggressive%20Behaviour.pdf.* This resource covers the specific definitions and differences between assertive and aggressive behaviors, as well as the negative impacts of remaining passive.

- **Guiding Principles. Safe Havens: Supervised Visitation and Safe Exchange Grant Program.** *https://www.justice.gov/sites/default/files/ovw/legacy/2008/08/06/guiding-principles032608.pdf.* This guide introduces the guiding principles of supervised visitation, including equal regard for the safety of children and adult victims which covers workplace safety needs.

- **Child-Directed Interaction Skills.** *https://depts.washington.edu/hcsats/PDF/TF-%20CBT/pages/8%20Parent%20Management%20Training/Child-Directed%20Interaction%20Skills.pdf.* This handout displays an overview of tips for encouraging child-directed interactions between parents and children with specific examples of what to say and what to avoid saying.

- **Managing Strong Emotional Reactions to Traumatic Events: Tips for Parents and Teachers.**
  Managing Strong Emotional Reactions to Traumatic Events
  http://www.nasponline.org/resources/crisis_safety/angermgmt_general.aspx. This article relays common reactions to trauma, how emotions are displayed physically, and effective ways to manage strong emotions in yourself and others.

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New Training Manual for Florida's Supervised Visitation Programs

CHAPTER 4

WORKING WITH THE COURT

Case Scenario

Maxwell has been referred to supervised visitation with his two children, ages 5 and 14, by the family court. Maxwell has a history of substance abuse, and recently served a jail sentence after being pulled over for driving under the influence with his children in the car. The children are currently staying with their mother Maggie, who has been separated from Maxwell for several years. The monitor assigned to the case is required to understand their program's Agreement with the Court, understand how to provide safe visits, and understand how to keep a record of the visits with Maxwell and his children as part of that responsibility.

After completion of this chapter, you will be able to answer the following questions:

- What elements may be included in the program's Agreement with the Court?
- How should the monitor communicate with the court regarding Maxwell's case?
- What information about Maxwell and his children should the monitor include in the visit record?
- How often will the monitor have to communicate with the court about Maxwell's case?
- What should the monitor do if Maxwell's previous employer requests information regarding the visits?

Introduction

This chapter describes how cases are ordered by the court to supervised visitation programs and outlines the requirements for Program Agreements with the court. In addition, the chapter describes how visit records are compiled, used, and maintained. Communication with the court by program directors and staff is also discussed, as well as the purpose of and preparation for staff testifying in court about a case. Frequently asked questions about working with the court are also addressed.

What will I learn in this chapter?

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

- Describe the kinds of cases that can be court-ordered to supervised visitation;
- Identify the authority responsible for determining the range of cases accepted by programs;
- Discuss the ways that programs communicate with the court;
- Describe four different kinds of reports to the court;
- List the typical elements of a report to the court;
- Identify the role of program staff in testifying in court about a case.

Snapshots and Facts

- Courts refer cases to supervised visitation programs when the judge or magistrate has reason to believe that the child could be endangered by visiting with a parent in an unsupervised setting.
- Families are most often referred to supervised visitation in order to safely implement:
    - Juvenile Dependency case plans;
    - Divorce-related parenting plans; or
    - Domestic Violence Injunction-related parenting plans.

Cases Referred by the Court

The majority of cases ordered to supervised visitation program are referred by judges in circuit courts in Florida. Most cases originate as juvenile dependency cases (governed by Chapter 39, Florida Statutes), divorce-related court cases (governed by Chapter 61, Florida Statutes), or cases that are part of an Injunction for Protection Against Domestic Violence (Florida Statute 741.30). Cases can also come from criminal court.

Juvenile Dependency Cases

As the Supreme Court Steering Committee on Families and Children in the Court explains:

> Any time there is a concern that a child has been or is in immediate danger of being abused, abandoned, or neglected it is heard in Juvenile Dependency Court. This kind of court is all about making sure that children are safe and protected and helping families with the problems that brought them into court in the first place.
>
> Dependency court is not about punishing parents or handling criminal charges.

Family Law Cases

Divorce and post-divorce-related cases can also include allegations that one parent abused or neglected the child, or allegations that the child is unsafe if unsupervised with a parent because of the parent's substance abuse, mental illness, threats of kidnapping, domestic violence, or other type of parental problem.

Domestic Violence Injunction Cases

When one parent has obtained an Injunction for Protection Against Domestic Violence against the other parent, courts sometimes order that any visitation between the Respondent parent and the children be supervised.

Scope of Services

According to the Minimum Standards, supervised contact programs must determine the range of services they offer, dependent upon available resources. The Standards add that if resources permit, services must be available for dependency, family law, domestic violence cases or other cases as designated by the chief judge. The scope of services should be clearly defined in the program agreement.

Agreements with Court

Court referrals require an Agreement with the Court in the circuit in which the program is located that specifies the following:

1. the scope and limitations of the provider's services,
2. the local procedures for court referrals, and
3. the manner and procedures for communicating with and providing reports to the court.

An Annual Affidavit of Compliance is also necessary.

The Scope and Limitations of the Provider's Service might include:

1. A list of the kinds of cases that the program can accept.
   - Some programs cannot accept cases involving allegations of child sexual abuse because of inadequate staff expertise or security personnel (see chapter 12 on Child Physical and Sexual Abuse).
   - Some programs may be required by contract with DCF to accept a certain number of dependency cases, and only have a limited number of 'slots' available for other kinds of cases.

2. The circumstances under which a particular case may be declined by the program, such as:
   - The volatile nature of the case or client, after consideration of the facts and background of the case;
   - The fact that staff may not be adequately trained to manage issues identified during intake;
   - The fact that security provided by the facility may not be adequate to keep the families, staff, or surrounding community safe;
   - Insufficient resources.

3. The fact that the program's written operational policies and procedures are incorporated into the Program Agreement.

The Procedures for Court Referrals to the Provider might include:

1. The means by which the program can receive referrals from the court. There are two issues that must be resolved:

   - Who provides the court with an order to sign?
   - Who delivers the court order to the program?

- In some circuits, it is the parties or their attorneys who deliver the court order to the Supervised Visitation Program.
- In others, the clerk of court has a designated spot for the orders to be placed, and visitation program staff collect the orders periodically.

The Manner and Procedures for communicating with the court and providing written reports to the court might include:

The ways include written reports or verbal communication (in a pre-determined manner), and may be made immediately upon incident, upon request from the court

or agency, or by subpoena duces tecum.

This provision exists because supervised visitation programs need a way to send documentation to the court; they are not parties to the cause.

This documentation may include:

1. visit reports, which are accounts of events that took place at a visit;
2. critical incident reports, which provide a detailed account of potentially harmful behavior exhibited by a parent or child, either toward another client or program staff/volunteer during a visit;
3. termination notices, when a case has been terminated from the program

DID YOU KNOW?

A Supervised Visitation Program may decline to accept a particular case because the program does not have the expertise (e.g., a sexual abuse case) or have adequate security on site (e.g., a domestic violence case).

Sample Letter of Agreement

IN THE CIRCUIT COURT,
_____JUDICIAL CIRCUIT,
IN AND FOR_____COUNTY, Florida

LETTER OF AGREEMENT BETWEEN_____VISITATION PROGRAM and THE_____JUDICIAL CIRCUIT

This Letter of Agreement outlines specific criteria to be used by the Judicial Circuit, and the Safe Visits Program. These criteria are necessary to protect all families referred to the Sunshine Visitation Program, as well as staff, volunteers, and the surrounding community.

The COURT agrees to the following:

1. To ensure that referrals are appropriate for the level of service available in a program.

2. To work with staff of Sunshine Visitation Program to establish policies and guidelines to protect all families referred to supervised visitation. The court acknowledges that cases involving domestic violence and/or child sexual abuse require special precautions and staff training.

3. To authorize Sunshine Visitation Program staff to accept or decline court referrals. Programs shall decline to accept a case for which they cannot reasonably ensure the safety of all clients, program staff, and volunteers, including but limited to the following reasons:

a) The volatile nature of the case or client.
b) Visitation personnel are not adequately trained to manage issues identified in the intake.
c) Facilities are not adequate to provide the necessary level of security.
d) Insufficient resources.
e) Conflict of interest.

4. To establish a timely mechanism for review of cases referred to Sunshine Visitation Program.

(This might include a provision that each case be reviewed after a certain number of visits, or weeks, or months. For example: The court will schedule each case for a review hearing to check on the status of the case every four months.)

5. To establish protocols for appropriate communication between the court and the Visitation program. For example:
The program shall provide copies of all critical incident reports directly to the judge's assistant on yellow paper and provide a copy to the Clerk of Court for filing in the court file.

6. To pay for any services needed to accommodate a family's language barriers or special needs, including sign language interpreters, foreign language interpreters, etc.

<u>The Safe Visit Program agrees to the following:</u>

1. To ensure that all staff who monitor visits have specific training in child development, child abuse indicators, child sexual abuse, domestic violence, mental health, substance abuse, parental alienation, cultural diversity and crisis intervention consistent with training from the Clearinghouse on Supervised Visitation and documented in personnel files.

2. To accept only those case referrals for which staff have the requisite case background material, training, and security in place to safely monitor contact.

3. To decline any referrals of cases when staff lack necessary training or education, when background material has not been received, or where lack of appropriate security may allow re-victimization of child.

4. To establish guidelines for staff to utilize in all cases, including specific guidelines for use in cases involving domestic violence and child sexual abuse. All guidelines should be pre-approved by the court.

5. To develop policies for handling and reporting of critical incidents.

6. To suspend visits in cases when the child appears to be traumatized by the visit, or when the visiting parent engages in inappropriate behavior or violates program rules.

Chief Judge's Signature and Date _____

Program Director's Signature and Date _____

Safe Visits Florida

Affidavit of Compliance

The Safe Visit, Florida Program is in compliance with the Minimum Standards for Supervised Visitation as set forth by the Administrative Order of the Supreme Court of Florida dated November 18, 1999, and in accordance with Administrative Order (Number) of the (Blank) Judicial Circuit Court.

This affidavit of compliance was completed by (Name of Director) on the (DATE) day of (MONTH) (YEAR) while acting in his/her official capacity of Program Director for the Safe Visits Florida Program.

_____	_____
Affiant's Signature	Signature
_____	_____
Date	Date

Notary Seal

IN THE CIRCUIT COURT,
_____ JUDICIAL CIRCUIT, IN AND FOR
_____ COUNTY, FLORIDA
CASE NUMBER: _____
DIVISION: _____

In the Interest of _____
D.O.B. _____

ORDER FOR SUPERVISED VISITATION IN DEPENDENCY CASES

PURSUANT TO FLORIDA STATUTES, the Court hereby orders as follows:

1. There have been (circle one) findings or allegations of (check one or more of the following)

   ☐ child abuse ☐ child neglect ☐abandonment
   ☐ other: _____.

2. Check one: ☐ The mother _____ and/or ☐ the father _____

and/or other is/are hereby ordered to use the Visitation Program with the following minor children:

a._____ d/o/b: _____
b._____ d/o/b: _____
c._____ d/o/b: _____
d._____ d/o/b: _____
e._____ d/o/b: _____

3. Within _____ days the Child Protective Investigator or the Dependency Caseworker or case/care manager will provide to the supervised visitation program a completed Standard Program Referral Form.
4. The frequency and length of the visits will be pursuant to Program policies or _____ subject to the availability of program resources.
5. Transportation:

a. ☐ DCF/Sheriff's Department will transport, or arrange for the transport of the child.
b. ☐ The Community Based Care agency will transport, or arrange for the transport.
c. ☐ Other: _____.

6. The Policies and Procedures of the Visitation Program are hereby incorporated by reference into this Order and the parties are ordered to comply with all rules, regulations and policies of the program.
7. The child protective investigator, or dependency case worker/care manager shall contact the program at (phone number) _____within three days of the hearing at which

supervised visitation is ordered to schedule an intake/orientation for the visiting parent. No visitation will occur until the visiting parent(s) have completed an intake/orientation.

8. The program may decline to accept a case, and may suspend or terminate an open case, for the following reasons:
    a. The case will place or places an undue demand on the program's resources;
    b. One or both of the parents have failed to comply with the visitation agreement, the directives of the visit supervisor, or the Court's Order;
    c. Safety issues cannot be effectively addressed by the program.
9. Written notification shall be provided to the Court and to the case worker/case manager if any case is declined, suspended, or terminated.
10. The non-custodial parent shall not remove the child(ren) from the premises of the Supervised Visitation Program without program/court authorization from the supervised visitation program. Should the noncustodial parent (or another person acting on his behalf) do so, law enforcement authorities including, but not limited to the [local police and sheriff's office], are hereby directed and authorized to use all reasonable means necessary to return the child(ren) to the Custodian of Record.
11. Special considerations:

_____

_____

12. Supervised Visitation Program Reports will be provided to the Court/Case manager (circle one) every six months or as follows:

_____.

DONE AND ORDERED at _____ Florida on the day of _____, 20_____.

_____

CIRCUIT JUDGE

Copies to:
Program
Petitioner
Respondent

By order of this Court, pursuant to §§ 39.0132(4)(a), 39.0139(4) & (5), and 39.814(4), this order on Supervised Visitation may be provided only to the parties to the case and to the visitation center at which the court ordered visitation is to occur. Further dissemination is prohibited.

IN THE CIRCUIT COURT,
_____ JUDICIAL CIRCUIT, IN AND FOR
_____ COUNTY, FLORIDA
CASE NUMBER: _____
DIVISION: _____

PETITIONER NAME _____ Petitioner,
-and
RESPONDENT NAME_____ Respondent.

ORDER FOR SUPERVISED VISITATION (Non-dependency cases)

PURSUANT TO FLORIDA STATUTES, the Court hereby orders as follows:

1. Both parties are ordered to comply with this Court Order.

(Check one) ☐ The petitioner or ☐ respondent or ☐ other is hereby ordered to use the Visitation Program to have contact with the following minor children:

a. _____ d/o/b: _____
b. _____ d/o/b: _____
c. _____ d/o/b: _____
d. _____ d/o/b: _____

2. Check One:

☐ Visitation is strictly limited to the minor children and the visiting parent.

☐ Visitation is between the minor children, the visiting parent, and visitors authorized by the court and/or the program, pursuant to specific program policies regarding safety and accountability.

☐ Visitation is in accordance with the Limitations on Visitation set forth in the attached Final Judgment of Injunction.

3. Frequency of visits: Visits shall be held according to program policy, or described below: _____.
4. Every visitation program has unique policies with regard to costs. The costs of the supervised visitation program will be allocated as follows:

   _____
5. Failure to pay may result in the Court issuing a judgment against the responsible party, suspension of visitation or such other sanctions as may be appropriate, including Contempt of Court.
6. The Policies and Procedures of the Visitation Program are hereby incorporated by reference into this Order and the parties are ordered to comply with all rules, regulations, and policies of the program.
7. The parties shall contact the program at (phone number) _____ to schedule an intake/orientation. No visitation will occur until the parties have completed an intake/orientation.

8. This order will be automatically rescinded 30 days after its issue date if it is not acted upon by the visiting party unless otherwise noted here:

_____.

9. The program may decline to accept a case, and may suspend or terminate an open case, for the following reasons:
    a. The case will place or places an undue demand on the program's resources;
    b. One or both of the clients have failed to comply with the visitation agreement, the directives of the visit supervisor, or the Court's Order;
    c. Safety issues cannot be effectively addressed by the program.
10. Written notification shall be provided to the Court if any case is declined, suspended, or terminated.
11. Case Review: This case shall be reviewed in six months or upon motion of either party or program staff.
12. The visiting parent shall not remove the child(ren) from the premises of the supervised visitation program without the court/program's authorization. Should the parent (or another person acting on his behalf) do so, law enforcement authorities including, but not limited to the [local police and sheriff's office], are hereby directed and authorized to use all reasonable means necessary to return the child(ren) to the Custodian of Record.
13. Other active cases exist involving these parties and children, including:

_____

14. Other: (for example, level of supervision, provisions making visitation contingent on participation in treatment or counseling, conditions precedent to visitation, video-taping/recording of visits, etc)

_____

_____.

15. Reports to the Court: The Supervised Visitation Program shall submit Reports to the Court as follows
    a. every three months
    b. every six months
    c. as follows _____.
16. Reports to the Court shall contain:
    a. ☐ summary information (visit log, intervention summaries, and critical incident reports only)
    b. ☐ detailed visit information (summaries and specific descriptions of parent-child interaction)
    c. ☒ other _____.

DONE AND ORDERED at _____ Florida on the day of _____, 200_____.

_____

CIRCUIT JUDGE

Copies to: Program Petitioner Respondent

Records of Visits

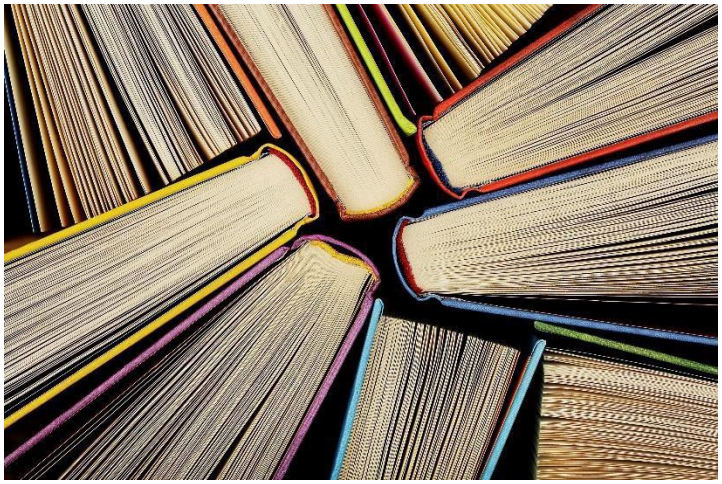
Records of Parent/Child Visits. A provider must maintain a record of each visit. The record must be factual and contain at a minimum, but not limited to:

- Client identifier or case number
- Who brought the child to the parent/child contact
- Who supervised the parent/child contact
- Any additional authorized observers
- Date, time and duration of parent/child contact
- Who participated in the parent/child contact
- Critical Incident Reports, if any. They must include a detailed description of the incident, who was involved, and what actions were taken by the program
- An account of ending, cancelling, or temporarily suspending of the parent/child with the reasons for ending or suspending the contact
- Any failure to comply with the Program's procedures
- Cancellations, tardiness, or no-shows, and explanations for those
- Incidents/suspicion of abuse or neglect as required by law; documentation if a call is made to 1-800-969-abuse or other abuse hotline
- **Visitation Notes** of the parent-child interaction, either Summary or Observation Notes
- **Contact Notes** which are summary accounts of all other contacts made by the program staff in person, in writing, by telephone, or electronically with any party the children, the court, attorneys, or other paraprofessionals involved in the case.

Visitation notes. Supervised Visitation Programs should have policies and procedures regarding other kinds of documentation they may keep about the contact, such as Summary or detailed Observation Notes on the interaction between the parent and child.

Summary Notes. Summary Notes provide an overview of the interaction that took place between the parent and child during a supervised visit. The Summary Note must be factual, objective, and absent of any professional recommendations. Unlike

the detailed Observation Note, the Summary Note shall not contain a comprehensive list of all behaviors observed between the parent and child.



Observation notes. These notes should offer a comprehensive account of events that took place between the visitor and child during visits, signed by staff/volunteer that completed the notes. They should include facts, observations, and direct statements, not opinions or recommendations. All notes should be documented so it is sensitive to the cultural identification of the family, the safety needs of vulnerable parents and/or the child(ren), and provisions of Florida law. Observation Notes may be reviewed by the Court, the other parent or his/her attorney, and other agencies.

In the past, Programs have reported numerous instances in which the documentation they have kept has been used later by the parties to gain the upper hand in litigation, to harass the Program, and to harass each other. Moreover, descriptions of body language and emotions especially when relayed by a person from a different cultural background could be misinterpreted.

Thus, a decision to keep Observation Notes about visits should be based on an Agreement with the Court and/or DCF/CBC as to the Program's roles and obligations, the safety needs of the parents and children, and the reason for the recording of such details.

Unless they are specifically required to keep detailed observation notes by the courts or DCF/CBC, which may have a legitimate need for such detail, Programs should consider keeping only summary notes, without lengthy details of activities and observations.

Reports to the Court. The local Agreements with the Court and/or DCF decide the frequency and contents of Reports to the Court. However, no Program will make recommendations as to the long term placement of the children in such reports.

If Agreements with the Court and/or DCF do not address reports to the Court, the following standards apply:

Reports to the Court must be made if a Critical Incident occurs. Unless otherwise specified by the Agreement with the Court, other reports must be submitted every six months to the Court. Reports should summarize information within the Records

of parent/child visits. Contact notes and Intake notes should not be included, unless otherwise ordered by the Court.

A copy of the Reports should be sent to all parties. Their attorneys, and attorney for the child.

Required Language for Observation Notes and Reports. Language in Observation notes and Reports should indicate observations 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.

Parties Requesting Reports at Other Times. The Agreement with the Court/DCF should state the Program's policies about releasing information regarding visits/visit files and additional Reports that parties may request. If the Agreement does not state those policies, and a party requests any information regarding supervised visitation or any documentation kept in the file outside of the timeframe, usually six months, the party must file a Motion for such, and make a showing of good cause that can be challenged by the other party or Program.

Evaluation Reports. Evaluation reports are those that provide professional recommendations and opinions regarding the parent/child contact, or not produced by Florida's Supervised Visitation Programs, except under rare circumstances. Evaluation reports can only be made by a licensed mental health professional or someone with equivalent credentials. Additionally, without prior approval from the chief judge of the court, reports should not include recommendations or opinions, especially regarding the future visitation access between a parent and child who are supervised by the Program.

Information-sharing policy. Programs should develop information-sharing policies that protect the safety of participants to the greatest extent possible and are consistent with federal laws. These policies shall have written confidentiality policies.

Maintenance of Records. Programs should keep all records until whichever comes first: for five years after the last recoded activity, or until the child reaches the age of majority (18 years).

Destruction or Records. Programs should develop policies consistent with state and federal laws regarding the destruction of records.

753.04

Until the standards for supervised visitation and supervised exchange programs are completed and a certification and monitoring process is fully implemented, supervised visitation programs must confirm in a Letter of Agreement the willingness of the program to comply with the Supreme Court's standards.

Frequently Asked Questions

If I start a supervised visitation program in my county, does the local court have to sign a Letter of Agreement with me and send cases to me?

No. The court is not compelled to work with any program. Typically, the Chief Judge will only sign agreements with programs that have demonstrated that they provide a secure, child-friendly setting, follow the standards, provide trained staff, participate actively in statewide trainings, and understand safety considerations.

If I have a problem with a case, can I just call the judge on the phone and tell her?

No. Your program's agreement with the court should dictate how you will communicate with the court. Except in an emergency, you should not contact the court in any other manner than the court has agreed to.

REMINDER:
Annual Affidavits of Compliance with these Standards must be kept on file with the Circuit Court where the Program is located.

When the Court makes a referral to my Program, who pays the cost of those services?

In family court and injunction cases, the answer is usually the parents, with the costs of the visit divided equally. However, the Court or the Program

can decide another payment schedule: for example, in some cases the referring court will order one parent to pay most or all of the costs of visits. In addition, programs can reserve the right to allow one party to pay the costs of the visits, especially if only one parent has the ability and willingness to pay.

The issue of payment must be decided before the visits occur, so that the financial issues are resolved before visits begin. Many programs have provided visits and not received the promised payment from the parties. This has caused financial problems for programs in the past. In dependency cases, the costs of the visit are generally absorbed by the child welfare agency managing the case. The costs are determined by the contract that the program has with the agency. Programs should be aware that the cost of the visit is the same when the parent cancels or shows up for the service: staff still must be paid, paperwork completed, and the program site must be made available for the visit. Therefore, programs are penalized if the child welfare agency refuses to pay for cancelled visits. In 2015-2016, there were over 11,000 cancelled visits. This represents a significant cost to programs who must prepare for visits regardless of whether those visits are ultimately cancelled or fulfilled.

If a client has a grievance, how does it get resolved?

Every program is required to have a grievance procedure pursuant to the 1999 Supreme Court Standards. Most grievances can and should be resolved at the program level, but those that cannot must be referred to either the judge that ordered the case to supervised visits, or (if that's not possible), by the Chief Administrative Judge of the circuit. From experience we know that some grievances are avoidable. When programs are transparent as to their policies and procedures, especially regarding payment and record keeping, they report fewer grievances.

If I meet a local judge in a public place, it is appropriate for me to talk to him or her about my program?

General conversation about your program – the mission, the hours of operation, the location, staff changes – are all public record, and they can be discussed informally with judges. However, no one from your staff should engage judges in case-specific informal conversation. Judges already know those rules, but staff/volunteers may not. Therefore, it is essential that you train your staff to prevent them from engaging in improper behavior.

Can a program director be qualified as an expert on supervised visitation during a trial/hearing?

Yes, but it's not common. It is much more likely that the director is called as a witness to testify to actual behavior and case-specific information in litigation

where the visits are relevant to the parties' motions.

How often do visitation staff testify about cases?

The answer varies. Some programs report that they are subpoenaed to testify at least a few times a month. Other programs report that they are rarely called upon to testify about the visits that took place, with parties instead agreeing to rely on the notes that are kept and filed in each case.

Does my program need to hire a lawyer to represent my staff at hearings?

We don't know of any programs that have an attorney on staff, but we do know that some programs have agreements with local attorneys for rare cases in which the program director wants legal representation. Some programs ask local attorneys to take such cases pro bono, or without cost. Others ask their Boards of Directors to pay the cost of counsel.

Can the court force my program to take a particular case?

Program directors have a great deal of discretion to reject cases, especially when they do not have the security, the staff expertise, or the resources to safely provide a visit. This rule was created in the 1999 Standards, and it has generally worked well to protect programs from being forced to take cases. There have been cases in which the program has negotiated for more resources in order to accept complex cases that they ordinarily might not be able to accept. For example, programs have negotiated with the court to have additional security on site to be able to accept certain cases. They have also limited the days on which the parties could set visits (because of the availability of certain trained staff or the ability of the program to provide one-on-one visits, instead of group visits).

How does the Court know about my Program's hours of operation and case acceptance procedure?

The Court generally only knows what you have told it. Thus, the Clearinghouse encourages programs to keep local judges and trial court administrators apprised of hours of operation, kinds of cases accepted, kinds of visits held (e.g. standard, or therapeutic visits), the mission of the program, and other important but general information. This should be done in writing on a bi-annual basis, unless changes in the program administration or the bench occurs. New judges that rotate onto the benches that typically order visits (dependency judges, family court judges, etc.) should be informed as soon as possible about program rules and polices.

PRACTICE EXAMPLES

Case Scenario 1

George is currently subject to an investigation for child sexual abuse. His youngest daughter Jane (11) told her mother, Susan, that George had touched her inappropriately. Because of the pending investigation and the concern for Jane's safety, the Miller family is referred to supervised visitation services.

Discussion Questions:

1. What documents will the court assess in order to make an appropriate referral for the Miller family?

2. What needs to be kept in mind when referring the Miller family to a supervised visitation program?

3. What kind of supervised visitation programs would be appropriate for the Miller family's case? What kind would be inappropriate?

Case Scenario 2

You are a supervised visitation monitor for the Harris family. They have been referred to supervised visitation services after the mother, Laura, obtained an Injunction for Protection Against Domestic Violence against the father, Robert. Robert is ordered to have visitation at the Program. The couple have a son named Louis, who is five years old. During the visit, Louis appears happy doing arts and crafts with his father. However, Laura shows up a few minutes early and Robert sees her in the parking lot through an open window. He begins to yell at her through the window, saying that she ruined his life. Louis appears terrified and starts to cry.

Discussion Questions:

1.What action would you take to protect Laura and Louise?

2. What kinds of notes would you include in the Observation Notes?

3. Would you make a Critical Incident Report to the court?

4. Would you allow visits to continue? If so, under what circumstances?

Quiz Yourself!

1. **What type of court are cases of child abuse, neglect, or abandonment typically heard in?**
    a. **Divorce-related court**
    b. **Injunction for Protection Against Domestic Violence court**
    c. **Juvenile Dependency court**
    d. **Criminal Court**

2. **TRUE or FALSE: An Agreement with the Court should specify the scope and limitations of the provider's services, the local procedures for court referrals, and the manner and procedures for communicating with and providing reports to the court.**

3. **Which of the following should NOT be included in a visit record?**
    a. **Visitation Notes**
    b. **Irrelevant personal information about the client**
    c. **Date, time, and duration of parent/child contact**
    d. **Who supervised parent/child contact**

4. **What are the general standards regarding when a Report to the Court be written to update the Court as to the case's status?**
    a. **Whenever a Critical Incident occurs, or at least every six months**
    b. **Whenever the professional feels like it**
    c. **After each visit**
    d. **Once per month**

5. **TRUE or FALSE: Programs should develop information-sharing policies that protect the safety of participants to the least extent possible and are consistent with federal laws.**

Answers: 1. C 2. TRUE 3. B 4. A 5. TRUE

Training Manual for Florida's Supervised Visitation Programs

CHAPTER 5

CONNECTING THEORY TO PRACTICE: TRAUMA-INFORMED CARE

Introduction

The Clearinghouse often disseminates trainings and research to programs to assist in staff development and to constantly improve services. While these topics can range from theories of practice to new statistics on child abuse, the next step in practice is to bridge the gap between research and suggest how it can be used to improve client services. It can be difficult for monitors to understand how to link relevant scholarly information and theoretical frameworks to everyday practice. This chapter will provide information about valuable theories and research as well as the steps to translate these theories into supervised visitation practice.

What will I learn in this chapter?

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

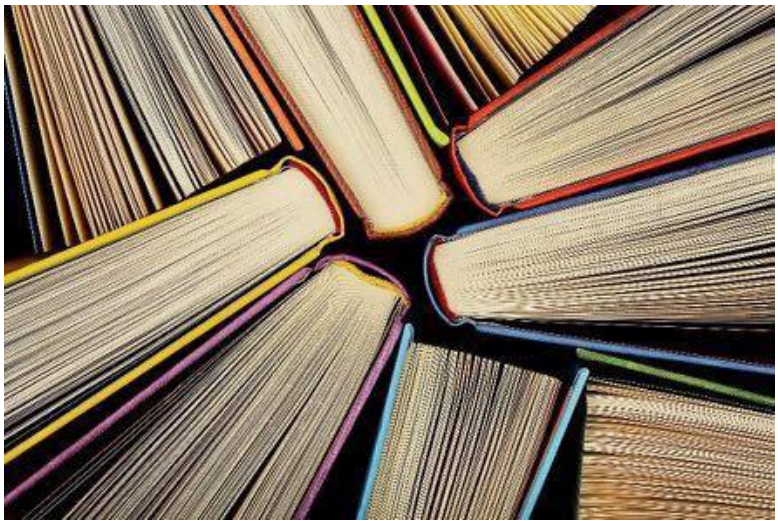
- Define theories relevant to supervised visitation;
- Understand the importance of learning theories and research;
- Describe the strength-based approach of human services;
- Teach clients how to identify their own strengths;
- Understand the impact of childhood trauma on adult behaviors;
- Create an environment and skill set that is trauma-informed;
- Identify barriers to implementing theories into practice;
- Define the importance of continuing education and skill development;

- Understand how to provide services successfully based on research and theoretical frameworks.

Understanding Theory and Research

For the purposes of supervised visitation, theories provide a framework for understanding clients and the goals of visitation. Theories can help us shape practice, predict what may happen in the future, and understand what has happened in the past.

Why We Need Theory



In simple terms, theory helps explain why people do what they do. This is helpful in a practice like supervised visitation because clients will often come from very different backgrounds and communities than the monitors and other staff.

Explains client situations and predicts behaviors. Theory provides an explanation for what is happening in each situation between families, monitors, and children. With supervised visitation as a specialized practice, it is valuable to use theory to better serve families and to prepare for visits.

Provides a starting point for monitors. When first beginning work with children and families, some monitors may have had a great deal of education, but may lack extensive experience. Understanding theory and research behind specific issues can help monitors have a starting point for which to engage in practice with clients.

Helps monitors develop an organized plan for their work. When monitors and staff understand what they are looking for and what to expect, it becomes much easier to develop a service plan for visitation. For example, the reasons behind developing a plan to distribute resources to parents will be easier to understand when using theories to support such actions.

Offers a clear framework in some chaotic situations. Sometimes information can be chaotic and overwhelming to staff, but using a theoretical framework can

help bring meaning to observations. Theories can also make organization and the processing of information clearer.

Identifies knowledge gaps. When using a theory or framework for practice, monitors and staff can identify unique cases and work to increase their knowledge and research on new topics.

Theories Relevant to Supervised Visitation

There are several theories that are relevant to supervised visitation; monitors should become familiar with them and their implications.

Adverse Childhood Experiences – This theory states that childhood experiences have a tremendous impact on an individual's future adult experiences. It is important for monitors to understand the impact of adverse childhood experiences and how they may play a role in family functioning.

Trauma-Informed Care –This theory advances the idea that social service providers will not always be able to identify trauma but should assume that all clients have experienced some traumatic event(s). With this theory, providers are expected to work through service delivery without re-traumatizing a client.

Protective Factors – Research shows that children in families that have certain protective factors are at a far reduced risk for child abuse and maltreatment. The protective factors include nurturing and attachment, knowledge of developmental stages, parental resilience, supportive social connections, concrete community supports, and social and emotional competence of children. It is important for monitors to know how to build the protective factors into supervised visitation practices to help support family health.

Strengths-Based Approach – This theory, a core of social work practice, is useful for supervised visitation because it allows monitors and staff to focus on all clients' abilities, talents, and resources rather than only on clients' deficits or problems. Considering that all cases are different and some problems may be difficult to overcome, it is important for staff to help rebuild parent-child relationships by

focusing on strengths. Such a focus helps create a positive experience for all involved.

Systems Theory – This theory is rooted in the idea that clients come from multiple systems in which an individual function. Parents and families are often working with many different community organizations or programs. The systems theory allows monitors to think about systems outside of the visitation center and how all systems affect the client. Rather than thinking about the client's environment in a cause-and-effect manner, systems theory places the person and situation in an interrelated whole.

Adverse Childhood Experiences

There have been numerous studies and research conducted that seek to define the impact of childhood experiences on adult outcomes. The Adverse Childhood Experiences (ACE) theory explains and continues to expand on this impact and can be applied to social services and supervised visitation.

The Study

This study was originally started by Dr. Felitti, who discovered that many of the adult participants dropping out of his first study had experienced sexual abuse during their childhoods. This discovery inspired a new study that explored the relationship between adverse childhood experiences and the adult development of mental health problems and physical illnesses.

The study included more than 17,000 participants from 1995-1997; they were asked questions about traumatic or stressful events they might have encountered as children. Participants were also asked about their current health status. The

traumatic events are known as adverse childhood experiences or (ACEs) and participants' ACE scores were determined by their answers to the questions.

The study included questions regarding:

- Abuse – Emotional, physical, and sexual;
- Neglect – Emotional, physical;
- Household Dysfunction – Mother treated violently, household substance abuse, household mental illness, parental separation or divorce, incarcerated household family member.

The ACE Score

- The ACE score is the total count of the number of ACEs reported by individuals, with each category of experience counting as one (1) ACE.
- The score is used to determine the amount of stress that an individual experienced during childhood.

The Findings

As seen in the charts below, when over 9,000 women were asked about emotional neglect experienced as children, 16.7% answered that they had experienced such neglect. 12.4% of the men who participated answered that they had experienced emotional neglect. Of all of the participants, over 28% had experienced physical abuse as children. At the conclusion of the study, it was found that more than half of participants reported at least one ACE. In addition, at least 1 out of 5 participants had three or more ACEs. As an individual's ACE score increased, their risk for developing mental and physical health problems increased as well.

Abuse	Women (N= 9,367)	Men (N= 7,970)	Total (N=17,377)
Emotional	13.1	7.6	10.6
Physical	27.0	29.9	28.3
Sexual	24.7	16.0	20.7

Neglect	Women (N= 9,367)	Men (N= 7,970)	Total (N=17,377)
Emotional	16.7	12.4	14.8
Physical	9.2	10.7	9.9

Household Dysfunction	Women (N= 9,367)	Men (N= 7,970)	Total (N=17,377)
Mother Treated Violently	13.7	11.5	12.7
Household Substance Abuse	29.5	23.8	26.9
Household Mental Illness	23.3	14.8	19.4
Parental Separation or Divorce	24.5	21.8	23.3
Incarcerated Household Member	5.2	4.1	4.7

Number of Adverse Childhood Experiences (ACE Score)	Women	Men	Total
0	34.5	38.0	36.1
1	24.5	27.9	26.0
2	15.5	16.4	15.9
3	10.3	8.6	9.5
4 or more	15.2	9.2	12.5

The Link Between ACE and Health Problems

The Centers for Disease Control has identified a correlation between an individual's ACE score and health problems.

As a person's ACE score increases so does the risk for several health problems, including:

- Alcoholism
- Depression
- Illicit drug use
- Injection of drugs
- Ischemic heart disease (IHD)
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- Smoking
- Obesity
- Suicide Attempts

Children

When children experience traumatic events, the stress from such events can have lasting effects on the child's developing brain. The toxic stress of experiencing something traumatic can make it possible to lose the ability to process events (good or bad) properly. This can lead to the development of unhealthy coping skills such as substance abuse.

The Effects of ACEs

Adverse childhood experiences produce toxic stress. Persistent stress can create neuron damage in a child's brain. Children who have suffered from exposure to trauma have a harder time concentrating, following directions, or even learning because their prefrontal cortex (the area responsible for self-regulation and executive functioning) has been affected by early stress.

Poor executive functioning has several consequences such as:

- The inability to control impulses
- Difficulty regulating emotions
- Difficulty handling challenges

Disease and Illness

The stress response affects our immune system, which is what our bodies need in order to fight off disease and illnesses. Our immune system also serves to control the levels of inflammation in our bodies, therefore, when our stress response keeps our inflammation levels from being regulated, illnesses like heart disease and type 2 diabetes can develop.

Trauma-Informed Care

After discussing the impact of adverse childhood experiences, it is easy to segue into trauma and the lasting effects that trauma can have on clients. Rather than focusing on childhood experiences, trauma-informed care suggests that most people have experienced trauma and it is the job of social service providers to learn about the effects of trauma to deliver the most effective services.

The Basics of Trauma

The word "trauma" describes experiences or situations that are emotionally painful and distressing, and can be often pervasive and disabling to an individual's everyday functioning. Trauma overwhelms the individual's ability to cope with difficult situations, leaving him or her feeling powerless.

There are different forms of trauma; some forms include violence, rape, and assault. This can also include an overseas soldier's experience in war or an individual witnessing violent acts in the community. Trauma also results from the effects of neglect, abject poverty, discrimination, and oppression.

The impact of trauma can be radically life-altering. Trauma can lead to depression, substance abuse, Post-Traumatic Stress Disorder, and/or anxiety disorders.

Supervised visitation professionals who interact with clients who have experienced trauma should be understanding and sensitive to those experiences. Visitation providers should be knowledgeable about the individual's history in order to know how to properly empathize and respond.

The Short and Long Term Effects of Trauma

Trauma's effect on an individual depends on many things: his or her life experiences before the trauma, his or her natural ability to cope with stress, the severity of the trauma, and the level of support offered by friends, family, and professionals (promptly after the trauma occurs).

Short-term

Individuals experiencing the short-term effects of trauma may:

- Turn away from loved ones initially because their support systems don't seem to understand their situations.
- Have trouble falling or staying asleep.
- Feel agitated and constantly be on the lookout for danger.
- Be startled by loud noises or something/someone behind them when they don't expect it.

Long-term

Individuals experiencing the long-term effects of trauma may:

- Re-experience the trauma though memories.
- Self-medicate with drugs or alcohol to numb the pain.
- Become upset or anxious when reminded about the trauma (by something the person sees, hears, feels, smells, or tastes).
- Feel anxious or fearful of being in danger again.
- Become angry, aggressive, and/or defensive.
- Have trouble managing emotions because reminders may lead to anger and/or anxiety.
- Have difficulty concentrating, focusing, or thinking clearly.
- Have a lasting effect on mental and emotional health.

For Trauma Survivors

In order to provide trauma-informed care to adults and children, service providers need to understand the following:

- Trauma experiences can be dehumanizing, brutal experiences that rob someone of any human emotion or experience.
- Trauma-informed care should exist in all human services.
- Trauma-informed care shifts the perception from "what's wrong with you?" to "what has happened to you?" This shows a move away from victim-blaming.
- There is a correlation between trauma and mental health issues and chronic conditions.

For adult clients, it is important to look at any past trauma and determine how to provide treatment that addresses both past trauma experiences and present issues, like substance abuse or chronic illness.

Adults may experience trauma due to:

- Serving overseas in the military and developing PTSD.
- Physical, sexual, verbal abuse (either in child- or adulthood).
- Being a victim of domestic violence.
- Being a victim of rape or assault.
- The lasting effects of a natural disaster (fire, hurricane, etc.).
- Loss of a significant other, parent, or child.
- Prolonged experience of poverty, oppression, or discrimination.

Children may experience trauma due to:

- The loss of a parent, friend, or pet.
- Physical, sexual, or verbal abuse.
- Neglect or maltreatment.
- An unstable or unsafe environment.
- Bullying.
- Surviving a natural disaster (fire, hurricane, etc.)
- Separation from a parent.
- Witnessing domestic violence.

Common Responses to Trauma

After experiencing trauma, a child's response is affected by multiple factors and situations. While trauma is unique to the individual, there are still some common age-related patterns of response to trauma.

Table 5.1 Common Responses to Trauma		
Age of Child	**Child's Response**	
Toddlers and Preschool – *18 months to Age 5*	• Crying, whimpering, screaming • Moving aimlessly • Trembling • Speech difficulties	• Irritability • Repetitive reenactment of trauma themes in play • Fearful avoidance and phobic reactions
School Age – *Ages Six to Twelve Years of Age*	• Sadness or crying • Poor concentration • Irritability • Fear of personal harm, or other anxieties • Nightmares and/or sleep disruption	• Bedwetting • Eating difficulties • Attention-seeking behaviors • Trauma themes in play/art/conversation
Adolescence – *Ages Thirteen to Eighteen Years of Age*	• Feelings of extreme guilt • Reluctance to discuss feelings about traumatic event • Flashbacks • Nightmares • Emotional numbing • Depression • Suicidal thoughts • Difficulties in peer relationships	• Delinquent or self-destructive behaviors • Changes in school performance • Detachment and denial • Shame about feeling afraid and vulnerable • Abrupt changes in or abandonment of former friendships

Background Information on Trauma-Informed Approaches

Trauma-informed care is a strengths-based service delivery approach that is grounded in an understanding of, and responsiveness to, the impact of trauma. It emphasizes physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment in their lives. A trauma-informed approach to the delivery of services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events. It involves four key elements of a trauma-informed approach:

1. **Realizing** the prevalence of trauma;
2. **Recognizing** how trauma affects all individuals involved with the program, organization, or system, including its own workforce;
3. **Responding** by putting this knowledge into practice; and
4. **Resisting** re-traumatization.

Key Principles of a Trauma-Informed Approach

Trauma is experienced in a different way for all clients and monitors should be aware that it is better to adhere to principles in responding to traumatized clients rather than adhere to strict actions. The six principles include:

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice, and choice
6. Cultural, historical, and gender issues

These principles are generalizable across multiple settings and can be used as specifically or broad as monitors see fit.

Trauma-Informed Approaches in Supervised Visitation

Parents experiencing trauma may seem distracted, frustrated, angry, depressed, or anxious. Children experiencing trauma may seem distant, scared, or depressed. It is important to recognize that trauma can happen to competent, healthy, and strong, people and that no one can completely protect him- or herself from a traumatic event. Visitation monitors should be sensitive to the issues that the child may be facing, as well as to the issues a visiting parent may be experiencing.
Visitation monitors should look for ways that they can improve the interaction and bonding between parent and child positively. While looking for ways to establish a safe place for the child, supervised visitation staff should watch for behaviors that may signal anxiety or re-traumatization.

Keys to Trauma-Informed Care

1. Many of the clients in social services have suffered trauma.
2. Survivors need to be respected, informed, connected, and hopeful regarding their own recovery.
3. Trauma and traumatic reactions are often inter-related (e.g., substance abuse, disordered eating and sleeping, depression, anxiety).
4. Social service providers need to work collaboratively with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors.

Provider Competence

"Trauma-informed approaches" involve the provision of care that, borrowing from the field of cultural competence, is "trauma-competent."
Individuals and services providing trauma-informed approaches should cater to the individual needs of each child to best promote empowerment and effective treatment. These can include ethnic or cultural differences, mental or physical disabilities, or language barriers.

Safety

Trauma-informed care must begin with the provision of safety, both physical and emotional, by adult caregivers to the traumatized child. In the absence of safety, the child will be unable and often unwilling to alter behavior, consider new ideas, or accept help. Children concerned about their survival cannot broaden their focus, engage in self-reflection, or allow themselves to be emotionally vulnerable. Trauma-informed organizations, programs, and services attempt to understand the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate. Therefore, these services and programs can be more supportive and avoid re-traumatization.

As a supervised visitation monitor, you will encounter and work with many families who have suffered some sort of trauma. It is important for you to understand what trauma is, what trauma-informed care entails, and to understand the principals to deliver services in an effective manner. As a visitation monitor you can help families feel safe and give them back control and empowerment over their lives.

Safety Skill

As part of trauma-informed visitation, monitors can help children feel safe by asking children how they feel about visitation and establish a word or sign to use if the child feels unsafe. Monitors should ensure that they fully understand the safety concerns of the case and that the child feels safe with the assigned monitor.

Applying a Trauma-Informed Lens to Practice

As social service providers become more and more aware of the impact of trauma on clients and client systems, it is important to take the initiative to recognize the existence of trauma and how to best work with clients affected by traumatic events. In addition to the recognition of the unique impact trauma has on the supervised visitation realm, programs can work to change their culture to ensure the safety and comfort of all clients within the program. Programs can use the following guidelines and recommendations to help place trauma in the focus of all client serving activities.

- *Incorporate trauma knowledge into new intake paperwork* – Programs can use intake as a time to discover unforeseen trauma and include questions to understand the client's needs in regard to coping with that trauma.
- *Evaluate existing practice models and organizational structure* – Programs should think about what their current process and system feels like to the client. Monitors should try to evaluate the process from referral to termination and see what it may feel like from the client's perspective. Monitors can then ask questions such as:
    - Is this sensitive to the client's needs?
    - Could this process be harmful in any way?
    - How can I be more accommodating while still prioritizing safety?
    - What might be triggering about this situation?

- *Keep visits calm and eliminate stressful events or people* – While it can be difficult to predict when a parent or child will become angry or out of control, it is in the best interest of the monitor to keep situations as calm as possible, and when there is any sign of anger, stress, or triggers, attempt to divert their impact on the clients.

- *Seek to talk with clients in a safe and secure setting* – Avoid busy and loud offices, consider emphasizing the value of privacy and respect for the client.
- *Explain what is going to occur during intake and visitation* – Ask client if he or she feels concerned about any part of the process and also ask what would make him or her feel safe. Most importantly, try to follow through as much as possible.

- *Give the client some control or choice* – Ask clients what will make them feel the most comfortable. Maybe this includes using a certain monitor, or a certain room for visitation. Some children may prefer to do specific activities that will help calm them or may want to avoid other stressful activities.

The Trauma-Informed Environment

Trauma-informed care traditionally is viewed in light of its impact the development of programs and staff interactions with clients. Given the nature of those who are in need of supervised visitation programs, it is important to understand the prevalence of trauma as a part of clients' lives. The mere event of losing custody of a child is traumatizing for a non-custodial parent, and being removed from a parent is traumatizing to children. In addition to this, domestic violence, child abuse, substance abuse, neglect, and many other potential traumas may have occurred in the lives of the parents and children who use supervised visitation programs. Trauma-informed care extends far beyond the interpersonal interactions of the

visitation but also include the environment and culture of the organization. Survivors of trauma are likely to be hyperaware of anything that may be potentially triggering to them. It becomes important to develop an appropriate environment so that those being served are able to feel safe and receive the maximum benefit from services. Cultivating an environment where a client feels valued will allow for more helpful environment. A healthy, trauma-informed environment will allow an organization and staff to effectively provide care.

The Trauma-Informed Visit Environment

In the supervised visitation setting, the culture of the organization will either help or harm the organizations ability to provide care. The trauma-informed environment extends far beyond the visitation monitor working with families. Rather, it is the whole organizational culture that creates a more helpful environment. The trauma-informed environment demonstrates the following characteristics.

The trauma-informed environment emphasizes all of the following qualities:

Safe, calm, and secure.
The trauma-informed environment promotes feelings of safety and decreases potential stressors or traumatizing experiences for clients. The environment is aesthetically pleasing. Organization policies and practices are designed to avoid re-traumatization. Privacy is respected, and the physical layout is easy to navigate.

Understanding of the prevalence of trauma.
All staff has been trained on the prevalence of trauma in the populations served. This training should be universal to all domains, whether they have direct contact with clients or not. This should increase the responsiveness of the entire workforce to the populations served to better provide services. The trauma-informed environment should understand that service providers also have histories of trauma. Emerging best practices is disseminated to all staff and updated training takes place regularly.

Culturally competent.
All domains of an organization are sensitive to the cultural influence on the families served and how an individual's culture may influence how he or she responds to trauma. Additionally, the organization and the client are able to communicate appropriately and understand one another. Translators and materials in different languages are used as necessary.

Gives clients a voice, choice, and advocacy.
Populations served have a say in the planning, implementation, and evaluation of program's efforts to improve services. Regular evaluation of the organization by consumers is used. When appropriate, the consumer has a say in their own services.

Recovery and consumer driven.
Emerging best practices are continually used and the organization updates regularly to provide the best standards of services.

Healing, hopeful, honest, and facilitates development of trusting relationships.
Staff in an organization work together and speak positively of one another at all times. The culture of the staff is to support one another and work towards greater collaboration. Care is taken to not betray the trust of the clients, who may feel that they cannot trust others.

Practices

There are a number of best and worst practices an organization should consider. It is important for supervised visitation programs to consider the impact the organization has on the clients through the existing practices. The following matrix has been adapted from the National Council for Behavioral Health.

Table 5.2 Program Practices		
Domain	What Hurts	What Helps
Relationships	…interactions that are humiliating, harsh, impersonal, disrespectful, critical, demanding, or judgmental.	Interactions that express kindness, patience, reassurance, acceptance, and listening help clients.
Physical Environment	…congested areas that are noisy, poor or confusing signage, uncomfortable furniture, and non-inviting paint on the walls.	The setting is comfortable and calm, furniture is clean and comfortable, wall coverings and posters are pleasant and convey hope.
Policies and Procedures	…rules that are commonly broken, policies focus more on organization's needs rather than client, policies that make the client "jump through hoops" to get the care they need, and language and cultural barriers.	Rules are fairly explained, emphasis is on what the organization can do, there is transparency in documentation and service planning, materials and communication are available in native language of the client, and the client is allowed provide feedback into the organization.
Attitudes and Beliefs	…asking questions that convey the idea that something is "wrong" with the parent or child, regarding difficulties as a result of some other issue, such as mental health.	Asking questions for the purpose of understanding what harmful events may contribute to the current problem; Recognizing that some non-constructive behaviors are used as a coping mechanism for trauma.

Protective Factors

Many social service providers have become familiar with factors that may increase a family or individual's chance to experience harmful outcomes. These well-known risk factors – including substance abuse, mental illness, poverty, isolation, and lack of knowledge about child development -- may increase a family's risk for child abuse and maltreatment. Research also demonstrates that there are six protective factors that can reduce the likelihood that violence will occur within a family. These factors

can help create strong, resilient families and will help to prevent added stress over time. Learning about these protective factors is essential to supervised visitation monitors whom have a direct avenue to interact and support families. The Clearinghouse has an E-Book series on the six protective factors. Monitors should refer to these resources for more information on implementing protective factors in visitation services. This chapter will briefly discuss the theories behind the protective factors and provide monitors with information necessary to translate this information into appropriate service with clients.

The six protective factors include:

- **Nurturing and attachment**
  Research indicates that children with parents who nurture them and develop attachment with them are at reduced risk for child abuse and maltreatment. Nurturing children and developing attachment with them is the process of a parent bonding emotionally with his or her child through kind, supportive, age-appropriate behavior. In this process, the child learns to trust and feel secure with the parent. Nurturing and attachment are keys for developing bonds between parent and child.
- **Knowledge of child developmental stages**
  Children with parents who understand child developmental stages present a reduced risk for child abuse and maltreatment. Knowledge about child development is gained through the parent learning about how the child changes emotionally, physically, and mentally, and the needs that accompany these changes. This knowledge allows parents to have realistic expectations of a child's behavior and abilities, as well as to be able to fulfill the child's needs from birth to adulthood.
- **Parental resilience**
  Families with parents who have resilient coping skills are also less likely to experience abuse. Parental resilience is defined as a parent's own inner resources and coping skills that help them to handle stress and crises. Resilient coping skills allow a parent to be able to solve problems, keep calm

when upset, and make it through challenging times. When parents are resilient, they are better able to build strong and resilient families.

- **Supportive social connections**
  The presence of supportive family members, friends, and neighbors helps keep families emotionally healthy and encourages positive parenting practices. Research indicates that these supportive social connections help parents cope with the many challenges of parenting.
- **Access to concrete community support**
  When parents have access to concrete community supports during times of need, their families and children are at a reduced risk for child abuse and maltreatment. When a family is struggling to meet basic needs, this stress can lead to family dysfunction. Concrete community supports are social services that provide basic resources such as food, water, shelter, safety, health care, and mental health care. Other services that can be included in community supports are childcare, domestic violence services, substance abuse treatment, employment assistance, housing, transportation, and financial literacy training.
- **Social and emotional competence of children**
  Research indicates that children who have well-developed social and emotional competencies are at a reduced risk for child abuse and maltreatment. Emotional competence is a child's ability to identify and express his or her feelings. Social competence refers to a child's ability to interact with other people. Emotional competence and social competence go hand-in-hand, as both involve skill sets that help a child to express, define, and interpret emotions. Emotional and social competencies also allow children to relate and respond to the feelings of others, as well as to communicate their own needs.

Implementing Protective Factors in Practice

Securing the knowledge about the child and family protective factors is a key part of helping families, but it is important to translate this information into easy-to-follow steps for all monitors. The Clearinghouse has developed checklists for monitors to use to operationalize the protective factors theory. These steps make it clear how simple tasks by the monitor can help parents develop and strengthen protective

factors. Tasks can include providing parents with easy to follow information and coaching, encouraging parents to participate in certain activities that strengthen the parent-child bond, providing and following up on resource information, and suggesting that a parent work on improving certain skills, such as setting goals.

Strengths-Based Approach

In the strengths-based approach, we refer to the polices, practice methods, and skills that identify and build upon the strengths of children, families, and communities. In supervised visitation, monitors can acknowledge each client's unique set of strengths and challenges and use them to partner with the client in providing visitation services. The strengths-based perspective is important to incorporate in supervised visitation practice because it reminds us that every person and family can use their strengths to create a positive experience during visitation.

Principles of the Strength-Based Approach

As previously stated, the strengths-based approach draws social service providers aware from an emphasis on deficits, and focuses on identifying an individual's strengths and how those strengths can be beneficial during visitation. The following list includes the basic principles of the strengths-based approach.

1. ***Every person has strengths.*** This is the absolute belief that every person has potential and it is his or her unique strengths and capabilities that will determine how his or her future will hold.
2. ***Every environment is full of resources.*** Along with believing in the strengths of the individual, we must acknowledge the possibility of all environments to provide help and opportunity for our clients.
3. ***Every person has the urge to succeed.*** Change is inevitable and all individuals have the urge to be better. Clients can explore their own world and improve themselves within their own situations and their communities.
4. ***Positive change occurs in the context of relationships.*** People need to know that someone cares about them and believes in them. It is important for providers to facilitate the process of supporting change and capacity building for clients.
5. ***People are more confident moving into the future when they start with what they know.*** When people become aware of their own strengths, they

realize that they have been doing something right all along. They will then feel more confident that they can move towards their goals building from their strengths that they already know and have.

6. ***It is important to value differences.*** When looking at an individual's strengths, it is important to remember that his or her strengths will be different from others. Providers should be creative and discover an individual's unique strengths and how to use them as assets in service delivery.

In general, monitors can consider the strengths-based approach as the assumption that all clients have the capacity to grow and change. The most important part of this approach is the collaboration and partnership between parents and monitors. Monitors should listen carefully to understand. It is then the work of the monitor to find opportunities for new competencies or client goals.

Empowerment

Promoting empowerment is done by believing that people are capable of making their own choices and decisions. Empowerment is an important part of the strengths-based approach and is used to build relationships. Parents feel more confident and strong when monitors provide opportunities for decision-making. By enabling parents to feel empowered, monitors can transfer power from the environment to clients, increase their strength, and contribute to their well-being.

Strengths-Based Practice Activities

Helping Parents Identify their Strengths

The activities below are helpful in providing opportunities to discuss a parent's strengths. Print out the handouts and use as needed for incorporating the strengths-based approach.

How Are You Strong?

There were good things about you before you had children, but having children often makes you want to be a better role model. Raising children makes parents stronger. The graphic below lists different strengths you may have. Look at the list and circle the strengths you have. Then list the top five strengths you feel most confident about below.

Strength #1: _____

Strength #2: _____

Strength #3: _____

Strength #4: _____

Strength #5: _____

Try this! Write down the word on a piece of paper and let the parent tape it to his or her shirt.

Discussion Questions

Ask yourself these questions about the strengths you identified and write your responses below. Take this time to think on your personal strengths and how you can appreciate and grow them.

1.) Is there a strength you feel you have developed that surprised you? Why do you think you were not able to recognize it before?

2.) How would you describe yourself if someone asked you about your life? What strengths would come to mind in your description? Do you feel a particular strength is central to your personal identity?

3.) Think of a situation you did not handle well, and identify what strengths could have been useful during that time. How might this have changed the outcome of the situation?

4.) Was there strength you do not feel you currently have, but would like to develop in your life? What are some ways you could start to practice this strength?

How Has Being a Parent Changed You?

Think about what you were like before you had children. Now how have you changed by being a parent? Below are some different ways you may have changed as you raise your children. Read each statement and underline any you feel are true. Then write down the top three ways you feel you have grown.

Personal Development

- I have found that I am stronger than I thought I was.
- I am better able to solve problems.
- I am better able to accept my life.
- I have more confidence.
- I am more reliable and dependable.
- I have greater courage when facing new situations.

Relationships

- I can count on others in times of trouble.
- I am more caring.
- I value my friends and family more.
- I show support to others.
- I put more effort into relationships.

New Meanings

- I have a better understanding of what I believe.
- What I think is important has changed.
- I can take on difficulties.
- I have a stronger religious faith.
- I believe my life is important.

New Possibilities

- I am more likely to change things that need to be changed.
- I have found new interests and hobbies.
- I am able to do better things with my life.

The #1 way I have grown: _____

The #2 way I have grown: _____

The #3 way I have grown: _____

Putting Strengths to Practice

The theory behind strengths-based practice is clear and can be thought of as a simple approach to working with clients. In reality, it may be difficult to find strengths in clients when clients feel upset and frustrated. Below are some scripts to reframe negative comments from clients and to be persistent with using the strengths-based approach.

Global Compliments

While monitors should strive to find individual and unique strengths in clients, there are many strengths that can be attributed to most individuals. A global compliment will point out a factor that can be viewed as a strength and can then later be used to build upon to find other strengths.

- Parent attends visitation for the first time.
    - "I know that it can be difficult to attend supervised visitation and I know that you feel that you don't need to be here, but you showed up, and that says a lot. You are a dedicated and committed individual for showing up to visitation to rebuild your relationship with your child."
    - "I understand that it can be frustrating to cope with this custody battle, but you have really shown resilience and strength by showing up here for visitation. Many people just give up after working through a long court battle like yours. You are really determined to be with your child and that is so important."
- Parent states that he or she has no strengths or goals.
    - "It's clear that you are frustrated with this situation, but I've heard you talk about your sister multiple times and how much she has helped you. That is a major strength to have family and social support. That support from your sister is really going to help you reach your goals."
    - "I appreciate you attending our follow-up meeting today, I hope that you know that you have shown real compassion with your kids during visits and that contributes a lot to this process. That strength is hard to come by and you are working hard towards your goals. Can you tell me more about her?"
    - "I know it can be hard to participate in visitation, but I think that you are clearly showing that your goals include being with your children. Every time you come to visitation, you are getting closer to your goal of improving your relationship with your children."

- Parent has overcome substantial obstacles but still feels hopeless.
    - "I know it can feel really difficult to move forward, but you have already overcome so many obstacles and here you are. You are really showing how resilient and persistent you are, and that is a strength that not many people have."

Scripts for Monitors

Case Scenario 1: Jana is a new visiting parent at SAFE visitation center. Her children have been removed from her custody due to multiple arrests on drug related charges. Jana feels hopeless and frustrated that she may never regain custody of her children. Part of her intake screening includes the following conversation:

> *Jana* – I just can't do anything right. I'm never going to get my girls back home with me.
>
> *Monitor* – I can tell you're upset, and I know it can be difficult to comply with visitation services when you're dealing with many other pressing issues in your life.
>
> *Jana* – Yeah! I have to keep up with my drug court and the requirements from the judge are really overwhelming. They're setting me up for failure.
>
> *Monitor* – I know that you feel defeated but you have so much drive and passion for reaching your goals. I know you mentioned that your parents are working closely with you to keep up with the court requirements. What is their support like?
>
> *Jana* – I guess you're right, my parents have really been helping me out a lot. They let me stay with them until I find a job and my mom has some connections to get me a few interviews.
>
> *Monitor* – That support from your parents is so important. You really have a good thing going for you by having them in your corner. Let's figure out how we can build off of that support to get what you need out of visitation. Can they help you with transportation to visits?

Think About It

How did the monitor reframe and find Jana's strengths?

If Jana didn't have support from her parents, what other strengths can you find in her story?

How can you find strengths in a client when he or she is frustrated?

Case Scenario 2: Derek is a parent who has been using visitation services for about six months in hopes of gaining unsupervised visits with his son, Jeremiah. Derek

has made significant progress and has been on a diligent case plan to gain unsupervised visits. Over the last three months, Derek has been able to dramatically rebuild his relationship with Jeremiah and in recent visits Jeremiah even said "I love you" to his father. Last week in a hearing, the judge ordered Derek him to another six months of supervised visitation, even though Derek had expected only three. This setback has really upset Derek and he feels no hope to move forward in visitation services.

> *Derek* – I've done all this hard work and it's just being dismissed like I don't deserve to be with my son.
>
> *Monitor* – I see you are upset. But, I want you to think about how much progress you've made over your time receiving visitation services.
>
> *Derek* – It clearly doesn't matter what I've done. The judge can't see that and now I'm stuck doing this visitation longer.
>
> *Monitor* – Derek, I know you may feel like giving up, but I really want you to think about Jeremiah. Your relationship with Jeremiah is important. Don't give up now!
>
> *Derek* – Jeremiah is finally seeing me as his father but now he's going to think I can't get anything together.
>
> *Monitor* – You have done so much, and it's evident to everyone. Jeremiah will be glad to continue spending visits with you even if they are supervised. Your relationship is growing stronger. Let's focus on that.

Think About It

In what other ways can you find strengths in Derek's case?

How did the monitor continue to change the mood of the conversation?

How can you prepare to respond to a client who truly does not believe he or she has any strengths?

Implications for Supervised Visitation

This next section will discuss how to use the theoretical frameworks and research to improve service delivery. In addition, it is important to discuss the need as well as the barriers to connect theory to practice.

Process of Making Connections

Monitors will often learn about issues, values, and skills through training from supervisors or through the reading of a training manual. The hardest part of learning is figuring out how to connect the information learned in a "classroom" setting and make it relevant to the experiences monitors have within the agency. When deciding to do a certain action, it is important for monitors to learn to ask themselves "why am I choosing to do this?" Monitors should be able to articulate the rationale that supports their decisions in their work with clients. In some cases, supervisors or trainers may need to prompt monitors to make the connections between tasks and the reasons behind the tasks.

REMINDER:

As a monitor, if you feel that you are unable to make connections between what you have learned and your practice skills with clients, you should reach out to your supervisor to assist you with making these connections. It is important to seek help when needed to improve your skills.

Challenges in Integrating Theory and Practice

Beginning the process of integrating theory and research into practice often comes with its own challenges and barriers. Some barriers include:

- New monitors may focus on completing tasks first to be as productive as possible in the workplace. New monitors may be less inclined to focus on the reasons behind their tasks.
- Monitors may imitate the actions of their trainer or supervisor and may not seek to understand why actions are taken.

- Some program directors may not encourage staff to critically analyze their work practices to determine if they are actually helping a family.

Connecting Theory to Practice

The following tips may help with making theory -to -practice connections.

- *Feel comfortable with training material.* In general, the first step of connecting theory to practice is understanding the theories that one is trying to connect. The research should provide monitors with a starting point. Whether the theory is on ACEs or about working with substance users, monitors should have a thorough understanding of the information in order to incorporate the theory into practice settings.
- *Work through case scenarios relevant to theory.* When learning about theories and research, try to read case scenarios relevant to the topic. Case scenarios will likely present cases that are common or easy to see the theory in action. As you read through case scenarios, consider what you might do if one thing had been different. This type of critical thinking will help you build flexibility and prepare for numerous slightly different scenarios in practice.

- *Understand that not all cases will fit into the framework of a theory.* While theories can be very helpful in predicting behavior and building service plans, they are not meant to be applied to all cases. Different approaches are needed to suit different circumstances. Remember: that no single theory can explain everything.
- *Reflect on previous experience.* Along with building of the knowledge you've gained through the classroom setting, it is essential to look upon your past experiences during visits to see if there are similarities or differences. These experiences will help you build upon the knowledge you have already gained.
- *Be flexible and use critical thinking skills.* Because not all cases are the same, it is important to be flexible from case to case. In addition, thinking critically about a case and client will allow you to decide how to best work with clients.

- *Seek help from a supervisor*. Monitors should seek assistance from supervisors with experience and knowledge. Supervisors will help monitors make connections that may not be obvious. The use of supervisors will serve to help monitors polish their theoretical knowledge and practice skills.

Continuing Education

Many theories are studied continuously and lead researchers to make new discoveries all the time. As the knowledge base changes, supervisors and monitors should stay informed by attending trainings, reading research materials, and disseminating relevant information to staff and parents. By continuing to learn and connect new theories to everyday practice, staff will contribute to their own professional development as well as provide the most effective services.

Quiz Yourself!

1. (T/F) Traumatic events affect everyone in the same way.

A. True
B. False

2. Which of the following is a protective factor for child abuse?

A. Parental race
B. Parental ethnicity
C. Parental resilience
D. Parental language skills

3. In what ways can monitors implement trauma-informed care into their program?

A. Treat clients respectfully and assume that they have experienced trauma in their lives.
B. Work to create a positive, calm environment
C. Explain exactly what is going to occur during visitation
D. All of the above

4. Which of the following theories are important to supervised visitation?

A. Ecological-Life Model
B. Psychosocial Approach
C. Adverse Childhood Experiences (ACEs)
D. None of the above

1.B;2.C;3. D;4.C

1. **The National Council for Behavioral Health** offers a number of trainings and resources to help organizations implement the most recent best practices. The website is https://www.thenationalcouncil.org/.

2. **Thrive Initiative** is the Maine-based organization for leading organizations to become trauma-informed. The Trauma-Informed Agency Assessment can be accessed here. The website is http://thriveinitiative.org/.

3. **Trauma Informed Care Project** is available at http://traumainformedcareproject.org/.

4. **The Chadwick Trauma-Informed Systems Project** is part of *The National Child Traumatic Stress Network* and has created a guide for administrators in child welfare systems. Website at http://www.chadwickcenter.com/CTISP/images/TICWPracticeToolkit.pdf.

5. **Healing the Damage: Trauma and Immigrant Families in the Child Welfare System** is a toolkit made for social service providers to help with addressing trauma of immigrant families. Culture plays a prominent role in this toolkit. Website at http://cimmcw.org/wp-content/uploads/2015/03/CICW-toolkit-trauma-immigrant-families-March-2015.pdf.

6. **Trauma-Informed Approach and Trauma-Specific Interventions** is a site by SAMHSA. This site provides users with an overview of trauma-informed care and plenty of resources for different populations and professionals. Website at http://www.samhsa.gov/nctic/trauma-interventions.

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CHAPTER 6

RESILIENCE

Case Scenario

Carina has been involved in visitation with her 10-year-old son, Ian, for about two months due to her severe substance abuse issues that she is receiving treatment for. During their visits, Ian has become increasingly withdrawn and hardly talks to his mom. When he does talk to Carina, he is often angry and begins yelling things like "You don't care about me" or "I hate you". Ian's grandmother has been caring for him the last two months, and she informed Carina that he is failing most of his classes and has been suspended once for getting into a fight with another child. Within the three months, Carina will complete her case plan and she will regain custody of Ian. She believes that Ian will be unmanageable by that time if she doesn't do something and she is afraid of the stress their strained relationships might create.

After completion of this chapter, you will be able to answer the following questions:

- What stressors may be affecting Carina and Ian?
- In this situation, what is the connection between trauma and resilience?
- How can building resilience help Carina and Ian in this situation?
- What indicators show that Ian is exhibiting low resilience?
- How can Carina help Ian build his resilience, and how can visitation staff help?

Introduction

In this chapter, visitation monitors will learn about resilience and its role in the families and children they work with. First, it is important to understand how trauma and resilience are connected.

Supervised visitation programs will frequently work with families who have a history of trauma. Traumatic experiences can cause various negative short term

and long-term effects on individuals, and are particularly harmful to children's developmental processes. When individuals are resilient, they "bounce back" from the adverse effects of trauma. Visit monitors should work with families and children to enhance their resiliency in order to ultimately prevent or weaken the effects that long term trauma can have on families. Additionally, resilience serves as a protective factor for parents and children and can assist them in overcoming typical life stressors, not just traumatic experiences.

What will I learn in this chapter?

This chapter provides information about trauma, stress and resilience particularly in regard to their effects on children and families.

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

- Understand the impact of trauma and stress
- Identify the ways trauma affects child development
- Define Resilience
- Recognize factors that can aid or inhibit resilience
- Help children and parents build their resilience

Snapshots

Below are facts related to the issue of trauma and resilience.

- It is estimated that 61% of men and 51% of women will experience at least one lifetime traumatic event.

- Abused children are seven times as likely to have significantly weakened self-regulatory functions (planning, goal-setting, self/social monitoring, abstract reasoning, etc.), language, and memory abilities.

- Without at least one supportive adult relationship helping children learn to cope with and recover from stressful events, many otherwise tolerable events can be toxic to their body's developing systems.

- Parents without resilient coping skills are at increased risk for drug and alcohol abuse, and may develop health problems related to stress, such as headaches, stomach aches, muscle pain, and trouble sleeping.

Overview of Trauma

The term "trauma" refers to experiences that cause intense physical and psychological stress reactions. Trauma can refer to a single event, multiple events, or a set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening. These experiences can have lasting adverse effects on an individual's physical, social, emotional, or spiritual well-being.

Below are several types of traumatic events, although it is not an all-inclusive list, as trauma differs for every individual.

- Experiencing or witnessing interpersonal violence (domestic violence, child abuse)
- Physical, sexual, or institutional abuse or neglect
- War, terrorism, or natural disasters
- Stigmatization due to gender, race, poverty, sexual orientation, or incarceration

Trauma overwhelms one's ability to cope and deal with everyday stressors and activities. Individuals who have experienced a trauma will fall within a continuum from feeling overwhelmed to overcoming the trauma. As a supervised visitation monitor, many times when you first begin working with a family, they will be on the overwhelmed side of the continuum.

Hopefully, towards the end of a visit monitor's time with the family, they will have moved to the overcoming side of the trauma continuum, indicating the processing of the trauma and the development of adaptive coping skills.

Impact of Trauma

Scientific research has shown that since children's brains are still developing, experiences of abuse, neglect, and other forms of trauma can actually alter connections in the brain. When these connections are altered in children, it can affect how they will function later in life.

DID YOU KNOW?

The first three years of a child's life are the most sensitive to both positive and negative outside influences

There are specific periods when certain brain developments occur, which if interrupted by trauma, can impair later development and behavior. The brain develops as a chain

reaction: if one connection is not made, it affects everything else that is supposed to come after it. The development of each part is dependent on receiving specific stimulation. Without making the connections on one level, the brain cannot just skip it and move on.

Our brain creates these connections based upon our surroundings, processing the nonstop stimulation we encounter in the womb, after birth, and for every single day after that. These patterns are embedded in our brain, and we learn to respond to our surroundings by what we have previously encountered. For example, when children are abused, their brain internalizes that experience, which can unconsciously shape how they interact later in life.

Table 6.1
Effects of Trauma

• Learning delays • Regression • Dissociation/detachment • Hyper- vigilance constantly scanning surrounding for safety), • Lack of social skills • Anger • Low self-esteem • Drug or alcohol use	• Lack of impulse control • Difficulty reasoning • Depression • Hyper-arousal (when the fight or flight response is triggered due to loud noises or other unexpected situations, even if there is no threat of harm) • Difficulty adapting to new people and settings

Trauma in particular can cause an individual to experience toxic stress which research has shown to be the most damaging to the brains developmental processes in children.

Toxic Stress

Toxic stress, which can damage brain architecture, may occur when individuals experience trauma that is chronic, uncontrollable, and/or extreme.
When children experience severe or chronic trauma such as abuse, certain parts of their brain that are involved with fear, anxiety, and impulsive responses may over-develop. At the same time, the areas in their brain that are involved with reasoning, planning, and behavioral control may under-develop.

Below are the various ways that toxic stress can affect an individual's brain:

- Physical abuse and neglect has been associated with a reduction in volume and activity of the major brain structures involved in emotional regulation.

- Trauma affects the Hypothalamic-Pituitary Axis, increasing hypersensitivity to cortisol, and an individual's vulnerability to depression.

- Trauma increases sympathetic ("Fight or Flight") nervous system activity. This often manifests as exaggerated startle or defense responses to situations or events that are not typically threatening or harmful.

- Abused children are seven times as likely to have significantly weakened self-regulatory functions (planning, goal-setting, self/social monitoring, abstract reasoning, etc.), language, and memory abilities.

The table below is also in chapter 13, *Domestic Violence and Supervised Visitation*

Table 6.2
Long-Term Effects of Excess Stress

Effect	*Explanation*	*Outcome*
Increased Cortisol	An increase in stress hormones like cortisol can poison circuits in the child's brain	Depending on which circuits are damaged, the child's ability to form new relationships may be permanently disrupted.
Disassociation	Being in "fight or flight" mode for extended periods of time with no option for either.	The child shuts down in order to avoid the stress.
Fear Conditioning	Child experiences "embedded stress" and remains at a high level of stress for long periods of time	Increases the likelihood of anxiety troubles throughout the child's life.
Mental Health	Children exposed to domestic violence are at a higher risk of developing mental illness. This includes substance abuse, learning disorders, hyper arousal, increased violent tendencies, etc.	Increased startle response, serious sleep disorders, anxiety, hyperactivity, conduct disorder, attention deficit and hyperactivity disorder (ADHD), and PTSD

Without at least one supportive adult relationship helping children learn to cope with and recover from trauma and stressful events, many otherwise tolerable events can be toxic to their body's developing systems. This can cause the stress system to activate more easily and longer than is normal, causing stress-related physical and mental illness later in life, and can lead to depression, anxiety disorders, smoking, drinking, overeating, poor sleep habits, cardiovascular disease, diabetes, stroke, and other lifelong negative impacts.

However, supervised visitation programs are in a unique position to help children develop coping skills, such as resilience, to combat the effects that toxic stress and trauma can have.

Defining Resilience

Resilience is a person's ability adapt to and thrive after experiencing negative situations. Other descriptions of resilience characterize it as the ability to "bounce back", to rebound from adversity, and to "bend, but not break".
For healthy development, resilience helps to protect the brain and other organs from problems with over-active stress response systems, and can reduce potentially toxic levels of stress to become tolerable. Research has shown that resilience can reduce the psychological damage that events or moments in a child's life such as maltreatment, poor parenting circumstances, violence, poverty, war, or natural disasters might cause.

The most important thing to remember about resilience is that it can be nurtured, taught, and effectively learned which is incredibly important when working with families and children who have a history of trauma.

Important Reminders About Resilience

Resilience….

- Is like a muscle, it can be strengthened with daily positive interactions with others.
- Can be enhanced by at least one caring and supportive relationship with an adult.
- Is not set in stone. A child who is resilient during one situation may not be resilient in all situations
- Can be developed in many ways. Some children tend to build resilience through strong, caring relationships, and others tend to build up resilience through active problem-solving.

Factors Correlated with Resilience

In order to strengthen resilience in individuals, it is helpful to know what factors are correlated with an individual who has a high level of resilience and those factors which are associated with low levels of resilience.

General factors connected with **high** resilience

- Having an easygoing, optimistic, or positive outlook
- Practicing self-compassion
- Positive relationships with close family
- Social support
- Well-developed problem-solving skills
- Peer group acceptance
- Strong sense of personal identity
- Ability to act independently of others
- Strong sense of humor, empathy, and compassion
- Emotional regulation skills
- Having healthy lifestyle choices, including healthy eating, and adequate sleep and exercise.
- Practicing relaxation techniques (deep breathing, mindfulness, etc.)

Things correlated with **low** resilience:

- High levels of adversity or negative life events
- Presence of mental illness
- Sense of guilt or shame about past trauma
- Stressful home environment
- Negative self-beliefs
- Seeing the world as unsafe, unpredictable, untrustworthy
- Sense of hopelessness

Using Supervised Visitation to Build Resilience

Developing and strengthening resilience in parents and children is a protective factor that aids tremendously in creating healthy families.

Research indicates that children with parents who have resilient coping skills are at reduced risk for child abuse and maltreatment. Resilient coping skills allow a

parent to be able to solve problems, keep calm and collected when upset, and make it through challenging times. When parents are resilient, they are better able to build strong and resilient families.

When children are resilient, they are able to overcome challenging situations and significantly decrease the negative effects that can occur from traumatic experiences.

In the following sections, visit monitors will learn how to help parents and children build their resilience.

Building Resilience in Parents

When a family is confronted with stressful situations, a child will look to his or her parents for reassurance, strength, and guidance on how to cope. Research shows that how a parent handles these situations can have a greater impact on the child than the stressor itself. When a parent responds to a difficult situation with patience, positive coping methods, and uses effective problem solving skills a child will feel safe and supported as a member of a strong and resilient family.

When parents share their worries and anxiety during visitation, monitors have a chance to help build resilience and coping strategies. Because parents may not recognize the ways stress may impact their interactions with their child, supervised visitation monitors can help parents understand the importance of coping with stress in a healthy, positive way, and modeling coping behaviors for their children.

Monitors can work with parents to understand what causes and triggers stress, currently inappropriate or unhealthy coping methods (such as drinking alcohol and smoking), and the impact of stress on the family dynamic. After identifying stressors and existing coping skills, monitors and parents can identify healthy coping skills (such as listening to music, going for a walk, etc.) and preventative methods to reduce stress.

Preventative methods can include pre-planning, recognizing triggers when stress is building, using appropriate coping skills to avoid a blow-up, and communicating clearly to avoid misunderstandings. Supervised visitation monitors can also work with parents to help build self-care into coping skills and daily routines, as parents who do not care for themselves are unable to care for their children.

Learn to Manage Life Stressors
The following tips may be useful for parents to manage stressful situations. Monitors may print these out for parents or encourage parents to implement these strategies in their lives.

- **Take a deep breath.** When you are feeling overwhelmed by a stressor some immediate relief can come from closing your eyes and taking a few deep breaths to clear your mind and refocus on the issue at hand.

- **Reach out to friends and family.** The support that comes from your social connections can be valuable when dealing with stressors. Identify people in your life who are trustworthy and understanding. Share with them your thoughts and concerns about the stressors you are facing.

- **Get active.** Research shows that exercise can provide immediate relief during a stressful time. Take a walk, go for a swim, or dance it out and feel a sense of refreshment that can last for hours.

- **Take a break.** When a situation is very stressful it can be hard to think about much else. Give yourself permission step away from the issue to focus on what you need to relax.

- **Do something that you enjoy.** Whether it's settling in with a good book, taking up a new hobby, or having coffee with a friend, it is important to leave time for the activities which you are passionate about. This time will help you diffuse the stress of the day.

Resilient Parents...
The following points will provide a picture of what a resilient parent looks like.

- **Prioritize self-care.** Parents that make healthy eating, exercise, and rest a priority will model good practices for their children and be well

positioned to cope with crises and support their family. Remember, parents and children have strengths which will support them when they are facing challenges!

- **Remain calm when frustrated**. A parent who uses his or her coping skills effectively when confronted with stress can manage a crisis with a clear and level mind.

- **Engage social resources.** A parent that has a strong social network is able to call on family, friends, and community resources, such as religious organizations and groups, to help in a crisis, as well as to provide comfort and stress relief.

Helping Children Become Resilient

Children will primarily learn how to become resilient by modeling their own behaviors and coping strategies after those of their parents. Parents also play an important role in helping their children develop resiliency and their own coping skills.

How Parents Can Help

1. **Build Caring Relationships**
   A caring relationship is one in which your child feels loved, understood, accepted, and protected from harm. There are many ways to create caring relationships. For instance, you can give your child attention and affection with smiles; or show interest in his or her day and activities. Playing with your child and comforting them when they need it are good ways to build trust and create a close relationship.

2. **Be a Positive Role Model**
   - Listen to your child and others
   - Stay calm
   - Show patience
   - Show positive outlook

- Recognize strengths
- Take responsibility

3. **Gather Community Resources.**
   An important part of building resilience is to reach out for help when you need it. Building a network of people and resources you can count on will show your child that it is okay to ask for help. Community resources can be beneficial in many ways.

4. **Develop Self-Regulation**
   Self-regulation is what helps us handle life disappointments, worries, and frustrations. You can help your child build self-regulation by making sure your child gets enough sleep and eats healthy foods. In order to learn and understand patience, you can practice waiting with your child. For example, you can play waiting games with them such as "Red Light – Green Light" or "Freeze."

5. **Support Confidence**
   When we have confidence in our abilities, it helps us respond to our problems with resilience. Ways to help your child with his or her confidence:

   - Encourage your child to keep on trying
   - Show your child that mistakes are okay
   - Offer your child choices and opportunities to make decisions
   - Read or tell your child stories
   - Teach your child ways to solve problems and resolve conflicts

6. **Develop a Positive Outlook**
   Being resilient includes looking for positives in life. By seeing things in a different perspective and making the best of situations you can help show your child how to bounce back from disappointment. For example, if an outdoor picnic had to be cancelled because of rain, stay positive and have the picnic inside. Creating new plans and adapting to speed bumps are crucial to being resilient!

7. **Encourage Responsibility and Participation**
   Responsibilities will allow your child to feel like he or she is contributing. By participating in sports or other activities your child will feel like he or she is a part of something. Having responsibility and participating in activities will help build your child's interests and strengths

Resilience and Middle School Children

School-aged children often reveal their levels of stress through school performance. Just as an adult's performance at work diminishes with increasing stress, children also find it difficult to focus on schoolwork in times of high stress. Anytime a child's grades are slipping significantly, it should be a red flag that alerts caring adults to explore what is going on in the child's life.

Middle school can be an extremely difficult time for children. They tend to have new groups of friends and challenges. It is important to reinforce empathy and help the child keep perspective. Encourage parents to talk to children about their own feelings during stressful situations; this teaches children that it is acceptable to express their emotions when they feel overwhelmed.

By watching the parents display positive coping methods, the child may feel more in control and confident when dealing with a stressful situation.

Resilience and High School Adolescents

It's important to talk with parents about being on the lookout for changes in their teenager's behavior. Although a new circle of friends or radical change in dress style can merely be a sign of self-development, parents should be wary of these changes as a possible indicator of stress. Adolescents sometimes use unhealthy coping methods in reaction to stress, such as giving into peer pressure, rebellion, or using or abusing substances.

Any suspicion that a teenager may be abusing substances calls for parental involvement, as well as potential professional guidance. It is important to engage adolescents in conversation about stress, coping, and resilience. Parents should create a safe environment in which adolescents feel they can express themselves on these issues without being judged.

Parents can help adolescents develop positive skills by presenting possible stressful situations and appropriate coping methods adolescents can use if they encounter any of the situations. Adolescents will then be able to identify stress when it arises and will have options for how to handle it healthily.

Conclusion

Developing resilience is a process. All people, even the most stable and resilient, reach their limits with stress at times. It is not a sign of weakness for a child to be stressed, but simply a part of life.

Supervised visitation providers should inform parents that they can help guide their adolescents on building resilience, but it's important to note that what works for one individual may not work for another. Parents can help their adolescents identify positive coping methods and resilient behaviors that most relate to them as an individual.

Online Resources

Here is a list of online resources about resiliency that you may find helpful:

1. Center on the Developing Child's Resource Center.
http://developingchild.harvard.edu/resources/
A resource with multimedia, digestible briefs and in-depth papers on children, toxic stress, and development.

2. Enhancing and Practicing Executive Function Skills with Children from Infancy to Adolescence.
http://developingchild.harvard.edu/wp-content/uploads/2015/05/Enhancing-and-Practicing-Executive-Function-Skills-with- Children-from-Infancy-to-Adolescence-1.pdf
A guide to developing executive function skills at all ages.

3. Youth symptoms of exposure to domestic violence.
http://www.nctsn.org/content/ages-and-developmental-stages-symptoms-exposure
Although specifically about exposure to domestic violence, many of the symptoms listed here are applicable to reactions to toxic stress in general.

The American Psychological Association has developed a series of tips, and if you would like to know more, we encourage you to look over them:

http://www.apa.org/helpcenter/resilience.aspx
http://www.apa.org/helpcenter/road-resilience.aspx
http://www.apa.org/helpcenter/talking-about-stress.aspx
http://www.apa.org/helpcenter/stress-children.aspx
http://www.apa.org/helpcenter/stress-talk.aspx
http://www.apa.org/helpcenter/stress-teens.aspx
http://www.apa.org/helpcenter/bounce.aspx
http://www.apa.org/helpcenter/manage-stress.aspx
http://www.apa.org/helpcenter/stress-tips.aspx
http://www.apa.org/helpcenter/exercise-stress.aspx
http://www.apa.org/helpcenter/managing-stress.aspx
http://www.apa.org/news/press/releases/stress/2009/signs-stress.pdf

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CHAPTER 7

CULTURALLY RESPONSIVE SERVICES IN SUPERVISED VISITATION

Case Scenario

Twenty-six-year-old Mr. Quiñones has been court ordered to come to your visitation program because of a substance abuse allegation. His two sons (ages 3 and 5) were placed with their mother and are allowed supervised visits with their father every other weekend. The supervised visitation program that Mr. Quiñones has been ordered to attend is predominantly staffed by white females. Additionally, Mr. Quiñones is extremely mistrusting of any state-run agency due to his family's experience and past issues with immigration.

Over the course of the first month, the supervised visitation staff and volunteers began to notice certain behaviors, such as Mr. Quiñones being late every weekend, not listening to the supervised visitation monitors, and not being forthcoming with personal information. At his last visit, he told the monitor "You don't know anything about me."

After completion of this chapter, you will be able to answer the following questions:

- What factors do you feel might be contributing to Mr. Quiñones's behavior?
- How do you feel that the visitation center could improve their services to be more culturally competent? On an agency level? On an individual level?
- What could the program director do or say to increase Mr. Quiñones's participation?
- What cultural values and beliefs do you feel could be contributing to Mr. Quiñones's behavior?

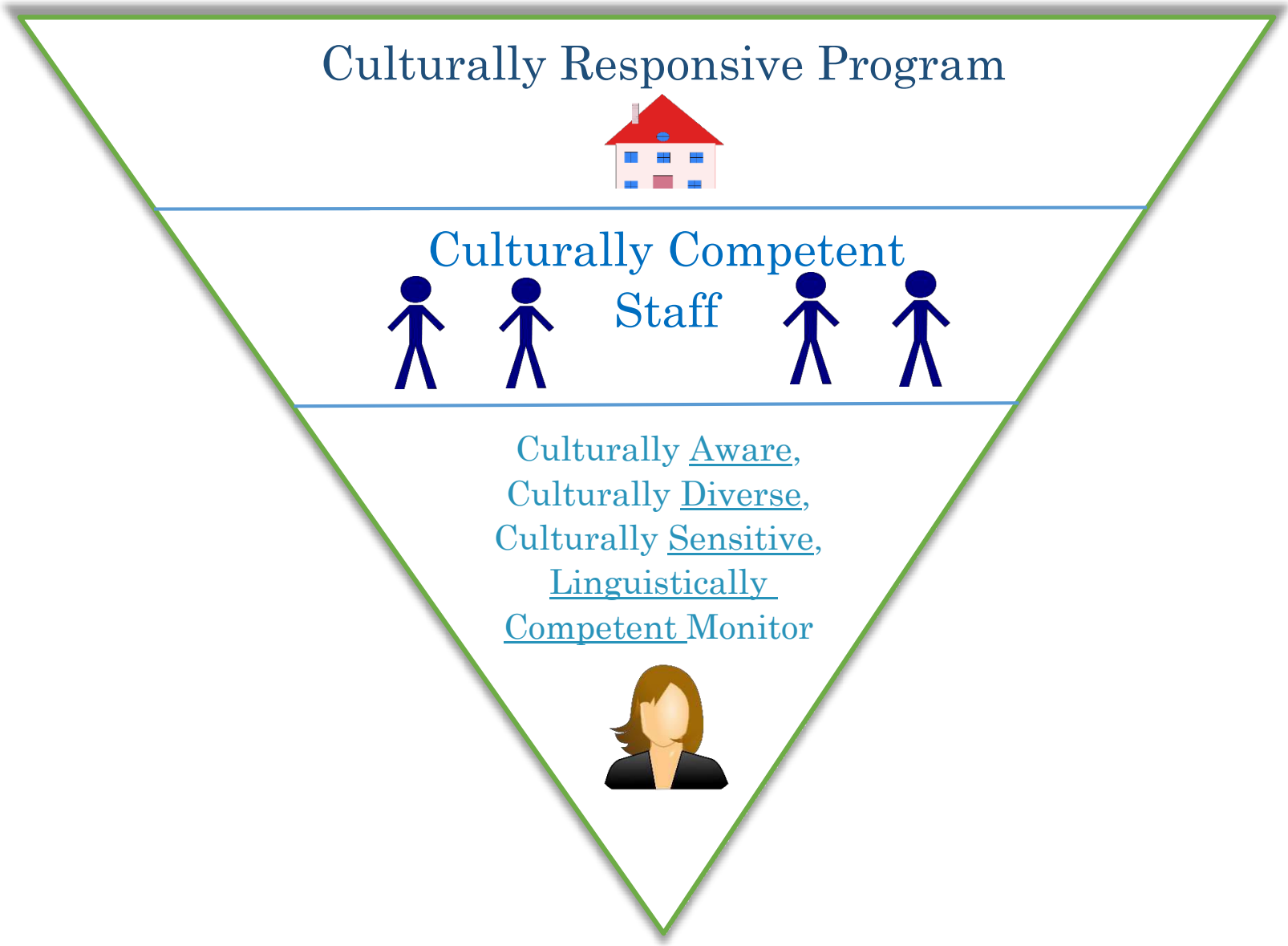
Introduction

It is important that supervised visitation monitors are always respectful and culturally appropriate when working with clients. Families referred to supervised visitation programs may represent every ethnicity, creed, doctrine, and sexual orientation in our culture. Visitation monitors must be aware of their own cultural biases and gain awareness about the differences across cultures to be effective.

This chapter will help monitors develop skills to reflect on their own culture, become culturally responsive to all, and provide information on how to create a culturally responsive program that yields the best services to all families.

Culturally Responsive Services Framework

In this chapter there are terms which may seem similar; however, the meaning of each is distinct and has a place in the framework of culturally responsive services. The image below is to help you visualize how each of these terms make up this crucial aspect of supervised visitation.



What will I learn in this chapter?

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

- Understand terminology relevant to discussing culturally diverse families
- Identify the importance of culturally responsive services
- Reflect and understand one's own identity and biases
- Understand concepts related to cultural responsiveness including diversity, awareness, sensitivity, and linguistic competence
- Identify and demonstrate effective strategies for working with culturally diverse families

Snapshots and Facts

- The 2014 US Census determined that the United States had a racial and ethnic composition of:
    - 77.4% White
    - 13.2% Black or African American
    - 17.4% Hispanic or Latino
    - 5.4% Asian
    - 1.2% American Indian and Alaskan Native
    - 0.2% Native Hawaiian or other Pacific Islander
        - *US Census Bureau Quick Facts, United States, 2014*
- In Florida, the third most populous state in the nation, the majority of White Americans is higher than the national average, as well as the percentage of African Americans and Hispanic or Latinos. The racial and ethnic composition of Florida is below:
    - 77.8% White
    - 16.8% Black or African American
    - 24.1% Hispanic or Latino
    - 2.8% Asian
    - 0.5% American Indian and Alaskan Native
    - 0.1% Native Hawaiian or other Pacific Islander
        - *US Census Bureau Quick Facts, Florida, 2014*

The Importance of Culturally Responsive Services

Providing families with culturally responsive services is the key to having a successful supervised visitation program. In a family-centered practice, visitation programs that provide culturally responsive services promote a healthy and supportive environment for all. It is essential that programs learn how to become more culturally responsive in order to provide families with the services they deserve. Otherwise, programs may risk providing inadequate and insensitive services. In this chapter, cultural competence will be referred to as a part of a culturally responsive approach to services.

The Role of Culturally Responsive Services in Supervised Visitation

When programs and monitors are culturally responsive, each client is treated fairly and in a way that acknowledges their dignity and worth. Families are more responsive and satisfied when they feel like the program addresses how they are unique as individuals and as a family. Every family is different, so it is important for monitors to understand how their cultural beliefs and practices may differ. In a culturally responsive program, monitors will take the time to work with parents and children to better understand them as a family.

While one approach with a specific family may be extremely effective, that same approach with a different family may not be. Culturally responsive services allow monitors to understand this difference and gives them the tools to adjust their approaches with parents and children in order to provide effective services.

STOP and THINK

- **In what ways do you ensure that you are culturally competent as a monitor?**
- **Is your program diverse?**
- **Does your program value cultural competency?**
- **How can you become more culturally competent?**

Supervised visitation needs culturally responsive services for the following reasons:

- Strengthens legitimacy of the program
  - Cultural competence ensures services are better tailored to each client.
- Strengthens buy-in
  - People will know that the program respects the dignity and worth of every person.
- Strengthens services
  - Parents and children will feel greater satisfaction knowing the program works hard to understand them for who they are. This creates a positive environment of support.

Benefits of Cultural Responsiveness

When programs make the effort to build their cultural competence and response, children, parents, staff, the program, and the community, all benefit.

Parents and children

Families may have a better experience with a program if they feel the visitation monitors are dedicated to getting to know their family without an overemphasis on preconceived notions about participants in the program and why they are there. Being culturally competent and responsive means avoiding judgment and communicating acceptance. Thus, families may have more positive outcomes overall.

Staff

When supervised visitation monitors are culturally responsive, they will naturally see more positive results in working with diverse families. This will contribute to less burnout and a more successful work experience.

Organizations

Organizations benefit from refined practices and improved relationships with families. Being culturally responsive may mean that an organization is more capable and fit to serve the members of various communities.

Building Cultural Competence to Create Culturally Responsive Services

In the past, social service providers have focused on cultural competency as a requirement to providing the best care to clients. While cultural competency is an important concept to promote in social services, it is crucial that monitors go beyond competence and work to respond to the differences that exist in families. This chapter expands on cultural competence and its role in culturally responsive services.

Defining Cultural Competence

Cultural competence is the practice of acquired behaviors, attitudes, awareness and skill to work effectively in cross-cultural situations. Culture can be broadly defined as the shared values, knowledge, traditions, and beliefs of any group of persons. As illustrated previously, monitors will be given many opportunities to hone in on their cultural competency skills.

REMINDER:
Cultural competence is a key component of building culturally responsive services. Cultural competency and responsiveness are long-term learning processes that monitors will develop throughout their time in the field.

Cultural competency is a process that is constantly evolving. Monitors need to be open to growing in this process. The most effective monitors are open to adjustments to their behavior and attitude as often as necessary. As such, supervised visitation monitors should reflect on their present attitudes and behaviors and look for ways to improve.

Changes in Cultural Competence

In the past, it has been a common practice to employ "color blindness" when working with clients from various backgrounds and cultures. This philosophy allowed service providers to work with and accept all clients. While this philosophy was well-intentioned, it is insufficient in service delivery because it often overlooks the broad range of differences throughout the population. Today, it is best to promote the understanding of needs from a wide range of diverse clients.

Many professional organizations recognize the importance of cultural competence and social diversity and include it within their code of ethics and mission statements.

Key Terms

Part of the journey to cultural competency begins with understanding the meaning of the following words:

- **Acculturation**: the process of adopting cultural traits or social patterns of another group, especially a dominant one
  http://www.dictionary.com/browse/acculturation
- **Classism**: prejudice against or in favor of people belonging to a particular social class
  http://www.oxforddictionaries.com/us/definition/american_english/classism
- **Collectivistic cultures:** the individual's identity is one's membership and role in a group
  http://www2.pacific.edu/sis/culture/pub/1.2.4-_activity_-_individual.htm
- **Cultural assimilation:** the process of adapting or adjusting to the culture of a group or nation or the state of being so adapted
  http://www.dictionary.com/browse/assimilation
- **Discrimination:** the behavior or actions, usually negative, towards an individual or group of people, especially on the basis of age, gender, race, social class, etc.
  http://www.simplypsychology.org/prejudice.html
- **Diversity:** the inclusion of individuals representing more than one national origin, color, religion, socioeconomic status, and sexual orientation
  http://www.dictionary.com/browse/diversity

- **Ethnicity:** a social group that shares a common and distinctiveculture, religion, language or the like. Ethnicity is preferred over race. http://www.dictionary.com/browse/ethnicity
- **Ethnocentrism:** the belief in the inherent superiority of one's own ethnicity, group or culture http://www.dictionary.com/browse/ethnocentrism
- **Individualistic cultures:** the individual satisfiesthe needs of themselves before those of the group http://www2.pacific.edu/sis/culture/pub/1.2.4-_activity_-_individual.htm
- **Minority Group:** a sociological category that is differentiated, defined, and often discriminated against by those who hold the majority of positions of social power https://www.boundless.com/sociology/textbooks/boundless-sociology-textbook/race-and-ethnicity-10/minorities-81/minority-groups-475-3392/
- **Multiculturalism**: the preservation of different cultures or cultural identities within a unified society http://www.dictionary.com/browse/multiculturalism
- **Oppression**: the feeling of being heavily burdened, mentally or physically, by troubles, adverseconditions, anxiety, etc. http://dictionary.infoplease.com/oppression
- **Prejudices**: an unjustified or incorrect attitude (usually negative) towards an individual based solely on the individual's membership in a social group http://www.simplypsychology.org/prejudice.html
- **Race:** a group of persons related by common descent or heredity. Race is a social construct. http://www.dictionary.com/browse/race
- **Racism:** the belief that each race has characters or abilities specific tothat race http://www.thefreedictionary.com/racist
- **Stereotypes:** a simplified and standardized conception or image invested with special meaning and held in common by members of a group http://www.dictionary.com/browse/stereotyping

DID YOU KNOW?

Decades of research on cultural diversity has consistently shown that culturally diverse groups are more effective than homogenous groups at…

- **complex problem solving**
- **innovating new ideas**
- **gathering information**
- **promoting hard work and creativity**

While this is not an exhaustive list of terms that apply to cultural competence, it is valuable for monitors to know, understand, and consider the implications of each of these terms.

STOP and Think

- **Look at the terms above. What do each of those terms mean to you? To your community? To your clients? To your program?**
- **In what ways does classism, racism, sexism, ageism, etc. present itself in your life? In your community? In your client's lives?**

Four Key Elements of Cultural Competence

The Clearinghouse has identified the following four key elements in the practice of becoming a culturally competent monitor and program: cultural awareness, cultural diversity, cultural sensitivity, and linguistic competence. These key elements provide monitors with an understanding of specific behaviors and practices that will contribute to a more culturally competent and responsive environment for both staff and clients.

1. Cultural Awareness

Cultural awareness is a foundational element of cultural competence and is based on being cognizant, observant, and conscious of similarities and differences among and between cultural groups. In addition to understanding cultural differences and their impact on behavior, cultural awareness includes the recognition of one's own cultural influences upon held values, beliefs, and judgments, including those that may be derived from work culture.

Why do we need cultural awareness?

- It provides the basis for the many diverse clients who attend supervise visitation to engage and collaborate peacefully with you and your agency.
- Each client will come with their own unique life experiences and culture which will influence how they interact with their child.
- It will allow you an opportunity to adjust your service provision to the culture of your clients, so that everyone may have a better visitation experience.

How do we build our cultural awareness?

- Pay attention to those around you. What are the nuanced differences between you, your clients, and the other visit monitors and what do you share in common with them?
- Listen carefully to the opinions and perspectives of your clients and co-workers. Ask yourself what reasons that person may have for holding these opinions or perspectives?
- Keep an open mind. You may see, hear, or experience things which are unfamiliar to you, but may be important orcommonplace to others.

- Ask, don't assume. Cultural differences are not necessarily always visible.
- Expand your knowledge of other cultures by keeping updated on current events, traveling to new places, and finding ways to engage with cultures different from your own.

- Have respectful discussions with others about how they perceive current events and their impact.

Case Scenario

Regina is assigned to supervise a client named Lucas who emigrated from Argentina two years ago. She believes that it is important to develop working relationships with each of her clients to make each visit a more comfortable and safe environment. When Regina tries to ask Lucas questions about himself and about his day, he will answer only in short phrases. It takes time to build rapport with each client, so Regina keeps trying to generate conversations with Lucas. But she finds it to be very difficult because he speaks slowly and often with incorrect grammar.

Without cultural awareness:

Regina assumes that Lucas is unintelligent because of his poor grammar and manner of speaking slowly. She also thinks that he is unwilling to cultivate a respectful working relationship with her because he only offers brief responses. With this assumption, Regina becomes frustrated with Lucas and stops trying to make conversation with him.

With cultural awareness:

Regina recognizes that there is a language barrier with Lucas. She understands that communicating in a different language can be very difficult, but that the slow responses and mistakes in grammar do not reflect the value of his contributions to a meaningful conversation. Regina views this as an opportunity to work to understand each other and in the process learn more about Lucas and his culture. To do this, she finds a translator to help with the intake and visitation sessions with to make sure that she understands what Lucas is trying to communicate to her.

Being culturally aware does not mean that you need to be an expert on every culture; however, it does mean that you should be able to explore what makes you unique from others, what makes others distinct from you, and how you can learn more about these differences.

2. Cultural Diversity

Cultural diversity refers to the variety of differences which make each individual unique. There are many distinct components which can contribute to a person's cultural diversity.

Table 7.1: Examples of Cultural Diversity

Race	National Origin	Marital Status	Color
Ability/Disability	Ethnicity	Sexual Orientation	Social Status
Economic status	Education	Occupation	Religion
Gender Expression	Age	Gender/Sex	Parental Status

Why do we need cultural diversity?

It is important for your agency to be culturally diverse, so that it can…

- **Serve more clients:** An extensive scope of skills and experiences of agency staff, such as languages spoken or customs understood, will allow an agency to provide services to a broad range of clients from different backgrounds.
- **Work effectively with clients of different backgrounds:** Agencies which have staff culturally informed and prepared to serve clients of various backgrounds will be able to facilitate a more positive visitation experience for the clients, as well as themselves.

- **Promote a comfortable environment for the staff and clients:** Staff and clients will feel comfortable expressing themselves more in an environment which celebrates diversity and encourages them to do so.
- **Foster unique perspectives:** A culturally diverse workforce which feels supported to contribute their different viewpoints will offer ideas and solutions which would not have been mentioned otherwise.

STOP and Think

- **How can you contribute to an agency which encourages cultural diversity?**
- **What can you do to learn about clients whose backgrounds you are unfamiliar with?**

Keep reading to learn more about it!

What does it mean to be culturally diverse?

A culturally diverse agency is able to…

- Encourage the different contributions of agency staff when brainstorming ideas for agency initiatives and solutions.

- Have materials and literature in various relevant languages to accommodate clients of different backgrounds.

- Be knowledgeable about how to research different cultures, so that you may continue to learn how to best work with the many diverse clienteles of your agency.

- Have the diversity of the clientele reflected in the staff at your agency.

What happens when we do not have cultural diversity?

Without cultural diversity…

- An agency will be unable to work effectively with the diverse range of clients that they may encounter.

- Ideas and solutions will come from a narrow scope of only those with similar backgrounds.
- Agency staff will be unprepared to engage diverse clients and unable to learn how to best meet their needs.
- Clients of diverse backgrounds will feel uncomfortable and, in turn, their supervised visitation sessions will suffer.

Being knowledgeable about cultural diversity does not mean that you need to understand every background and custom of each client. You do, however, need to be able to engage each client respectfully and know how to learn more about their cultural needs.

Case Scenario

Ben has been a supervised visitation monitor for two years and has a new client named Amirah who is a Muslim-American immigrant from Pakistan. Over the past two years, Ben has worked with many different clients from many different backgrounds, including Muslim-Americans, and has had positive experiences. When he meets Amirah, however, he extends his hand in greeting, but she refuses to shake it and avoids eye contact.

Without cultural diversity:

Ben believes that Amirah is being rude because she is unhappy that she has to attend supervised visitations. He makes a mental note that Amirah will be a difficult client and to mention it to his supervisor.

With cultural diversity:

Ben consulted with his supervisor, before meeting with Amirah, to ask about what customs and traditions might be relevant when working with Muslim-American clients. Ben learns that some Muslim-American clients may avoid making eye contact as it can be impolite to do so in their culture. Furthermore, it is a custom for some Muslim-Americans to only shake hands with relatives. When Ben meets with Amirah and she avoids eye contact and refuses to shake hands he respects her decision and realizes that this may be a custom for her. In the following supervised visitation sessions Ben does not offer handshakes, so as not to make Amirah feel uncomfortable.

3. Cultural Sensitivity

Cultural competency requires a multi-faceted educational approach. Being competent in the area of sensitivity calls for service providers to be more than just aware of other cultures, groups and customs. It calls on service providers to take a step beyond tolerance of diversity and delve into what it means to function effectively in other cultures and work efficiently with members of the community.

What is Cultural Sensitivity?

Cultural sensitivity is one way that service providers can enhance their own cultural competency. Sensitivity is valuing and respecting diversity and being thoughtful to the way cultural differences make us all unique. Sensitivity is communicated when words, phrases, and labels are purposely avoided, especially when referring to any individual who may interpret such labels as ill-mannered or insulting. Discriminatory language focuses on the false negative perceptions about a certain subgroup and can be destructive in any environment, especially an environment where services are being sought.

Cultural Sensitivity includes the use of:

- **Neutral language** (ex: avoid slang, swear words, or any degrading words such as redneck, ghetto, white-trash, or any other word that targets a specific group of people negatively.)
- **Verbal and nonverbal communication** (ex: eye contact, use of silence, use of humor and sarcasm.)
- **Appropriate questions** (ex: avoid questions that target things that are not related to the service you are providing)
- **Appropriate physical contact** (ex: let the individual initiate a hand-shake, in some cultures it is disrespectful for a man to initiate a hand shake with a woman)

Cultural Sensitivity begins with:

- *Reflecting on your own biases and prejudices*
    - What do you think you know about a specific culture?
    - Challenge your assumptions. Could you be wrong?
- *Recognize the power and privilege your culture affords you*
    - Do not assume anyone is aware of certain resources
    - Provide every client with the resources they are eligible for and may find beneficial
    - Do not assume everyone is like you
- *Acknowledging opportunities to apply what you know*
    - Avoid making assumptions based on past experiences with subgroups
    - Use appropriate language when interacting with clients
    - Use non-judgmental questions when addressing clients

Cultural Sensitivity in Poverty

- One negative assumption about those who are experiencing poverty is that they are lazy. Not only is that untrue, but it is a toxic assumption for any individual providing a service. Many people who experience poverty work tirelessly to provide food, solidify childcare, find transportation, and maintain their jobs, housing, and safety.

    - Another assumption is that poor people want to live off of welfare. The fact is that most are experiencing poverty due to situations and circumstances beyond their control. For example, loss of employment, lack of education, death, divorce, or illness.

Cultural Sensitivity in Sexual Orientation

One negative assumption about same-sex parents is that they are different from people in heterosexual relationships or that they parent their children differently. Not only is this not the case, but beliefs like this can hinder your relationship with your clients. You will have the opportunity to work with families that may have two mothers or two fathers. These parents and their child(ren) should be treated with the same respect that you would give any heterosexual parent family. One way to be

sensitive in this situation would be to recognize the obstacles the family has had to overcome to get to this point and to avoid negative stereotypes.

Cultural Sensitivity in Spirituality and Religion

The population you serve will come from very diverse religious backgrounds. You will not always encounter clients who share the same beliefs as you. When you encounter these situations, keep in mind your beliefs are your own and should be kept to yourself. Furthermore, be sensitive to the needs of others. This includes respecting various religious clothing, food preferences, etc.

4. Linguistic Competence

Linguistic competence is the capacity of an organization and its personnel to communicate effectively.

Linguistic Competence and Supervised Visitation

Linguistic Competence is a key element of Cultural Competency and is an important resource for Supervised Visitation monitors. In any setting where a monitor is providing a service, linguistic competence can help make the families feel more understood and comfortable at the facility and with the monitor.

As an extension of a monitor's own linguistic competence, monitors may also need to provide or advocate for the provision of information, referrals, and services in the

language appropriate to the client. As mentioned above, some clients will come in with limited English proficiency. This may mean the monitor may need to enlist an interpreter for the client in order to ensure that they have access to all of the same resources.

Having language diversity is an asset to the community. Having linguistic competence is an asset to social service providers and the populations they serve. Some organizations believe that the start of the client's relationship with their services begins at the front desk where it is obvious if an organization has invested in valuing the demographics of those it serves. All of these elements should be identifiable upon entering a program.

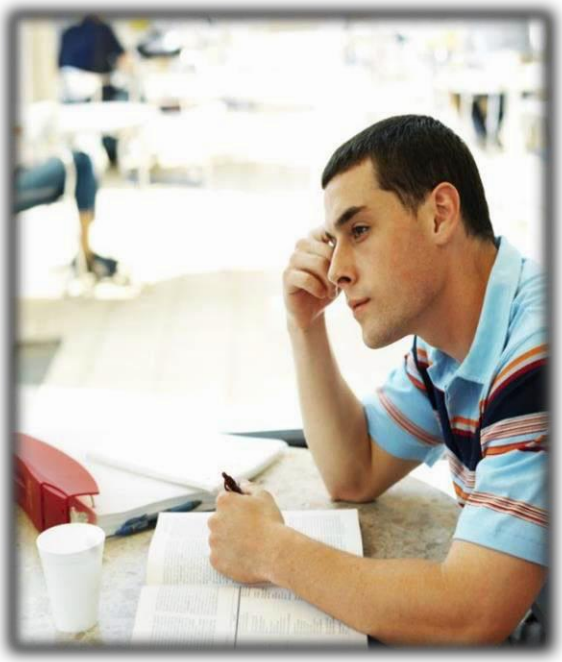
Accommodations may need to be available for:

- Persons with limited English proficiency
- Those who have limited literacy skills or who are not literate
- Individuals who are differently-abled (hearing, speech, or any physical limitations)

Language is an extension of personal identity and is influenced by one's own culture. It is one way individuals interact with others in their families and communities, and across different cultural groups. Individuals and groups have a right to use their language in their individual and communal life. Programs will need to develop language skills that meet these individuals' needs, which may require programs to enlist a translator.

Race as a Social Construct

As historian Nell Irvin Painter explained, "Race is an idea, not a fact." It is an idea that has long been used to oppress some people while privileging others.



The myth of race as a biological reality has been ingrained into our thinking for centuries. However, American sociologist W. E. B. Du Bois expressed skepticism over a century ago at the notion that social and cultural differences could be explained by biological differences. Du Bois's thinking is supported by modern scientific evidence, which demonstrates that race is a relatively modern concept that has been socially constructed.

Racial divisions are fundamentally arbitrary and deciding who is white has been not only fluid but also heavily influenced by *class* and *culture.*

<u>Things you may not have known about race:</u>

- *Race and Genetics*

In 2000, the Human Genome Project finally answered one of the most fundamental questions about race: What, if any, is the genetic difference between people of different skin colors—black, white, Hispanic, Asian? The answer: nearly nothing. As it turns out, we all share 99.99 percent of the same genetic code—no matter our race—a fact that, geneticist J. Craig Venter claimed, proves race is a "social concept, not a scientific one."

- *Race, History, and Discrimination*

  Throughout human history, various groups of people have tried to find ways to prove that they were better than others. Skin color has been one of the many ways this has been done. In the culture of ancient Greece, it was language, not physical differences that made one person different from another. Those who didn't speak the Greek language were considered to be uncivilized. In fact, the word "barbarian" stems from the Greek root word, "barbar," which means a person who does not speak Greek!

- *Slavery and Race*

  In the United States, when we think of slavery, race usually comes to mind. However, there have been many other reasons why one society has enslaved another over the course of history. In fact, some people think that the word "slave" comes from the word "Slav," which is a historical reference to the European Slavonic tribes who were enslaved by the Germans in the 1300s. In the 1600s, plantation owners in Virginia had a mixture of both European and African slaves. Eventually, African slaves began to be treated more harshly than European slaves.

Common Myths About Race:

Myth: Social inequalities can be justified by race.

Fact: The idea that one "race" is genetically superior to another has been historically used to justify fear, violence, hatred, and oppression. In reality, social inequalities should be viewed as the result of widespread discrimination.

Myth: Ignoring the issue of race will make racism disappear.

Fact: While race may not be a biological fact, it is a social reality that is used to justify discrimination. Blinding ourselves to the differences in human appearance will not make this problem go away. In order to advocate for a more just and harmonious society, it is crucial that we **acknowledge the painful history of racial discrimination and embrace diversity by increasing our cultural sensitivity and awareness**.

The myth that one "race" is genetically superior to another has been historically used to justify violence, discrimination, hatred, and oppression.

Becoming a Culturally Responsive Monitor

Acting as a culturally responsive monitor is a task that will evolve over time and requires self-awareness. As monitors become culturally responsive, they continually examine themselves and their behavior to determine how their attitudes and feelings influence their decision making. Whether you are a seasoned monitor or are just now beginning your journey in this work, it is important to constantly check in with your response to diversity and culture.

Guidelines to Becoming a Culturally Responsive Monitor:

- **Become aware of your own cultural background.** Acknowledge where you come from and the things you have experienced, and recognize the impact those factors will have on how you view others.
- **Become educated on the beliefs of the people you serve.** Acknowledge that the people you serve have unique experiences and circumstances that impact how they perceive you and the situation they are in.
- **Develop a positive attitude about approaching diversity.** When you approach diversity with enthusiasm and unconditional positive regard, you are doing a service to yourself and your clients.

- **Use familiar and appropriate greetings.** Taking the time to greet your client appropriately will make your client more comfortable which will help build rapport. It shows you care enough to enter into their world and have some knowledge about their culture/traditions.

- **Get to know your client and their family's traditions.** Don't be afraid to ask your client specific ways you can make them comfortable. This will open the lines of communication and demonstrate you have an interest in getting to know them.
- **Find commonalities of experience.** Perhaps you have hobbies in common, styles of parenting or outlooks on family. No matter what it is, establishing commonalities helps establish a bond between you and the parent and can break down the monitor/client barrier to help you see them as an individual with similar interests.
- **Be accommodating to the people you serve.** When scheduling meetings and visits, accommodate your client's work schedules, transportation needs, and religious holiday observances.
- **Identify areas where you or your organization can improve.** It is not possible to be knowledgeable and prepared for every situation that arises but it is still important to equip yourselves with the tools necessary to provide the best service possible. This means recognizing areas where you can learn more, do more and be more for the community.

Everyday Applications

Communication

When applying culturally responsive skills in your practice with families, it is important to remember the value of communication. Verbal and non-verbal ways of expression are influenced by the culture in which we are raised. Communication styles can vary across cultures in the following ways:

- Personal space
- Silence
- Dominance behaviors
- Volume
- Touching
- Eye Contact
- Interruption and turn-taking behaviors
- Gesturing
- Facial expressions

Table 7.2 Differences in Communication	
Eye Contact and Feedback Behaviors: In the United States, individuals are encouraged to look each other directly in the eye and participate actively in feedback behaviors (leaning forward, smiling, nodding, etc.). In contrast, people from other backgrounds may show respect or deference by not engaging in eye contact or participating more passively in their body language.	**Interruption and Turn-taking Behaviors**: Some cultures engage in conversation linearly, while in other cultures it may be more natural for several people to be talking at once. Listening skills to deal with different turn-taking rules must be developed.
Gesturing: Hand and arm gesturing can vary quite a bit in different cultural backgrounds. In general, extra gesturing should not necessarily be interpreted as excitement since it can just be an ordinary manner of communication, depending on the speaker.	**Facial Expressions:** Variance in this form of communication is also common, and again it is important to not assume that someone is cold or distressed based solely on one's own cultural experience.

Tips for Communication

- Listening is helpful when dealing with clients who have heavy or thick accents or use English as a second language.
- It is important to put focus on what the client is attempting to say and not how they are saying it.
- Communicating clearly and efficiently is vital when dealing with clients in general. Employees should make sure that clients clearly understand what is being communicated which can be done through asking questions to test for understanding, and then paraphrasing or clarifying more complex terminology.
- Supervisors should encourage monitors to use language that fosters trust and alliance and to always have a calm and positive attitude.

Want to know more about communication?

Check out Chapter 15, ***Practice Skills for Visit Monitors*** to receive additional training on communication skills.

Building Rapport

As part of creating culturally responsive services, rapport is going to be a key element of learning about the families in which you serve. Monitors can build rapport with clients to create a better experience for all families in supervised visitation. When engaging with clients and families, remember the following:

- **Pronounce names correctly**. If you don't know how to pronounce a name, ask the client politely.
- **Determine if there is any language barrier**, and ask the client if they would prefer the use of a translator.
- **Determine who is recognized by the family as being "in charge."** Will your program be authorized to include that person in key decisions?
- **Upon intake, describe expectation of the role that each participant will play.** Be sure to discuss these roles and expectations because they may differ from expectations that the family or client have.
- **Explain confidentiality.** Take the time to explain what will be regarded as confidential within supervised visitation relationships between monitor and family members and what will not be regarded as confidential. If applicable, explain possible effects that information shared with the monitor may or may not have on status of national residency.
- **Work with families in setting and prioritizing goals.** What are the family's expectations? How will they know when their goals have been achieved?
- **Examine available resources for the family.** What cultural resources have they turned to in the past? What was the outcome? Summarize the problem as you understand it (barriers to reunification) and make sure the clients know you understand it.
- **Discuss the family's interactions and rituals.** At intake, discuss what the client deems as "normal" interactions with family or kids (i.e. touching, interaction, eye contact, discipline, and the fact that there should be no physical discipline).

- **Explain the details of visitation and how it can help the family reach desired goals.** Monitors should discuss why supervision is deemed necessary and how it can help the family in the short-term andlong-term.
- **Simplify your language and avoid jargon.** Words that seem common to you and others in your field may be unfamiliar, confusing, or new to a client and/or family.

Strategies for Working with Diverse Families

Visit monitors will work with diverse families and must be able to develop skills and strategies to effectively facilitate visits with these families. Monitors must be aware of and vigilant about the dynamics that result from cultural differences and similarities between clients and monitors. In addition, monitors must work to prevent the exclusion of diverse clients in visitation services by attempting to meet the unique needs of all families.

EXAMPLE

A Spanish-speaking monitor may see a mother who "looks" as if she is from a Spanish-speaking country and approaches her and says "Hola, como estas?" The mother then looks at her strangely and says "I don't speak Spanish." These types of interactions, while well- intentioned, can make clients feel uncomfortable and can strain the client-worker relationship.

Respect the unique culturally-defined needs of all families. As a supervised visitation monitor, you may assume that every family's needs are circled around visitation and child welfare. Culture can play a pivotal role in the needs of a family and monitors must be sensitive to what those needs may be. Even though two individuals may share a cultural identity, other factors may cause them to respond differently to the same situation. Monitors should avoid the assumption of behaviors based on any cultural determinant.

Avoid stigmatizing cultures, races, etc. Avoiding stigmatization is an obvious part of working with culturally diverse families and should go without saying. Despite this general knowledge, social service professionals may make comments that are harmful but do not believe to be stigmatizing without even realizing it. Even well-intentioned comments can be harmful to clients from various backgrounds.

Acknowledge culture as a primary force in shaping a family's behaviors, values, and institutions. While it is common to think of culture in a sense of country or ethnic group, culture can also be developed through family dynamics. Family culture is a way of thinking, feeling, judging, and acting. Children and families develop fluid cultures that can and will differ from monitors and even other families at visitation. It is important for monitors to understand that they may not be familiar with some families' norms and should seek understanding rather than judgement.

Acknowledge that some values of families may be in conflict with dominant societal values. Families are different, despite their culture, race, or ethnicity. Because of these differences, monitors must be willing to accept families' cultural norms (as long as they are not violent, aggressive, or compromise safety) and spend their visit time in a way that makes them comfortable. In cultural responsive practice, monitors should be concerned with the comfort of clients in relation to their culture rather than their own understanding and comfort with cultures.

Expect that some clients' culture may impact their ability or response to receive services. Due to culture, community, and other variables, some families may be hesitant to receive services, seek help, or trust service providers. It is important for monitors to acknowledge this hesitation and allow for the client to build trust and comfort in the supervised visitation process.

DID YOU KNOW?

Women and men reported that where there was a person who did not understand them or was unfamiliar with them and their culture, they felt less willing to share or to trust that person (Williams, 2007).

Acknowledge that culturally diverse clients are usually best served by persons who are either part of their culture or in tune with their culture. This means that monitors may not work with all clients, and monitors should have families' best interests in mind. Clients and families may respond best with a monitor in tune with their culture or language. This strategy requires self- awareness from all monitors to determine client- monitor matches.

Understand clients' environment and community. Believe in clients and make sure they feel that monitors and workers value them, their experiences, their language, how they are living, and everything else that is included.

Discussing Culture with Clients

Every client should be asked questions about how the supervised visitation staff can express inclusion and demonstrate cultural competence. Consider utilizing a culturally competent script at intake to reduce ambiguity about diversity and help families feel more understood as they begin working with your program. The script below can help families feel heard and understood from the beginning of the supervised visitation process. After developing a script to begin the conversations of making families feel respected in their cultural differences, consider also surveying clients to determine their perception of your services. Ask clients if they were satisfied with your facility's approach to cultural diversity. Ask for specific ways improvements can be made if they found your service to be unsatisfactory. Cultural competency is a process of trial and error. The key is learning from mistakes and growing to be more culturally aware and sensitive.

Start by thinking about the questions in the table below, and then consider adding additional questions after consultations with staff and clients. Consider the diversity of your staff and the make-up of your community and population served when devising a specific script for intakes. Scripts may need to be modified to accommodate gay and lesbian clients, multi-racial families, multi-generational families, and families with one or more members that have a disability.

What to say…

Welcome to Safe Visitation Center. In order for us to best serve you and your family, we want to be as sensitive as possible to your specific cultural needs. We ask everyone these questions to be as inclusive as possible. We have a few questions we want to ask you in order to help us better understand and assist your family. Is that okay?

- Does your family have any religious or cultural beliefs that we can be aware of and support during visitations?
- Are there any religious holidays that your family typically celebrates together?
- Do you have any food preferences? Is there anything or time that you refrain from eating?
- Does your family have any prayer or religious rituals that can be acknowledged during visitations?
- Is there anything else regarding your family's traditions, beliefs, or values that you would like us to know as we seek to provide competent service to you and your family?

Thank you for sharing all of this with me today. I am going to keep your family's specific needs in mind throughout this process and I hope you will come to me with any other concerns you may have. I aim to be aware of and sensitive to your family's traditions and values.

As you work with diverse families, it is in your best interest to discuss your commitment to making client's experience in supervised visitation as respectful of their culture as possible. By asking appropriate questions, you can receive the information necessary for visitation while maintaining the respect and dignity of diverse clients.

You should include the use of:

Neutral Language: Avoid slang, swear or degrading words.

Verbal and nonverbal communication: Eye contact, use of silence, humor, sarcasm.

Appropriate Questions: Avoid questions that target things that are not related to the service you are providing.

Appropriate Physical Contact: Let the individual initiate a hand-shake or physical contact, and never force families to hug or kiss.

What NOT to say…

Welcome to Safe Visitation Center Mrs. Alba. Your last name is so exotic; I've never heard it before. What are you? In visitation we are limited with how we can help you celebrate holidays… what kinds of traditions do your people recognize? I don't see you as_____, I see you as a regular person. I'm not sure we need to focus on race or culture to work through visitation. Don't be too sensitive about it, we wouldn't allow that for anyone else either. That's interesting, I think I saw a documentary on that practice once.

- What are you?
  This question implies that you perceive the person you are speaking to as different and has a dehumanizing tone. People are not things and should always referred to with respect and dignity.
- Your people, people like you, those people, etc.
  Statements such as these group and seclude individuals from the speaker. These comments have a condescending connotation that creates a barrier between individuals.
- Terms such as exotic, ethnic, etc.
  These terms are harmful because they imply that the individual you are speaking of is not "normal" and furthermore reduces the individual to the definition of originating from a foreign or unknown place. These terms can be seen as backhanded reminders that people of color are less than human.
- We don't see color, race, etc. (colorblind)
  Colorblindness implies that clients will not be able to have their specific needs met due to their culture or race. Monitors must be aware that diverse families come with diverse needs.

With the comments above, the monitor fails to ask the client if she is willing to discuss anything related to her culture, race, or traditions. The monitor also uses microaggressions that lead us to believe the client is different, excluded, and less than others. The statements above are insensitive and focus on the client's race rather than on her needs for visitation in conjunction with her culture. Using terms, phrases, and questions that are harmful and insensitive can place strain, disrespect, and mistrust in the client-worker relationship. Diverse clients may feel as if the worker does not understand their culture or lifestyle and this can make it very difficult to have a positive visitation experience.

Avoiding Cultural Incompetence

Culturally incompetent monitors are harmful to a supervised visitation program because they can be offensive, ineffective, and render disproportionately unsatisfactory services to culturally diverse families. It can even damage a family's perceptions of the supervised visitation process. Many families are involuntarily ordered to participate in supervised visitation and will naturally have some hesitancies about the program. Cultural incompetence can further distance the parents from the monitors and families may be less likely to cooperate with the program as a result. Monitors need to make every effort to meet families where they are at and that means educating themselves on cultural issues in the supervised visitation process.

Cultural incompetence can include:

- Stereotypes
  - Prejudgments or prejudiced perceptions of the tendencies and behaviors of certain families. These stereotypes can negatively affect the capability of a visit monitor to accurately observe exchanges between parents and their children.
  - Stereotypes can interfere with how you perceive an individual's behavior as well as how you interact with them. Your implicit beliefs affect your demeanor and attitude towards individuals and families.

- Cultural Insensitivity
  - 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 very 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. Monitors need to be mindful of this process when working with culturally diverse clients. If a monitor is insensitive, it will negatively impact their relationship with the family.

- Personal Biases
    - Racial differences in parenting behaviors may be due to differences across racial groups in socioeconomic characteristics, such as income, education, or family structure, and differences in maternal characteristics are correlated with race.
    - A potential reporter may observe that a child has an injury which could be the result of maltreatment, but could also be due to an accident. A reporter who believes (correctly or not) that ethnic minority families are more likely to use physical discipline strategies may then be more likely to infer that a child has been maltreated.

- Lack of Cultural Knowledge
    - Determining a client's cultural background based on physical appearance and inaccurately assuming things about them.
    - Monitors never examining their own cultural identity and how that affects the service they are providing.
    - Believing that cultural traits are the same as ethnic traits.
    - Assuming that outcomes/duration of services should be same across cultures.
    - Believing one's own cultural values and traits are the best and the only acceptable ones.
    - Believing any culture or traits are better than the rest.

Self-Assessment

We recommend that every supervised visitation program take the Promoting Cultural Diversity and Cultural Competency Checklist available at**:** http://nccc.georgetown.edu/documents/ChecklistBehavioralHealth.pdf. Below are some examples from the checklist:

PROMOTING CULTURAL DIVERSITY AND CULTURAL COMPETENCY
Self-Assessment Checklist for Personnel Providing Behavioral Health Services and Supports to Children, Youth and their Families

Directions: Please select A, B, or C for each item listed below.

A = Things I do frequently, or statement applies to me to a great degree
B = Things I do occasionally, or statement applies to me to a moderate degree
C = Things I do rarely or never, or statement applies to me to minimal degree or not at all

_____1. I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of children, youth, and families served by my program or agency.

_____2. For children and youth who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.

_____3. I use alternative formats and varied approaches to communicate and share information with children, youth and/or their family members who experience disability.

_____4. I accept that religion, spirituality and other beliefs may influence how families respond to mental or physical illnesses, disease, disability and death.

_____5. I attempt to determine any familial colloquialisms used by children, youth and families that may impact on assessment, treatment or other interventions.

_____6. When possible, I insure that all notices and communiqués to parents, families and caregivers are written in their language of origin.

_____7. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.

_____8. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).

_____9. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant or mainstream culture.

_____10. I accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children).

Quiz Yourself!

1. _____is a prejudged preconception of how certain ethnic families behave.

A. Assimilation
B. Xenophobia
C. Stereotype
D. Homophobia

2. Which of the following is true about culturally diverse families?

A. Not every individual is comfortable or considers it respectful to engage in eye contact.
B. Some cultures reserve emotional expression for a very private place.
C. Some cultures will show affection differently to male and female children.
D. All of the above.

3. Which of the following would be considered cultural incompetence?

A. Providing pamphlets in multiple languages in the waiting room.
B. Using stereotypes as a basis for how to interact with different cultures.
C. Having a translator on staff for clients who speak the languages of the communities served.
D. Asking clients about their culture, if you are not familiar with it.

Answers: 1. C; 2. D; 3. B.

Visualization Exercise

Use the following guide to reflect with staff and peers about the different cultural attitudes and experiences of individuals within your supervised visitation agency.

Instructions:

For Part 1, the group leader should direct the group to close their eyes and visualize these questions as the leader reads them allowed. For part 2, the leader should lead a group discussion on the different points listed.

Part 1:

1. Picture your neighborhood. Who are your neighbors?

2. Think about your closest co-workers…

3. Who are your closest friends?

4. Think about the last time you looked for a new doctor, dentist, hair stylist, etc.…

Part 2:

Now think about how you define yourself. What group(s) and culture(s) do you identify with?

When you thought about the statements and questions above

- Did you picture people who were like you, or different from you?
- Do you often interact with people of different races, nationalities, sexual orientations, or religions?
- How do your friends, co-workers, neighbors and service providers reflect your culture?
- How are they different from you? Are they different from you?

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2. **Diversity and Cultural Competence.** https://www.socialworkers.org/pressroom/features/issue/diversity.asp. This resource provides a historical and societal context for the necessity of diversity.
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    - More training and resources in the health care profession

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CHAPTER 8

THE IMPACT OF DEVELOPMENTAL DISABILITY & CHRONIC ILLNESS ON SUPERVISED VISITATION

Case Scenario

Ms. Johnson has been referred to supervised visits with her three children ages 5, 7, and 8. The children were placed in foster care after a neighbor reported that Ms. Johnson had been using illegal drugs. After recently completing a rehabilitation program and being drug-free for several months, Ms. Johnson has been diagnosed with advanced multiple sclerosis. Ms. Johnson also has a developmental disability and has been having trouble understanding what her diagnosis means. Her children have been noticing her physical deterioration and are very upset by it. Ms. Johnson is confused as to why her children are now acting differently toward her and has been becoming increasingly angry and physically weaker.

After completion of this chapter, you will be able to answer the following questions:

- What might a visitor monitor do to address the emotions of Ms. Johnson and her children?
- What forms of communication between the program and the case manager might be helpful to facilitate this case?
- If the program's efforts to improve visits between the mother and the children were not successful, what steps might the program take?

Introduction

This chapter is divided into two sections:

Developmental Disabilities

Chronic Illness

Parents and children with chronic illnesses or developmental disabilities present unique challenges in supervised visitation. Each of these conditions can create stressors that may influence parenting as well as other aspects of a family's life. Financial stress, access to social services, and access to medical care are important factors that may arise when families cope with these issues. This chapter will discuss the impact of developmental disabilities and chronic illness on visitation separately. Supervised visitation monitors can use the information in this chapter to better understand how to support families coping with developmental disabilities or chronic illnesses.

Developmental Disabilities

It is reported that 15% of children from 3-17 years of age have one or more developmental disabilities. Developmental disabilities can be attributed to a mental illness or physical impairment or a combination of both which manifests before the age of twenty-two. Developmental disabilities can affect daily functioning and usually lasts throughout a person's lifetime. There are many different types of developmental disabilities that can affect parenting. A developmental disability can be present in a parent as well as a child, which may affect supervised visitation.

Chronic Illnesses

Chronic illness of a parent or child, whether cancer, diabetes, multiple sclerosis, or other conditions can detrimentally affect the parent or child's physical and mental well-being. These conditions may affect a parent's ability to adequately respond to a child's needs due to fatigue, pain management issues, or the progression of particular conditions. Such issues may affect the parent's ability to meet children's needs as well as cause additional stress. Also such issues with a parent could affect the child and their needs as well. Depression, lack of understanding, and frustration are issues that could be present in a child whose parent has a disability or chronic illness.

What will I learn in this chapter?

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

- Understand the common characteristics of developmental disabilities and chronic illnesses;
- Identify risk factors which may present the potential for harm during visits;
- Identify behaviors parents and children may have that could impact visitation;
- Understand how to respond appropriately whe a child who has a chronic illness;
- Understand how to respond appropriately whe and/or a child who has a developmental disabil
- Understand the impact that developmental dis illnesses have on parents, children, and supervised visitation;
- Resolve common conflicts that may occur because a developmental disability or chronic illness is present within the family;
- Facilitate activities for parents and children to do during visitation.

DID YOU KNOW?

As many as one in five people in the United States has a learning disability.

Part 1

Developmental Disabilities

Developmental disability is a term that encompasses a group of conditions that cultivate in the developmental period of a person's life. It is more common for developmental disabilities to be identified before a child enters school, around 6 years old. According to the DSM-V (Diagnostic and Statistical Manual), there is an organized list of neurodevelopmental disorders that can be identified through certain diagnostic criteria. The DSM-V is used to diagnose, define, and categorize mental illnesses, which includes developmental disorders.

DSM-V Neurodevelopmental Disorders

- Intellectual Disabilities
- Communication Disorders
- Autism Spectrum Disorder
- ADHD
- Specific Learning Disorders
- Other Neurodevelopmental Disorders

This section will address each DSM-V neurodevelopmental disorder and common symptoms. This chapter will also discuss how different developmental disabilities can affect parenting as well as supervised visitation. It is important to consider that all of the developmental disabilities listed could be prevalent in children and adults; they are not limited to a specific age range. This is important to understand because developmental disabilities can emotionally impact and physically limit both children and parents.

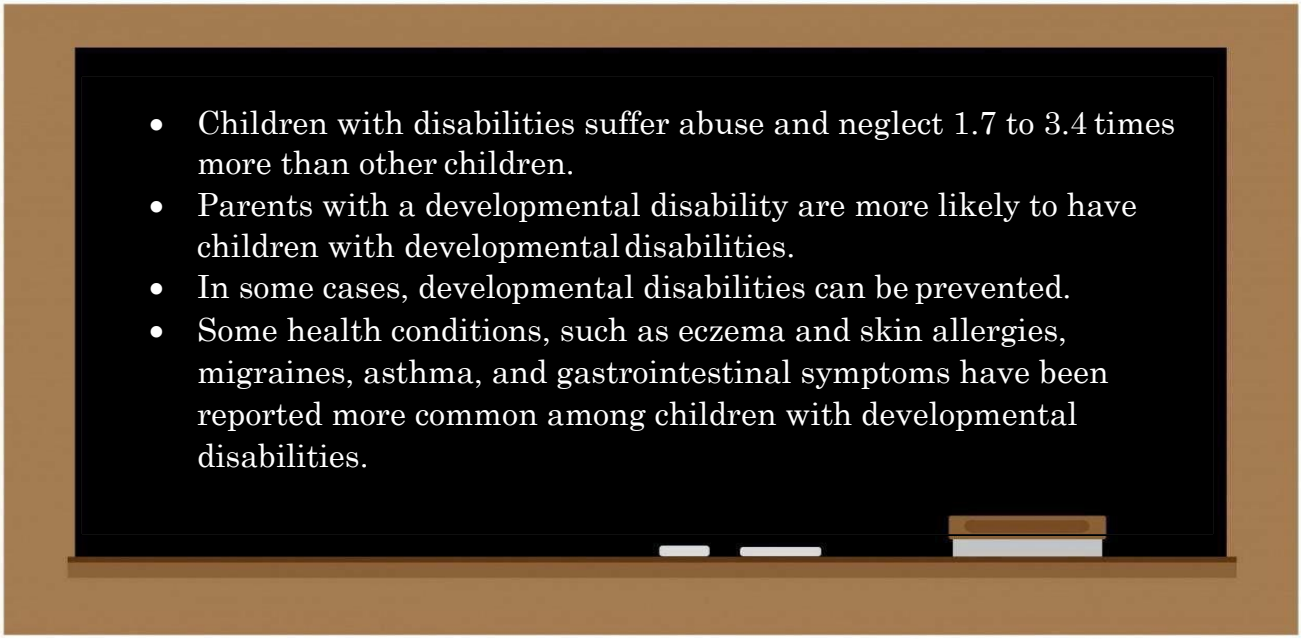


Table 8.1
Categories of Developmental Disabilities

Developmental Disability Categories			
Category	Definition	Symptoms	Disorders
Intellectual Disabilities	When an individual is lacking in general mental abilities. For example, academic learning, problem solving, and perception.	• A low intelligence quotient (I.Q.), 75 and below. • Limited functioning in communication, living independently, school, work, or social activities.	- Intellectual Disability (Intellectual Developmental Delay) - Global Developmental Delay - Intellectual Developmental Disorder

Communication Disorders	When an individual experiences a deficit in speech, language, and communication.	• Limited vocabulary • Difficulty with forming sounds or speech • Syllable repetitions • Repeating one word in a sentence • Difficulty inferring the meaning of a conversation	- Language Disorder - Speech Sound Disorder - Childhood-Onset Fluency Disorder (Stuttering) -Social (Pragmatic) Communication Disorder - Unspecified Communication Disorder
Autism Spectrum Disorder	A broad term encompassing individuals with observed differences in developmental behaviors.	• A baby does not babble or coo by 12 months old • A baby does not point or wave by 12 months • A child does not say words by 16 months • A child is observed with a lack of social skills or language at any age	- Autism Spectrum Disorder
ADHD	When an individual experiences difficulty paying attention or staying organized.	• Difficulty listening • Difficulty staying still • Disorganization • Not able to wait	- Attention-Deficit/Hyperactivity Disorder - Other Specified Attention-Deficit/Hyperactivity Disorder - Unspecified Attention-Deficit/Hyperactivity Disorder

Specific Learning Disorders	An individual that experiences learning difficulties and/or has difficulty demonstrating academic skills	• Spelling difficulties • Difficulty understanding the meaning of words or what is being read	- Specific Learning Disorder - Specificities: Dyslexia & Dyscalculia
Motor Disorders	When an individual experiences involuntary and abnormal movements.	• Difficulty in the performance of motor skills such as throwing a ball, using utensils, riding a bike.	- Developmental Coordination Disorder - Stereotypic Movement Disorder - Tic Disorder - Other specified Tic Disorder - Unspecified Tic Disorder
Other Neuro-developmental Disorders	An individual experiences limitation in functions, but they do not fall under a specific neuro-developmental disorder.	• A common example is a neuro-developmental disorder associated with prenatal alcohol syndrome.	- Other neuro-developmental disorder - Unspecified Neuro-developmental Disorder

According to the DSM-V, there are other neurodevelopmental disorders that should be considered as developmental disorders. There are certain environmental, medical, or genetic conditions that contribute to developmental disorders. Examples of other specific developmental disorders are Fragile X syndrome, Rett syndrome, epilepsy, low birth weight, fetal alcohol syndrome, tuberous sclerosis, and cerebral palsy.

Impact of Developmental Disabilities on Parents

Developmental disabilities may affect people differently. In some cases, a parent's developmental disability may have played a role in parenting decisions, shared time decisions, or visitation agreements. The presence of a developmental disability does not, in itself, mean that a parent lacks the ability to parent effectively. Parents with developmental disabilities may be faced with many barriers but should be given access to support as needed to perform any parental roles that may prove to be difficult. In addition, it is important for monitors to understand what impact developmental disabilities may have on a parent's ability to parent or participate in supervised visitation.

Parenting with a Developmental Disability

Parenting with a developmental disability often comes with the presumption of incompetence. This may lead to additional presumptions of abuse and neglect of children of such parents. Research shows little evidence to support the claim that parents with a developmental disability are more likely to neglect or abuse their child. In the past, it was common for children to be forcibly taken away from a parent with a developmental disability. Currently, evidence shows that support and training for parents with developmental disabilities can be very beneficial. Monitors should consider how some behaviors in visitation may be a result of a developmental disability and how to address, support, and work with parents that may be dealing with issues that stem from developmental disabilities.

In general, parents with a developmental disability can have differences in socialization experiences, life experiences, and learning styles. This can affect parenting by limiting how a parent behaves with his or her child.

Myths

People with developmental disabilities are all the same.
FACT: Developmental disabilities encompass a wide range of conditions with many different features. Some examples of developmental disabilities are ADHD, autism spectrum disorder, cerebral palsy, hearing loss, intellectual disability, learning disability, and vision impairment.

Persons with developmental disabilities live very different lives than those without disabilities.
FACT: Persons with developmental disabilities are often capable of holding jobs and living in the community with little or no social supports.

Persons with developmental disabilities do not have the same feelings as those without disabilities.
FACT: Individuals with intellectual challenges experience the same emotions of happiness, sadness, and desire to be accepted as any other person does.

Socialization Experiences

In this chapter, the term socialization experiences is defined by a person's capability to adjust to social norms and cultural practices, and to participate in social activities. Listed below are examples of socialization experiences a parent with a development disability might report.

- Learned dependency
- Rewards for obedience
- Lack of self-sufficiency
- Loyalty to kin
- Learned to not question authority
- Lack of normal problem-solving skills
- Limited social skills
- Expectation of social relationships to be unequal
- Feelings of stigmatization and rejection
- Learned to use cover-up techniques and compensatory behavior to conceal deficits
- Experienced harsh consequences for not meeting reasonable expectations

Life Experiences

Parents with a developmental disability may be at a higher risk for negative life experiences. Research shows that children with an intellectual disability are more likely to experience physical or sexual abuse than children without an intellectual disability. Childhood experiences may lead parents to have additional trauma to work with when parenting their own children. Parents with an identified disability could report the following from their childhood:

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

Learning Style Differences

Individuals with a developmental disability can be limited to certain activities. Parents with a developmental disability may have observable learning differences. Listed below are examples of learning style differences for an individual with a developmental disability.

- 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
- Difficulty applying knowledge from one situation to another

Emotional Impact

Parenting with a developmental disability can take an emotional toll. It is imperative for supervised visitation monitors to be aware of the emotional impact a developmental disability may have on parents. Awareness of the emotional influence will allow for better communication between the supervised visitation provider and the parent, the monitor and the child, as well as between the parent and the child. Below is a table explaining possible emotions parents with a developmental disability may experience.

Table 8.2
Emotions Parents with a Developmental Disability May Experience

Emotion	Why a parent may feel this way	How to respond
Anger	Anger might be present during certain activities at supervised visitation that the parent is not able to participate in.	Tell the parent how important it is for them to come to supervised visitation, because it shows he/she cares about the child. Discuss certain activities that are available that both the child and the parent will be able to participate in.
Embarrassment	The parent might not feel comfortable around other parents who do not have a developmental disability. The parent does not want to be stereotyped based on their disability.	Explain to the parent that he/she is in a safe place. Tell the parent the focus during a visit is on the child and how important it is that he/she comes to the visits.
Powerless	The parent does not feel in control of their situation or developmental disability. The parent might mention how he/she did not choose this and does not like the developmental disability.	Show empathy by listening to the parent and asking questions about his/her feelings towards the developmental disability.
Sadness	The parent is upset because he/she views his/her developmental disability as a huge obstacle that gets in the way of his/her relationship with the child.	Give the parent time to process his/her sadness. Explain the importance of each visit. If needed, the monitor can talk separately with the parent to thoroughly talk through his/her sadness.

Parenting a Child with a Developmental Disability

Parenting a child with a developmental disability can affect a parent's stress, finances, relationships, and attitude. In this section, supervised visitation monitors will explore the impact that child developmental disabilities may have on parents.

Stress

Research shows that parents with children with a developmental disability reported higher levels of stress than parents with children who did not have a developmental disability. A child with a developmental disability may require more attention, supervision, and energy. Single parents can also experience more stress because they are fully responsible for the child when together. Parents may report the following:

- Exhaustion
- Never having time alone
- Not being able to do things for themselves
- Always feeling busy
- Strict schedule
- Loneliness
- Frustration

Finances

Some children with a developmental disability are encouraged to receive additional services. Some of these services may include behavioral therapists, play therapists, speech language pathologists, physical therapists, and occupational therapists. These services can bring financial burden to parents providing for their child in addition to more expensive child care services. The financial burden of medical and therapeutic services may also cause stress in parents. In some situations, parents may not be able to afford specialized services for their child. For monitors, it is important to know and understand the available resources in the community to assist parents.

REMINDER

As parents experience stress and seek support, it is crucial for monitors to continually help these parents develop and fine tune the protective factors in their lives. For example, monitors can help parents with creating social and community supports to help with their children with developmental disabilities.

See the Protective Factor E-Books for more information on the development and implementation of protective factors for families in supervised visitation.

Relationships

Studies show the effects of child developmental disabilities on parents and their relationships. Evidence suggests that parents with a child who has a developmental disability participate less in social gatherings than parents whose child does not have a developmental disability. Caring for children with developmental disabilities can be time consuming and emotionally draining for parents. Because parents have less time to participate in social gatherings, they may experience more stress. It is important for parents to have good social supports and community resources. Social supports are resources in the community (friends, groups, organizations, services) that can provide help to another person when they are stressed or in need of assistance.

Some examples of emotional experiences, why a parent may be feeling this way, and how a visitation monitor can respond are listed in the table below. Parents caring for a child with a developmental disability do not exclusively experience the emotional responses listed, so it is imperative for monitors to assess each parent and child relationship individually.

Table 8.3
Emotions Associated with Parenting a Child with a Developmental Disability

Emotion	Why a parent may be feeling this way	How to respond
Disappointment	The parent is disappointed that his/her child is not living a life without a developmental disability.	Ask the parent about times when he/she witnessed his/her child happy. Remind the parent that the focus needs to stay on the present and how to make life better for the child.
Sadness	A parent is sad because the child may have to experience different challenges in life than children without a developmental disability.	Allow the parent to talk if they express that need. Explain to the parent that it is okay to feel sad, but also go over goals for the parent and child to work on together. Also discuss known strengths of the child with the parent.
Fear	The parent could be afraid that the child will not experience the same things as a child without a developmental disability. For example: fewer socialization experiences, classroom concerns, and independence.	List all of the experiences the child will and could experience more with help from the parent.
Guilt	Some parents feel guilty, believing that they could have done something different to prevent the developmental disability.	Remind the parents of their strengths and encourage them to focus on the here and now with their child.

Impact of Parents' Developmental Disabilities

Developmental disabilities can affect a parent's ability to recognize or engage in appropriate family interaction. Particularly when parents have a developmental disability, children can be affected, so monitors in visitation may need to work with families in order to create a positive environment to build the parent-child relationship. Children face unique challenges and situations when coping with their parents' developmental disability.

Impact of Parental Developmental Disabilities on Children

Depending upon their age, a child may not understand why the parent has certain functioning limitations. A child whose parent has a developmental disorder may discuss experiences that are different than most. The following list provides examples of experiences from children of parents with developmental disability:

- Cooking dinner for everyone in the family
- Reading to the parent
- Communicating with other people for the parent
- Taking on a part-time job to help financially
- Feeling judged by others

In addition, a child of a parent with a developmental disability may experience different emotional reactions in certain situations. The table below offers examples of how a child may feel when his/her parent has a developmental disability, why the child could be feeling that way, and how to respond.

Table 8.4
Emotions of Children Coping with Parental Disabilities

Emotion	Why a child may be feeling this way	How to respond
Embarrassment	The child may be embarrassed that the parent acts a certain way due to their developmental disability.	The monitor should remind the child that visitation is a safe place and there is no judgment.
Sadness	The child may be sad that the parent is not able to participate in certain activities.	Validate the child's feeling of sadness. "That sounds hard." Ask the child what he/she enjoys doing with his/her parent.

Anger	The child may be angry that the parent is unable to fully take care of themselves, so the child has to act as a parent.	Validate the feelings of anger. "That sounds like a lot of responsibility. What is that like for you?" Tell the child that during visitation the focus is on the relationship with his/her parent. Remind the child that they will not have to act as a parent here if they do not want to.

Children with Disabilities

Children with disabilities are disproportionately represented in the social services and child welfare community. Children who are abused or neglected are at a higher risk for developing a variety of special needs. Child maltreatment may result in the development of a disability, which in turn can lead to further abuse.

Children are also abused and neglected due to a disability because family members do not understand the disability and the special services and treatment these children require. Sometimes children with disabilities are abused because of the additional stress (e.g., financial, emotional) caring for a disabled child puts on a family. Studies have shown that children with disabilities suffer abuse and neglect 1.7 to 3.4 times more than other children. In 2003, 59,000 children with disabilities experienced abuse or neglect nationally.

Bearing in mind the high likelihood that they will encounter family members who fall into this category, monitors and families need to:

- Understand what having a disability means to each person.
- Know the different types of childhood disabilities.
- Be aware of the barriers to helping this group of children.
- Educate themselves on the services and resources available.

Why are children with disabilities more likely to be abused?

Having a child with a disability can create added stress for the caretaker(s), especially if they are not well educated in positive parenting strategies. This stress creates a strain on the parenting skills of the caretaker(s). A lack of skill in parenting reinforces the child's negative behaviors and thus creates a cycle that adds stress for the caretaker(s). There are many barriers that stop children with disabilities from receiving the correct services and treatment. Less than 9% of child protection workers are knowledgeable around the issue of child maltreatment of children with disabilities.

Below is a list of barriers to be aware of:

- Family members not realizing their child has a disability.
- Child welfare workers not having training on disabilities; therefore, not recognizing them.
- Not knowing the services and resources available to help these children and families.
- Not knowing what disabilities make children eligible for government services.
- Communication challenges with the child and behaviors associated with the disability.

Note

"Parents may respond to the stress of caring for a disabled child with neglect rather than active violence, however when this neglect involves denial of food, medicine, and other life sustaining services, it must be considered a form of violence" (UNICEF, 2005).

What can programs do?

- Promote public awareness through public service announcements, posters, brochures and other mediums that promote healthy parenting and child safety and provide instructions for reporting abuse.
- Educate parents regarding positive parenting skills and how to reduce abusive and neglectful behaviors in the home.
- Facilitate parent support groups that allow parents to work together to strengthen their families.

- Provide or locate short-term care for children of parents in crisis situations.

Monitors must be aware of the types of services and resources these children are eligible for, and how to help these families with the added responsibilities. Monitors need to understand what a disability is, the types of disabilities children can have, the barriers to services and resources, and the services and resources available to children and families affected by a disability.

Experiences of Children with Disabilities

Developmental disabilities among children have recently become a more prominent issue. There is more awareness of the need for knowledge of children's development and services available to assess a family's situation when faced with a developmental disability concern. Children with a developmental disability may experience a different childhood than the average child. Research shows children with disabilities are more likely to be discriminated against and have exposure to violence than children without developmental disabilities. A child with a developmental disability can be affected socially, academically, and behaviorally.

Socially

While not every child with a developmental disability will experience fewer social interactions or connections, it is more likely for children with developmental disabilities to have fewer friends, experience bullying, and not engage in social activities. Parents of a child with a developmental disability may desire for their child to have more social interactions. The use of social supports is crucial for both parents and child when a developmental disability is present. Social supports allow for the parents to understand they are not alone as well as their child is not alone.

Academically

Certain developmental disabilities may call for more focus on academics. Learning disabilities usually require more academic attention than other developmental disabilities. In academic settings there are a variety of resources available for children with disabilities. For example, there are separate classes within schools with teachers who are specialized in teaching children with disabilities. Another alternative for children with developmental disabilities in the school system is to utilize an

Individualized Education Plan (IEP). An IEP is a written statement of educational need for an individual. This education plan gives the teachers, parents, child, and any other outside support an opportunity to express thoughts on possible improvements to a child's educational needs.

Behaviorally

With each type of developmental disability there are a variety of behaviors that align with the diagnosis. Behaviors observed from a child are also affected by the child's age. There can be a difference in behavior between a 5-year-old with a learning disorder and a 15-year-old with a learning disorder. Children can be sensitive to their developmental disorder, which is why explaining the effects of a developmental disorder to the child is imperative. Supervised visitation monitors should have an understanding of the limitations a child's developmental disability may have on visitation. Having an understanding of developmental disorders will increase communication between the monitor and the child, as well as the monitor and the parent.

Sibling Relationships

In supervised visitation, monitors may be faced with sibling relationships where one child has a developmental disability. These relationships have special considerations to account for when coping with a disability. Research indicates that age is an important factor when discussing the effects of a sibling relationship when a developmental disability is present. Possible experiences of a child whose sibling has a developmental disability include:

- Feeling that they have less family interaction than their friends
- Leaning more on peer relationships for support
- Feeling responsible for more chores around the home
- Wanting to assist in the caregiving of the sibling
- Feeling isolated from the rest of the family

Monitors can gain an understanding of sibling relationships during intake. Visitation is a time for all family members to focus on the parent-child relationship. Allowing for open and honest conversation during intake with a child whose sibling has a developmental disability gives time for monitors to understand what the child wants from their visit with the parent and can make the sibling feel included.

Monitoring Families Coping with a Developmental Disability

When working with parents who have a developmental disability, supervised visitation monitors encounter difficult situations. Understanding the effects of developmental disorders on parenting and some behaviors associated with each developmental disorder will assist the monitors in handling challenges that may arise. Monitors working with parents who have a developmental disorder can react to situations appropriately through education, facilitating fitting activities, and locating outside additional resources. Listed below are challenges that may arise:

- Inability to follow program rules
- Need to emphasize appropriate interactions during visits
- Need for assistance from the monitor during visits
- Exhaustion of program resources
- A parent's ability to use appropriate discipline with the child

Strategies for Working with Families and Developmental Disabilities

Supervised visitation personnel should be aware of unique issues when working with parents with developmental disabilities. The following are additional strategies that supervised visitation personnel can utilize when assisting parents with developmental disabilities and specific struggles they may encounter.

- Be very clear and direct when talking to parents.
- Avoid jargon or idioms, such as "a stitch in time saves nine" or "reap the benefits of." Use simple, plain language and avoid phrases that people may not understand.
- Personnel may need to repeat information.
- Assist parents by providing them with referrals to other agencies.
- Assist parents in accessing resources from additional agencies in the community.

- Spend extra time with parents by slowly and carefully going over the policies and procedures associated with your supervised visitation center.
- Encourage parents to ask questions if they become confused or if they are having trouble understanding what is going on.
- Personnel should ask if clarification is needed because parents may be afraid of asking.
- Validate parents' concerns or feelings and encourage them to express themselves.
- Be sensitive about parents' disabilities and do not patronize, belittle, or call them names.
- Do not assume disabilities are the cause of parenting issues. Assess environmental and social factors as well, such as poverty, mental health, and domestic abuse.

DID YOU KNOW?

Many adults in the U.S. have low literacy skills. Many speak English as a second language. Staff may not know that families have trouble reading, so it may be best to read the program rules out loud to avoid embarrassment on everybody's part.

Working with Children

Understanding behaviors associated with developmental disabilities will provide monitors with insight on a child's behavior. Monitors must be aware of challenges that may arise during a visit in addition to knowing about a child's developmental disability before visitation. Some challenges that may arise during a visit include:

- Child does not listen to instructions
- Child is upset when he or she is not able to play with certain toys
- Child throws objects at parent or monitor
- Child exhibits hyperactive behavior
- Child is not able to communicate verbally

Preparation for Visit

When facilitating a visit when a parent or child with a developmental disability, a visit monitor must be patient in establishing a positive, trusting relationship. This includes taking the time necessary to establish rapport, convey interest, exhibit consistency, and show respect. To enhance the opportunities for a parent or child with a developmental disability to have a positive visit, the visit monitor should

make sure that the expectations for the visit are realistic, reasonable, and fair. In a supervised visitation setting, preparation can include:

- Investigating reliable transportation resources to ensure that the parent can arrive to visits as scheduled
- Ensuring that the parent understands the importance of following program rules
- Breaking down long intake procedures into a smaller sequence of steps
- Reviewing program forms to ensure that they may be understood at the reading level of the parent (or having the visit monitor read and explain forms to parents)
- Avoiding reliance on children to communicate information to the parent
- Focusing on one task at a time
- Modeling and demonstrating appropriate 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 the parent and/or child will need increased attention from visit monitors during scheduled visits
- Being sensitive to signs of fatigue, inattention or disinterest

Activities for Visits

When an individual has a developmental disability, he or she may not be able to participate in certain activities. During visitation, monitors have the opportunity to facilitate activities that are achievable by both parties. Supervised visitation monitors should have ideas of what a parent and child can actively do together. Listed below are several examples of activities that could be facilitated by the visitation monitor to a parent and child when a developmental disability is present:

- **Clapping to Music**
- **Scavenger hunt**
- **Marching to Music**
- **Parachute Play**
- **Kite Flying**
- **Arts and Crafts**
- **Computer Games**
- **Cloud Watching**

Part 2

Chronic Illness

A chronic illness or medical condition is a health-related problem that lasts for three months or more. It affects a person's normal activities and requires regular hospitalizations, at home health care, and/or extensive medical care. There is an extensive list of different types of chronic illnesses. In this section, the focus will be on the impact chronic illness on supervised visitation for parents, children, and supervised visitation providers. This section will also provide monitors with resources and possible strategies for how to react when a child or parent is living with a chronic illness.

STOP and Think

Do you know of anyone with a chronic illness?

This section will provide information on several examples of chronic illnesses and symptoms of each illness. It is reported that 50% of the entire world's population has a chronic illness, which means it is likely that a supervised visitation monitor will encounter a parent or child with a chronic illness. Listed in the table below are examples of common parental chronic illnesses, an explanation of the illness, and symptoms for each.

Table 8.5
Types of Parental Chronic Illness

Chronic Illness	Explanation	Possible symptoms
Alzheimer Disease	A progressive disease that effects an individual's memory and other brain functions.	• Not remembering past events • Not able to recall people's names • Repeating questions constantly
Arthritis	When an individual's joints become inflamed in one or more areas.	• Experiencing pain in joints • Not able to move as easily as before • Joints feel stiff

Asthma	When an individual's airways are narrowed and swell.	• Experience a shortness of breath • Pain in chest • Wheezing attacks
Cancer	Cancer is a term that encompasses a greater number of diseases. Cancer is when abnormal cells have the ability to destroy body tissue at a high rate.	• Tiredness • Change in weight • Unexplainable muscle pain • A lump that can be felt under skin
Crohn's Disease	When an individual experiences the inflammation of lining of the digestive system.	• Diarrhea • Fatigue • Stomach pain • Weight loss
Diabetes	Diabetes is a collection of diseases that is defined by how an individual's body is affected by blood sugar.	• Weight loss • Tiredness • Increased urination • Always feeling thirsty
Heart Disease	Heart disease is a group of conditions that affect an individual's heart. Another term that is used with heart disease is cardiovascular disease.	• Pain in chest • Shortness of breath • Pain in legs, arms, or other areas of body • Dizziness
HIV/AIDS	HIV/AIDS is a condition when an individual's immune system is unable to fight viruses that can cause diseases.	• Fever • Muscle pain • Swelling
Multiple Sclerosis (MS)	MS is a disease that can damage the spinal cord and brain (central nervous system).	• Experiences weakness in limbs • Loss of vision • Slurred speech • Pain in parts of body
Parkinson's Disease	This is a progressive disease that affects an individual's nervous system.	• Tremors in hands • Slowness

DID YOU KNOW?

- As many as 1 in 4 children in the U.S. have a chronic health problem.
- In the U.S. alone, over 13,000 children are diagnosed with cancer each year.
- Type 1 Diabetes is one of the most common severe chronic childhood illnesses, affecting 1 in every 400 individuals under the age of 20.
- Cancer is the 2nd leading cause of death in the United States.

For children, chronic illness is an umbrella term for conditions that will always exist for the child. Children may be well or ill at any given time but will always live with their condition. Below is a list of chronic illnesses that children may be diagnosed.

Table 8.6
Types of Child Chronic Illness

Chronic Illness	Explanation	Possible Symptoms
Asthma	When an individual's airways are narrowed and swell.	• Experience a shortness of breath • Pain in chest • Wheezing attacks
Cancer	Cancer is a term that encompasses a greater number of diseases. Cancer is when abnormal cells have the ability to destroy body tissue at a high rate.	• Tiredness • Change in weight • Unexplainable muscle pain • A lump that can be felt under skin
Cerebral Palsy	A disorder that affects muscle tone, movement, and motor skills. Children usually lack the ability to move in a coordinated and purposeful way.	• Delay in in normal developmental milestones • Muscle tone that is too tight or too loose • Poorly coordinated movements • Presence of infant reflexes beyond infancy

Diabetes	Diabetes is a collection of diseases that is defined by how an individual's body is affected by blood sugar.	• Weight loss • Tiredness • Increased urination • Always feeling thirsty
Sickle Cell Anemia	People with sickle cell disease have red blood cells that are shaped like sickles or crescent moons. This condition can be painful, lead to serious infections, chronic anemia, and damage to body organs.	• Some degree of anemia • Painful swelling of hands and feet • Numerous infections • Chest syndrome, difficulty breathing, chest pain, coughing, fever • Painful crises in any part of body
HIV/AIDS	HIV/AIDS is a condition when an individual's immune system is unable to fight viruses that can cause diseases.	• Fever • Muscle pain • Swelling
Cystic Fibrosis	A genetic disorder that affects the lungs and digestive system. Disruption in normal functioning of epithelial cells, which line the passageways of the lungs, liver, pancreas, and digestive/reproductive systems.	• Lack of weight gain after birth • Failure to thrive on normal diet and good appetite • Skin may appear salty and lose large amounts of salt when sweating • Ability to breathe often decreases
Epilepsy	A disease of the central nervous system in which electrical signals of the brain may misfire. These miscommunications lead to seizures.	• Seizures • Staring spells • Confusion spells • Shaking spells • Unexplained deterioration in behavior or school performance

Spina Bifida	Birth defect that happens when a baby's backbone does not form normally. The spinal cord and nerves branch out and may be damaged.	• Detected during prenatal care • Abnormal tuft of hair • Collection of fat • Small dimple or birthmark • Often asymptomatic
Congenital Heart Problems	Heart conditions that are present at birth and are often treated with surgery or medication.	• Heart murmur • Breathing difficulties from lung congestion • Inability to gain weight adequately

Impact of Chronic Illness on Parents

When working with chronic illnesses, it should be considered that some parents will have a chronic illness and some parents will have children with a chronic illness. Each situation holds new and unique implications for visitation and monitors should be well-prepared to work with parents in either capacity.

Parenting with a Chronic Illness

An individual faces difficult challenges when diagnosed with a chronic illness. A parent with a chronic illness may encounter unique challenges when attempting to balance the responsibilities of being a parent as well as coping with the diagnosed illness. A parent diagnosed with a chronic illness can see effects in family stability, financial strain, and the emotional state of anyone involved. In this section, supervised visitation monitors will be able to understand the impact chronic illness may have on parenting. It is also important to remember that not all parents with a chronic illness will face these challenges. Every family is different and parents may not see as many challenges when they have support from family, friends, and the community.

Family Stability

When a parent is diagnosed with a chronic illness, the entire family is affected. Research shows that in marriages where one partner has a chronic illness, the divorce rate is 75% or more. Chronic illnesses cause most individuals to become tired easily, and those who

STOP and Think

- **What might Ms. Johnson be feeling about her condition of MS?**
- **How can Ms. Johnson's illness be impacting her relationship with her children?**

live with these illnesses spend a lot time in pain. This level of constant fatigue can cause instability in a household. Below are examples of what a parent with a chronic illness could be experiencing:

- Fatigue causing difficulty in certain tasks, such as making dinner for the children
- Inability to clean the house due to pain
- Needing significant help from friends and family
- Inability to participate in family activities such as playing outside with kids and attending school/sporting events

Financial Strain

Individuals with a chronic illness may likely seek constant medical attention, including doctor's visits and medications. With the added responsibility of providing for children, treatment of a chronic illness can be financially stressful. Financial stresses may include:

- Insurance not covering all of the treatment necessary for a particular illness
- Difficulty in keeping employment
- Needing to delay medical care to handle family expenses first

Emotional Impact

Chronic illnesses can place an overwhelming emotional burden on parents. Parents are responsible for their children, finances, family necessities (food, shelter, education), and the added stress of a chronic illness can magnify this many times over. Studies have revealed that many individuals with chronic illnesses become depressed; up to 1/3 of people with a chronic illness display symptoms of major depression.

Depression may even cause the symptoms of a chronic illness to worsen. The emotional impact can include:

- Not wanting to get out of bed almost everyday
- Not enjoying activities as one did in the past
- Isolation, including from children
- Negative attitude about most things

Parenting a Child with a Chronic Illness

With the rate of chronic illness among children at about 25%, it is likely that supervised visitation monitors will come across a child in visitation that is affected by a chronic illness. When a child has a chronic illness, the parents can be affected in multiple ways. The parent of a child with a chronic illness can experience stress, negative feelings towards the illness, and relationship differences. This section will discuss how supervised visitation monitors may understand the impact chronic illnesses can have on parents when the child is diagnosed with a chronic illness.

Parental Stress

When a child has a chronic illness, the parent may have increased responsibilities. Some children with a chronic illness must attend regular doctor's visits and may not be at a developmental stage in which they can take care of themselves. Parenting in itself is often tiring, and with the added worries of a child's special health needs, a parent can become significantly more stressed. Parents may experience the following:

- Needing to prepare unique meals for children
- Monitoring children to ensure medication is being taken properly
- Attending multiple doctor visits
- Monitoring children's general health and well-being

Emotional Impact

Studies show that parents of children with chronic illnesses commonly experience anger, guilt, fear, and sadness, though every parent may react differently when their child is diagnosed with a chronic illness. Listed below are possible emotional responses a parent may be challenged with when his or her child has been diagnosed with a chronic illness:

- Guilt
- Sadness
- Anger
- Fear of fatal condition

Relationships

Parents' relationships are affected when a child is diagnosed with a chronic illness because the time can be easily consumed with the child's needs. When one child of a family has a chronic illness, it is common for the parents to focus more of their attention on that specific child's needs than those of their other children, to socialize less, or to forget to engage in self-care.

Impact of Chronic Illness on Children

In visitation, monitors may encounter children with chronic illnesses or children with parents coping with chronic illnesses. Each situation presents unique challenges in visitation and monitors should be aware of the different dynamics that may exist.

Impact of Parental Chronic Illness on Children

When a child has a parent who has a chronic illness, they are commonly faced with different and difficult experiences. Every situation is different and should be approached differently, but there is research on the common impacts for children who have a parent with a chronic illness. This research shows children with a parent diagnosed with a chronic illness have fewer social interactions and greater negative emotional experiences.

Impact on Relationships

Children coping with a parent's chronic illness may have increased responsibilities at home. With many chronic illnesses the symptoms can include fatigue and aching. Parents may have to lean on children for support and rely on them for help around the house. If a child has added responsibilities around the home, there could be less time for social interactions and building relationships. Some examples of what a child may have to experience when a parent has a chronic illness include:

- Helping to prepare meals
- Looking after younger siblings
- Cleaning in the home
- Taking the bus to school
- Working a part-time job
- Missing school events

Emotional Impact

The age of the child must be considered when trying to understand the emotional impact of having a chronically ill parent. A six-year-old might be impacted

differently than a sixteen-year-old. Research shows that children with a chronically ill parent are more likely to experience lower life satisfaction than children who do not have chronically ill parents. Examples of what a child might be feeling include:

- Constant fear of a rapid decline in parent's health
- Anxiety about balancing family life and school life
- Anger towards the parent who has an illness
- Sadness for the parent
- Guilt when not taking care of parent
- Misunderstanding of parent's condition

Children with a Chronic Illness

Every child reacts differently to being diagnosed with a chronic illness. Children living with a chronic illness may not fully understand what their illness means and this understanding may depend on the age of the child. A diagnosed chronic illness may also impact a child's independence and social life. In this section, supervised visitation monitors will understand the impact a chronic illness can have on a diagnosed chronically ill child.

Helping Children Cope with a Diagnosis

For younger children up to 10 years old, understanding the complexity of an illness and how it is managed can be difficult. This can make it hard on parents to explain an illness and help children cope with how it may affect them. Below are common reactions to chronic illnesses by age group, and potential strategies for helping children navigate these experiences as they arise:

Table 8.7
Children's Reactions to Diagnoses

Age Group	Reaction	Response
Infant / Toddler 0 to 3 years	Infants and toddlers generally have very little understanding of their illness. They understand being in pain, not having a full range of motion, and may view separation from their parents for procedures or treatment as threatening the sense of security they are developing at this stage. They may cry, fuss or scream, as they are not at a stage where they can convey their emotional state in any other way.	Encourage parents to be present for any procedures which may be painful for the child, and stay with them (where possible) during other procedures or hospitalizations. They should hold, soothe, and interact with these very young children as much as possible to promote their sense of safety and security.
Preschool Age 3 to 5 years	Preschool age children may understand what it means for them to get sick, but they do not yet understand the nature of their chronic illness. Many believe that their symptoms (i.e. wheezing during an asthma attack) are what causes their illness rather than the other way around (the asthma attack is causing the wheezing). Because they are just beginning to form a sense of independence, this age group may try to gain control of their illness in ineffective ways (such as saying "If I don't wheeze I'll stop having an asthma attack"). Others will try to gain control by challenging parents about treatment; they may fight, cry, or outright refuse to take medication or undergo treatment procedures.	Direct parents to be firm with children about what they cannot give them choices about, but allow them to make choices where possible to help foster the sense of independence their children are learning. For example, parents should not ask "would you like to take your medication now?" This is not optional, as the medication is likely essential to a child's health care plan. Instead, encourage them to ask "which medication would you like to take first today?" or "Would you like me to come with you while you have your blood drawn today? Do you want to sit in my lap or do you want me to sit next to you?"

Early School Age **5 to 9 years**	Children in this age group are developing a better understanding of their chronic illness, and noticing how different they are from their classmates and friends. They often try to describe the reason they are ill in ways that are not logical (often referred to as "magical thinking'). For example, the child may believe that they caused their illness by behaving badly (hitting a sibling or telling a lie) or not listening to their parents (not eating their vegetables when asked or refusing to obey the rules).	Instruct parents to reassure their children that the illness is not their fault, and that there is no way that they could have caused it by doing or not doing a particular activity. Encourage them to involve children in managing their illness to help them better understand it (with close supervision by a responsible adult).
Older School Age **9 to 13 years**	These children better understand their illness and how it is treated, although they still do not respond the way adults do. They feel left out when they miss school or cannot participate in activities with their peers (such as sports or other extracurricular activities). Children with parents who restrict activities out of concern may begin acting out or making statements such as "I guess I'm not good enough to play soccer" or "I hate going to the doctor, I'd rather hang out with my friends and be normal."	Monitors should encourage parents to speak to their child's doctor about what activities may be safe for their child's level of ability, and what precautions to take to ensure safe participation. Reassure parents that protectiveness is normal, but gently redirect the parents to be less restrictive of activities with peers and allow their child to cautiously explore new things.
Adolescents **13 to 17 years**	At this stage, children are developing their own identity and becoming concerned with self-image. When a chronic illness or its treatment have a negative effect on their appearance (i.e. skin reactions, weight fluctuations, hair loss, etc.), many teens will go through stages where they neglect their	Parents who have thus far been very involved in treatment and care may find it difficult to fulfill this same role with a teenager. Monitors should instruct the parent to encourage their child to maintain their treatment regimen, and to speak to

	treatment or refuse to take medication. If the illness or treatment does have an effect on their appearance or behavior, they may fear bullying or worry about being unpopular with others, or experience being isolated by their peers for being different. They may also stop checking blood sugar regularly if they need to or follow a physician-recommended diet in order to appear more like their peers and fall more in line with what is popular or trendy or participate in social activities where doing so would attract attention.	their child's doctor about how medication may be differently affecting them during the normal changes which occur during adolescence to help with physical side-effects. Parents can also work their child's illness or its treatment into the discussions about independence, puberty, sexuality, alcohol, etc. which parents normally have with their teens in order to normalize them.

In addition to these helpful responses, it is important for monitors to encourage parents to help their child lead as normal a life as possible. Discuss how they can give their child responsibilities in the home which are manageable with their level of ability, maintain family routines (such as regular bed and meal times or family outings) as much as possible, and remind them not to be afraid to appropriately discipline the child to encourage positive behavior. Be prepared to offer guidance or resources and act as a sounding board for parents as they attempt this very difficult balancing act.

Independence

A child may become limited in his or her independence when coping with a chronic illness. A child's capability for independence differs from illness to illness and child to child. Independence also generally increases with age. Each child is different and it is imperative for children to know why they might not be able to do certain activities on their own. It is likely that children will begin to learn how to self-manage their illness as a teenager. Examples of differing levels of independence for a chronically ill child include:

- Parents needing to give insulin injections and test blood sugar levels for a younger child with diabetes
- Teenagers knowing to bring an inhaler when they play sports

- Parents needing to manage a younger child's food restrictions
- A 14-year-old learning how to take his or her own insulin injection
- A 16-year-old taking his/her morning medication without being reminded by a parent

Social Life

A child diagnosed with a chronic illness may not be able to participate in all social activities. As a child, not being able to join in certain activities can be frustrating and disappointing. Coping with a chronic illness as a child can also cause children to be emotionally distressed. Children diagnosed with a chronic illness tend to be less socially outgoing than children without a chronic illness. Children may be affected in the following ways:

- A child diagnosed with cancer may have to miss a semester of school for intense treatment
- A child may feel isolated because they do not know anyone with a similar illness
- A child may not be able to participate in a sports team due to a diagnosed illness
- A child may miss school dances, pep rallies, graduation, or other important events

Monitoring Families Coping with Chronic Illness

This chapter has made it clear that families coping with chronic illnesses face many challenges. These challenges may often spill over into the visitation process and monitors should be prepared to help families to the best of their ability. Monitors can help children build confidence and independence or help parents understand their child's illness and strengthen the parent-child relationship. Familiarity with illnesses will play an important role in a monitor's ability to work with families and provide support and referrals. In many cases, it is likely that the monitor can guide families in a positive interaction with regard to the present illness.

Guidelines to Interacting with Individuals Coping with a Chronic Illness

- **Avoid drawing attention to the individual's appearance.** In some cases, a chronic illness may not play a role in how a person appears. It is best to avoid making comments that would diminish the presence of the illness or the validity of the person. Monitors should never tell someone that he or she "looks great" or "doesn't look sick."
- **Acknowledge the person behind the illness.** Like best practices suggest, it is important for monitors to place the person first and the label after. While chronic illnesses may play a major role in a person's life, that person is not their illness alone. Engage in conversation that is not related to the illness. Make clients feel special and recognize them for something other than his or her illness.
- **Avoid implying that you understand his or her experience.** While it is important to be empathetic, it is also important to remember that there is no way that you can understand a person's suffering or pain if you do not have his or her same illness and experience. Relating to the person is not as important as validating his or her own experiences.
- **Offer specific help.** For many people, it can be difficult to ask for help and to even accept such help. It is much more valuable for others to offer sincere help and to ensure that the person knows that they are not a burden in any way.

Note

Rather than saying "I'm always tired too," try using other phrases such as, "this must be so hard for you," or "I can't imagine what you're going through."

Strategies for Facilitating Visits Involving Chronic Illness

There are many appropriate strategies for a visit monitor to consider when facilitating visits involving a parent or child with a chronic illness. Monitors should use the following strategies to help in working with clients to ensure a comfortable and safe environment for all involved.

- **Understand the progression of the individual's particular illness.** With a large number of illnesses and their ability to progress differently for every person, it is important for monitors to be aware of the role the illness is playing in the individual's life at the moment in time of visitation. Some illnesses may take a long time to cause problems for someone, or the illness can be at a stage that makes visitation very difficult. Consider the following: 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)?

TRAINING

Visit the Clearinghouse website to gain access to a full PowerPoint training on Universal Precautions.

http://familyvio.csw.fsu.edu/wp-content/uploads/2010/05/PP-Standard-Precautions_Final2.pdf

- **Employ universal precautions if the illness presents any risk of transmission to others in the program.** While programs employ universal precautions regularly, it is important to be especially cautious when specific precautions should be made. The best practice is to treat all fluids as if they could have an infectious disease. Refer to the Clearinghouse for a training module on universal precautions.

- **Seek appropriate training and education on common chronic illness and avoid misinformation.** This chapter will serve as a base-level source of knowledge for working with individuals diagnosed with a chronic illness. Although general knowledge is helpful, it is important for monitors to learn as much as they can

about an individual's case and to seek training if necessary. When learning about an illness, monitors will be able to determine if they should be on the lookout for anything specific or if they may need to make any extra accommodations.

- **Be sensitive to the needs of the individual.** Some illnesses may cause someone to tire easily or to be unable to focus or participate fully in visitation. Monitors should be aware of this and be sensitive to the individual's situation. If a parent cannot play, it may not be an attachment issue but rather an effect of his or her illness. If a child faints, it may not be related to heat or food but a symptom of their illness.
- **Make adequate accommodations.** In addition to working in compliance with the ADA requirements, providing a facility and visit that is accommodating will make someone feel comfortable and at ease during the visitation process. Accommodations can include accessibility ramps or providing sign language interpreters for the hearing impaired.

Sensitive Language

"Your mother is sick, and the doctor is doing what she can to make her better."

This statement may help a child cope with the emotions of seeing a sick parent.

- **Respond appropriately to parent or child's reaction to health status.** Whether the parent or the child is ill, either party can have a difficult time coping with the diagnosis or symptoms. One party may notice bruises or marks from radiation treatment or the constant fatigue that may come with many chronic illnesses. Seeing these symptoms may spark intense feelings and reactions from the other party and it is important for monitors to offer reassurance and comfort.
- **Refer clients to resources or support groups.** As with any client, monitors must seek to fill gaps in services and referring a struggling parent/caregiver or child to a support group can help them build community and social supports as well as coping skills.

Children with Medical Complexities

Some children with chronic medical conditions may be referred to as medically complex. These children require the highest level of services and support from healthcare providers. With the number of medically complex children in the United States expected to reach 5 million in the next decade, it is important for monitors and supervised visitation providers to understand the specific needs of this particular population.

REMINDER:

The presence of medical foster parents may cause conflict between staff, foster parent, and visiting parent. In order to avoid conflict, monitors should discuss all medical conditions and the role of the medical foster parent in visitation with all parties before the first visit. Monitors should also provide support and encouragement to visiting parents to learn from the medical foster parent in order to care for their children.

In many cases, medically complex children participating in supervised visitation will have a medical foster parent. Medical foster care placement is available for children (who qualify for Medicaid) to receive specialized medical and therapeutic care to overcome the physical harm and emotional damage they have suffered. In Florida, Children's Medical Services recruits medical foster care parents and provides training for them to care for the medically necessary needs of these children. In supervised visitation, medical foster parents provide an essential role in teaching visiting parents how to care for their children who have medically complex needs. It is important for monitors and visiting parents to understand the importance of using medical foster parents in supervised visitation. While these situations may be uncomfortable for the visiting parent, it is essential for the medical foster parent to be present for the best interest of the child.

Common Chronic Illnesses

It is vital for supervised visitation monitors to understand appropriate ways to communicate with clients who have a chronic illness. Understanding possible symptoms associated with common chronic illnesses will provide the monitor insight on different emotional reactions from the individual. Monitors need to be aware of challenges that may arise during a visit, and this includes knowing about common illnesses beforehand.

Asthma

Monitors have a number of responsibilities to prevent asthma attacks during visits.

- Ensure that rooms used for visitation are not cleaned with strong chemicals, including ammonia, bleach or fragrant cleaning products.
- Areas used for visits should be checked to ensure healthy air quality - free from dust, mold, smoke, and other allergens.
- If allowed outside during a visit, monitors should take note of the weather and watch for signs of wheezing and coughing. Avoid going outside when the weather has recently changed, if humidity is high or if it is cold out.
- Playing during visitation is permissible; however, be mindful that exercise is not too strenuous to avoid an attack.
- If the client is particularly prone to attacks, the monitor should connect the child/parent to resources for healthcare and any medications that may be needed.

Diabetes

Visit monitors should always make sure that the client is carrying his or her care kit at all times. This bag holds important medicines and care tools that can be used in preventing further complications from hypoglycemia and diabetic shock if the individual begins to experience problematic symptoms. Included in the kit may be a glucagon injection kit, which must be prescribed by doctor and can be very helpful in an emergency situation. Glucagon is a natural hormone that increases blood sugar, and can be injected if a person becomes unconscious from hypoglycemia. If the client does not have an injection kit, it may be a good idea to talk to him or her (or a parent) and explain the necessity of having it, along with informing them of any resources available if they cannot afford it.

For parents, who are just learning about a diagnosis, the adjustment period can be between 9 and 12 months. Diabetes control and general family functioning are difficult during this period and require support from the medical team. This is important for visit monitors to be aware of when supervised visitation takes place.

Good questions to keep in mind are:

- How long ago was the diagnosis made?
- Is there any connection between the client's illness and the reason for the supervised visitation?
- How does the parent/child respond and/or comment on the child/parent's diabetes?

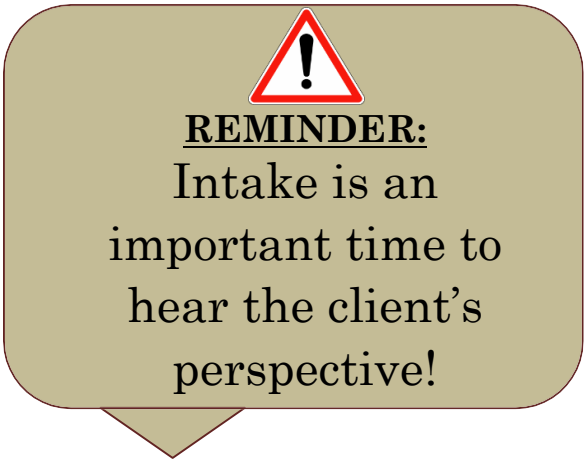
Tips for Visitation

- Be sure to ask about medical conditions of all family members who participate in visitation. Knowledge is the best tool for responding to health problems at visits.
- If a parent or child has diabetes, be sure that he or she has a care kit, or medicine kit, on hand during visits.
- Have some snacks at the center that are set aside for anyone who may have diabetes. Make sure that they are the appropriate type of snacks for children and that the child's parent(s) knows.

- Be empathetic. Diabetes is a medical condition, and those who have it didn't ask for it. Don't be annoyed or tense when someone tells you he or she has the condition as well as his or her limitations.
- Encourage games or activities that keep the child active when they are feeling well.
- Monitors should stay informed about any medical conditions the individual has, both chronic and temporary. If the child has an infection or other sickness, take extra precautions.
- Any allergies should be well documented, in order to avoid exposure during visitation.
- Learn to recognize signs of problems.
- Call emergency services 911 if someone loses consciousness or faints.

Preparation for Visit

Supervised visitation monitors are responsible for providing and preparing a safe place for parents and children to spend time together. The preparation of each visit and it is the responsibility of the monitor to know potential risks and problems that could arise during a visit. During intake, monitors will have the opportunity to learn about each visiting family and when a family is affected by a chronic illness, the monitor is responsible for using effective communication to better understand the situation. A chronic illness may significantly affect an individual's ability to be fully present during a visit. To guarantee positive and realistic visits, visitation monitors should understand the importance of speaking with parents and children about the expectations of the visit. When preparing for a visit, monitors should engage in the following practices:



- Investigate reliable transportation resources to ensure that the parent can get to the program as scheduled
- Ensure that the parent's expectations are heard and communicated
- Allow time to talk about chronic illness during intake if the parent expresses a desire to talk about it
- Ensure that the visits do not overlap with any scheduled doctor's appointments
- Be flexible; reschedule a visit if needed
- Assist a child or parent with standing up or opening doors if necessary
- Model and demonstrate appropriate interactions with a child

- Use encouraging words and embrace the strengths perspective
- Use empathetic practice
- Allow extended time for the parent to complete the intake process
- Be sensitive to signs of fatigue, inattention, or disinterest
- Prepare a list of community resources for families affected by a chronic illness

Empathetic Practice

Empathy is the ability to understand and recognize another's feelings as your own. Empathy allows professionals to share feelings and understand the perspective of a client. On the other hand, sympathy is a feeling of compassion but lacks the shared feelings or perspective. When working with families affected by either a chronic illness or a developmental disability, it is important for supervised visitation monitors to practice empathy. Both chronic illnesses and developmental disabilities can be sensitive issues to deal with. Utilizing empathetic practice as a supervised visitation monitor allows for individuals affected by a chronic illness or a developmental disability to feel heard and understood. Empathetic practice will also help monitors avoid offending clients in any manner. A few examples of how a monitor can use empathetic practice when working with individuals with a chronic illness or developmental disability are:

- Carefully listening to the stories of each individual
- Imagining your reactions if you were in the same situation
- Focusing on the feelings behind what a client is saying (e.g., scared, sad, lonely, angry, or overwhelmelmed)
- Taking out your own personal beliefs and biases and adopting a third person perspective

STOP and Think

- **How could a visitation monitor use empathetic practice with a visit with Ms. Johnson?**
- **How might Ms. Johnson's children be affected by their mother's developmental disability and MS diagnosis?**

PRACTICE EXAMPLE

Case Scenario

David, age 15, was removed from his home because his mother was identified as neglecting David's needs. David has a developmental disability and his cognitive and motor levels were assessed to be comparable to a child around the age of 5. David and his mother were referred to supervised visitation. David is having a noticeably difficult time being away from his mother and becomes angry during visits. David's mother also seems frustrated by the situation.

Below are discussion questions to assist in the understanding of how monitors should approach David's situation:

1. What could you say to David's mother to help ease her frustration?

2. What kind of activities could you suggest for David and his mother during visitation?

3. How would you prepare for the visit with David and his mother?

4. What challenges could arise with David during the visits?

5. What are possible reasons as to why David would be angry during visits?

1. National Center on Birth Defects and Developmental Disabilities. *http://www.cdc.gov/ncbddd/sitemap.html.* This source is a full A-Z index on topics of all developmental disabilities.

2. Diseases and Conditions.
http://www.mayoclinic.org/diseases-conditions. This source is a comprehensive guide on hundreds of health conditions.

3. Normal Stages of Human Development (Birth to 5 years).
http://childdevelopmentinfo.com/child-development/normaldevelopment/. This source provides an overview to typical behaviors to expect for children aging 0 to 5.

4. Children with Chronic Conditions.
http://www.med.umich.edu/yourchild/topics/chronic.htm. This is a resource to learn more about how chronic illnesses effect children and families.

MATCH THE TERMS & CONCEPTS

This activity allows you to test your knowledge of relevant terms to this chapter. Draw a line to match the words to their correct definitions.

Word 1: Sympathy	The ability to understand and share feelings of another individual
Word 2: Chronic Illness	A developmental disability caused by a brain deformity
Word 3: Diabetes	A group of conditions due to an impairment in mental or physical capabilities.
Word 4: Developmental Disability	A condition that is caused by high levels of blood sugar levels.
Word 5: Empathy	Feeling bad for an individual's situation.
Word 6: Autism Spectrum Disorder	A long-lasting health condition or disease

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Training Manual for Florida's Supervised Visitation Programs

CHAPTER 9

THE IMPACT OF DIVORCE AND SEPARATION ON FAMILIES

Case Scenario

David and Marie divorced four months ago, which resulted in high levels of tension over parenting time for their eight-year-old, Charlie. After an allegation that David had a substance abuse problem, a court referral was made for supervised visitation. David is unhappy with this decision because he believes that he is being unfairly treated for initiating the divorce. Marie is frustrated because of the time and finances it will take to bring Charlie to the Visitation center. They have moved into a small apartment and she is trying to make ends meet with her single salary. Charlie has expressed fear of the supervised visitation center and just wants to go back to living in his old house. He is excited to see his father and misses him, but feels bad about that because he has heard his mother say mean things about him.

The visit monitor hears the following conversation as Charlie walks in with his mother.
Charlie: But why can't we just visit Dad at the house.
Marie: Sweetie, your Dad doesn't want us at his house, that's why he kicked us out, remember?
Charlie: But he told me that he wanted me to come over so we could play catch.
Marie: Well sometimes Dad makes promises he can't keep and you're just going to have to get used to coming here, okay? Maybe you guys can do something different here!

The visit monitor steps in and leads Charlie to the visit room
David: Buddy! I'm so glad to see you!
Charlie: Me too Dad! I wish we could be at our house. I don't want me and mom to live away from you.
David: I know, but things are different now. And meeting at this place is all your Mom's fault. She's messed everything up!

After completion of this chapter, you will be able to answer the following questions:

- What are some problems in this scenario?
- What can you do to help the mother in this situation?
- What are some ways that you can help the father become less frustrated?
- What are some activities that the parent and child can do during the visitation?
- How can you ease the child's anxiety about the supervised visitation center?
- How can you talk to both parents about their conversations with their child?

Introduction

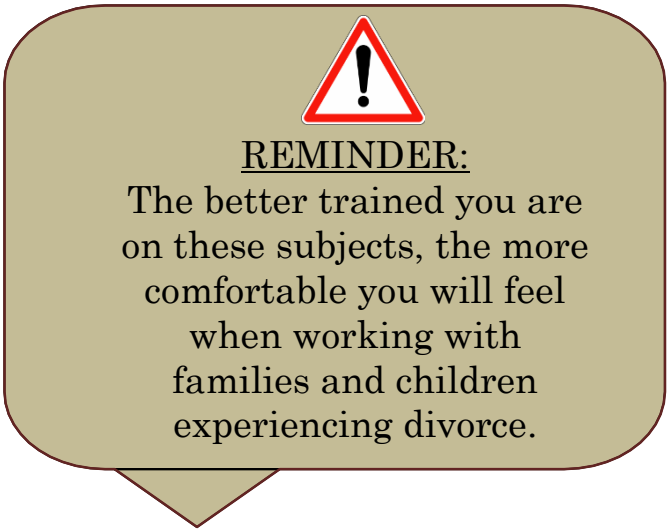
Divorce can be difficult for the whole family. It is important for supervised visitation providers as well as parents to understand the potential impact a divorce can have on each family member. This can allow for supportive measures to be put into place to limit those negative impacts and to provide for continuing healthy growth and development of children throughout and after a divorce.

What will I learn in this chapter?

This chapter provides an overview of the impact of divorce and separation on children and families.

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

- Discuss the prevalence of divorce in the US
- Understand the impact of divorce on children of different ages
- Recognize how and why children view divorce as loss and may experience grief
- Understand how divorce/separation may affect a child's behavior during visits
- Describe co-parenting and assist parents in understanding co-parenting behavior
- Identify co-parenting legal terms
- Understand the basics of Child Support
- Describe Florida's laws relating to divorce and custody and explain how judicial decisions on parental responsibility can impact visitation
- Pinpoint strategies to facilitate visits between parent and child in divorce/separation cases



REMINDER:
The better trained you are on these subjects, the more comfortable you will feel when working with families and children experiencing divorce.

Snapshots

In the United States, first marriages end in divorce between 40% and 50% of the time. According to the 2011 US Census Bureau, around 21% of men and 22% of women have been divorced. In first marriages, the average age of divorce is between 30 and 31.

DID YOU KNOW?

- Of the children in the United States, 35%, or about 25 million children under the age of 18, live in single-parent homes.
- Today, 42% of adults have a step relationship – either a stepparent, a step or half-sibling, or a stepchild. This translates to 95.5 million adults.

Effects on Children

Divorce is a trauma that affects the entire family. It's important for parents to understand how their children may be affected so that they can comfort them and support them. This section explores the different ways divorce may affect children in different age groups, and what supervised visitation workers and parents can do to support children at visits and at home.

Long-Term Effects of Divorce on Children

Studies on the long-term effects of divorce on children years after their parents divorced found that children of divorce showed higher rates of the following:

Physical Effects

- Poor physical health in general
- Higher rates of asthma
- Higher incidence of headaches

REMEMBER:
Parents should understand that they can support their children through this process to lessen the impact of divorce.

Academic Effects

- Poorer performance in school
- Lower rates of academic achievement
- Less likely to graduate high school
- Less likely to go to college
- Less likely to graduate from college

Psychological/Emotional Effects

- Increased anxiety and depression
- Long-term feelings of anger, hostility, and loneliness
- Long-term fear of being abandoned and lack of trust in others
- Difficulty experiencing grief and loss
- Less satisfaction with their lives overall

DID YOU KNOW?

Some of these characteristics or changes with children could become apparent in the visitation center. Together, parents and visit monitors can take steps to improve the parent- child relationship.

Interpersonal/Social Effects

- Increased rates of divorce for the children when they become adults
- Higher rates of unmarried women becoming pregnant
- Trouble committing or engaging in intimate relationships
- Early engagement in sexual relationships
- Less contact with parents

Developmental Needs of Children & Responses to Separation or Divorce

Children have different needs at different stages of development. In this section, children's needs during the respective stages of development are grouped as follows:

- Infants
- Toddlers
- Young Children
- Older Children
- Adolescents

Effects of Divorce on Infants (0 – 18 months)

During infancy, children learn to trust their caregivers and form attachments. At this age, infants can sense conflict, but cannot understand it. When a divorce occurs, an infant will not understand the change, but he or she will be able to sense the conflict, emotions, and a parent's lack of presence in the home. It is important to help comfort the infant during this stressful time.

The effects of divorce in infants include:

- Constant irritability and crying (more than usual)
- Becoming extremely upset and inconsolable
- Clinginess with caregivers
- Regressive behaviors (behaviors they had previously grown out of)

Table 9.1 *Supporting Infants Through Divorce*	
What Infants Need	**How Parents Can Help the Child**
Consistency	**Being consistent** • Parents need to make sure to keep the infant on a routine. Meal times, sleep times, and other routines should be maintained to make sure the infant doesn't experience too much change. • Parents should make every effort to keep the child in a familiar environment. If a parent must move, both parents should help the child become comfortable with the new environment by bringing something comforting from the home the child finds comforting.
Support	**Remaining calm** • If possible, parents should have the infant maintain consistent contact with both parents. • Parents should avoid having tense interactions with each other in front of the infant. Even though infants may not understand what is being said, they do understand when tension and conflict are present. Parents should have calm interactions when their child is present.
Comfort	**Being reassuring** • Parents should physically comfort the child through cuddling, holding, hugs, and similar physical affection. • During transitions from one parent's house to the supervised visitation center, parents should remember to keep an item the infant finds comforting with him or her, such as a special toy, a blanket, or other object.

Seek additional help if *the supervised visitation worker notices or receives information about a child's*

1. *loss of learned skills, including losing the ability to eat, talk, or crawl, or*
2. *a heightened emotional reactivity, such as anger, fear, or withdrawal that continues for days or multiple sessions, this can indicate a warning for psychological distress.*

Monitors should get help from a manager or supervisor if this occurs.

Effects of Divorce on Toddlers (18 months – 3 years)

Toddlers will have a better understanding of what is happening during a divorce than an infant, but still won't understand all of the different ways divorce will affect him or her. Toddlers will have a difficult time understanding the future following a divorce. Toddlers can sense a parent's absence, conflict, and emotions.

The effects of divorce in toddlers include:

- Being fussy or crying more often than usual
- Aggressive behavior
- Problems with sleeping
- Feelings neglected or ignored
- Regressive behavior (behaviors they had previously grown out of)
- Clinginess with caregivers
- Feelings of fear, anger, or shyness

Table 9.2
Supporting Toddlers Through Divorce

How Toddlers May Feel	How Parents Can Help the Child
Confused	**Being consistent** • Parents should try and keep consistent schedules so the child can anticipate what will happen in the future. • Although divorce is a major change, parents should avoid other major changes to the toddler's life when in the midst of a divorce. If possible, parents should avoid changing schools, homes, rooms, or other things that the child is comfortable with.
Unloved	**Showing love** • Parents need to show the child frequent affection – both in action and words. Hugging the child and telling him or her that he or she is loved allows the child to feel loved and secure. • Make sure that the toddler spends time individually with both parents, if possible, to help him or her feel loved and safe in his or her relationship with each parent.

Scared	**Comforting their child** • Parents need to allow the child to take time when transitioning from one parent's home to the supervised visitation center. If the child needs more time to say goodbye to one parent, the other parent should try to accommodate the child. • Both parents need to remember to be patient with the child. The child may become needy because he or she is scared of all the changes. Parents need to take the time to comfort the child and make an effort to ease any fears the toddler may have.
Sad	**Being reassuring** • In order to help a toddler with his or her feelings, parents should also take care of themselves. Parents should seek out help and support while going through this process and then they will be better able to help their toddlers. Toddlers can sense when their parents are upset and sad, and they will become sad when they see that a parent is sad. • Parents should allow the child to bring comfort items, such as toys or blankets, with him or her when going in for supervised visitation.

Seek additional help if *the supervised visitation worker notices or receives information about a child's*

1. *loss of learned skills, including losing the ability to eat, talk, crawl, using the toilet, or walk, or*
2. *a heightened emotional reactivity, such as anger, fear, or withdrawal that continues for multiple sessions this can indicate a warning for psychological distress.*

Monitors should get help from a manager or supervisor if this occurs.

Effects of Divorce on Young Children (4 – 7 years)

Young children have difficulty understanding divorce; however, they are aware of the concept of their parents as a unit. When divorce happens, a young child may have a hard time understanding, and may become upset by the idea of his or her parents no longer being together. Children in this age group may also start to believe that they are responsible for their parents' divorce.

The effects of divorce on young children include:

- Trouble sleeping and frequent nightmares
- Feelings of fear
- Problems making new friends
- Daydreaming and pretending (more than normal), sometimes focused on the parents getting back together

Table 9.3
Supporting Young Children Through Divorce

How Young Children May Feel	How Parents Can Help the Child
Worried	**Talk to their child** • After a divorce, the child may be worried that he or she will never see one of the parents. Parents should affirm to the child that he or she will still be in contact with both parents and is still loved by both parents. • Parents should explain to children how things will change, so that the child will understand and not worry about the future. When a schedule or home situation changes, parents should sit down with the child and discuss these changes and answer any questions.

Guilty	**Explain that it's not their child's fault** • Children at this age will often blame themselves for the divorce, so it is important for parents to continually explain to the child that it is NOT his or her fault. Divorce is the choice of the parents. • Parents need to avoid arguments, tense situations, or disagreements in front of the child, especially when the child is the focus of the discussion.
Rejected	**Telling the child that both parents love him/her** • The child may feel that when one parent leaves, he or she is rejecting the child. It's important to remind the child constantly of how loved he or she is by both parents. • Parents should help the child to maintain regular contact with both parents. This can be done by phone calls, time together, online communication, and other methods.
Confused	**Keeping things simple** • Parents need to explain clearly and periodically to the child what is happening. Children should understand how their lives will change and what is expected of them. • Children may sometimes believe their parents will get back together. Parents should make it clear that the divorce means that the parents will no longer be together.
Unable to Define Feelings	**Discussing the child's feelings together** • Younger children may have difficulty expressing their feelings surrounding the divorce. It's important for parents to engage the children in discussion of how they're feeling and help them name those feelings. • Parents can use books, games, or other media options that can help a child learn to name the emotions he or she is feeling. Parents can also seek out help from a child therapist to help the child as he or she deals with emotions.

Seek additional help if *the supervised visitation worker notices or receives information about a child's*

1. *Loss of learned skills, including losing the ability to talk or using "baby talk", bedwetting, or antisocial behavior, failure to progress further developmentally, or*
2. *Expressing anger, extreme sadness, or aggression, this can all indicate a warning for psychological distress in children.*

Monitors should get help from a manager or supervisor if this occurs.

Effects of Divorce on Older Children (8 – 12 years)

Unlike younger children, older children have a better understanding of what divorce is. It is common for older children to blame one parent for the divorce and pick a side in the dispute. One of the primary reactions older children have to divorce is feeling anger – towards the situation and the parents.

The effects of divorce on older children include:

- Anger manifesting in different ways, such as fighting or disrespect of the parents
- Headaches, stomachaches, or other illnesses
- School problems and not wanting to attend school
- Withdrawing from friend groups due to embarrassment, feeling isolated, and sadness

Table 9.4
Supporting Older Children Through Divorce

How Older Children May Feel	How Parents Can Help the Child
Worried	**Talk to the child** • Older children have a better understanding of divorce and may worry about the financial and emotional burden divorce may put on the parents. Parents should make an effort to not complain about the divorce, their finances, or the other parent in front of the child so he or she does not worry. • Sometimes parents will send messages through a child. This may make children nervous about passing along messages and worried about upsetting the other parent. Parents should avoid sending messages to each other through a child.

Isolated	**Connect with child** • Parents can encourage the child to join school and group activities. Parents can help the child find something he or she is interested in and look for a group to join. • A child may feel isolated from other extended family members in a divorce as well. These people may potentially serve as a support system. It's important for parents to explain to the child that he or she is still a part of the same family, even if the divorce is changing the parents' relationship.
Insecure	**Help the child feel secure** • Children can become insecure following a divorce; they may feel unloved and unsure of their future. Parents should make an effort to provide the child with stability and consistent love and affection so that the child can start to feel secure in the new arrangement. • Parents should go over the child's new schedule and transitions with him or her. If the child has any questions, the parents should try to answer them. If the child has any concerns, the parents should try to ease them.
They have to choose sides	**Never make the child choose sides** • During divorce, children may feel as if they have to choose sides. This is dangerous to the goals of co-parenting and to the relationship between the other parent and the child. Parents should continually emphasize to the child that he or she does not have to choose sides and that the decision to divorce was a mutual decision. • Parents should not express jealousy to the child when the child spends time with the other parent. Instead, parents should show the child they are happy the child is having a chance to bond with the other parent.

Seek additional help if *the supervised visitation worker notices or receives information about a child's*

1. *sleep complaints, headaches and stomachaches,*
2. *antisocial behavior, or*
3. *anger and hostility directed toward someone or something else,*

this can all indicate a warning of psychological distress for this age group.

Monitors should get help from a manager or supervisor if this occurs.

Effects of Divorce on Adolescents (13 – 17 years)

Adolescents go through many social, emotional, and physical changes. When a divorce occurs, the adolescent may feel even more overwhelmed by the great changes. While adolescents often put on a brave face and act as though the divorce doesn't affect them, they are affected just like children of other age groups. Following a divorce, adolescents may respond in a variety of ways.

The effects of divorce on adolescents include:

- Personality changes that include heightened feelings of anger, resentment, and sadness
- Acting out and disobeying parents, such as refusing to follow plans that had been established
- Increased desire to be independent and more actions indicating independence
- Isolating him or herself from family and friends
- Engaging in riskier behavior

Table 9.5
Supporting Adolescents Through Divorce

How Older Adolescent May Feel	How Parents Can Help the Adolescent
Angry	**Talk to the adolescent** • Parents should talk to their adolescent! Opening up the lines of communication helps to decrease the amount of conflict, while also showing the adolescent that his or her opinions matter. • Parents should not talk about the details of the divorce with the adolescent. Learning more about the disagreements may make the adolescent angrier and cause him or her to be upset at one or both of the parents. • Parents should make the effort to understand that the adolescent may be angry. His or her life has been drastically changed, and it wasn't his or her choice. Parents should try to understand that anger is normal and allow the adolescent the vent anger in healthy ways. Parents may also look for a counselor or support group for adolescents that specializes in divorce as an outlet for the adolescent to vent that frustration.

Burdened	**Never make the adolescent choose sides** • Sometimes during a divorce, parents may try to be the adolescent's friend rather than parent. This may include complaining to the adolescent about the other parent, like one would to a friend. Parents should make sure they maintain the appropriate parental boundaries with adolescents so the adolescent doesn't feel like he or she needs to take care of the parent. • Parents should do their best to allow the adolescent to remain an adolescent. During divorce, some adolescents may feel like they have to grow up and take over the responsibility left by the parent who has left. Parents should make sure to not place adult responsibilities on the adolescent during this time of transition and change.
Out of control	**Tell the adolescent what to expect** • Parents should make an effort to keep the adolescent's schedule as stable and consistent as it can be. Just as with younger children, adolescents need consistency during this period of change. • Parents should clearly communicate with the adolescent so that he or she knows what to expect. During this time, adolescents may feel like they have no control over anything. Being informed will help the adolescent feel in control because he or she will know how things will change and what will be happening in the future. • Parents should make an effort to give the adolescent control over as much as possible, within reason.

Seek additional help if *the supervised visitation worker notices or receives information about the following issues with the child: irritability, feelings of worthlessness, depressed mood, difficulty concentrating, poor appetite, and fatigue. It is more difficult to identify distress in adolescents due to the common occurrences of mood swings and behavioral difficulties. The most common red flags are the adolescent engaging in alcohol, drugs, or other dangerous activity, anger, verbal hostility, or physical aggression, and depression.* **All of these red flags for distress could indicate a need for professional help.**

Table 9.6
How Divorce May Affect Children at Supervised Visitation

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 experience separation anxiety if they have formed a secure attachment with their caregivers and may fear abandonment	Developmentally inappropriate behavior Becomes upset easily Ill-tempered/cries easily Demonstrates insecure attachment Emotionally withdrawn or shy
Toddlers A safe environment for exploration Parent attentive to needs Verbal explanations appropriate for age A patient caregiver Consistent daily routine	Toddler may fear separation Toddler may fear abandonment	Becomes upset easily/ill-tempered and cries/whines Physically hangs on to parent Emotionally withdrawn Throws temper tantrums Shows aggressive behavior (hitting, biting, kicking, scratching, etc.)
Young Children Protective parent Freedom to explore Defined roles for parent Contact with other children for socialization and play To show autonomy and mastery	Blames self for parents' problems Feels guilty or ashamed Fears punishment or rejection Feels frightened or confused Has fantasies of parental reconciliation Feels jealous May regress to an earlier age	Difficulty expressing feelings Acts younger than true age Toileting accidents Fights with siblings

Older Children 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 Developed sense of competence	Feelings of sadness or anxiety Feelings of guilt or fear Feelings of shame or 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 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 or depression Feelings of anger or disappointment Feelings of self-doubt Lacks self-esteem Shows parental behavior Emotionally unbalanced Partakes in sexual behavior prematurely May feel relieved parents are divorced	Insincere disconnection or apathy Expresses sadness, anger, shame and/or disgust Questions family relationships Pulls away from family

Divorce as Loss

Divorce is a loss of the current family structure. Parents and children can feel loss over changes that occur in their homes, neighborhoods, schools, jobs, schedules, routines, roles, expectations, and family structure. Processing these changes, and the grief associated with the losses, is necessary for family members to move forward.

Parents need to keep communication open with their child about the changes that are taking place so that he or she is able to express and discuss grief and sadness. Although many changes and losses occur in divorce, the parental role is a permanent role that does not change. The grief that children and parents feel over separation and divorce is more of a process than a time-limited event. Parents should remember that throughout this process, children are depending on their parents for their needs to be met. It is crucial to help parents understand that their responsibilities to their children remain constant, regardless of the separation or divorce.

DID YOU KNOW?

The 5 Stages of Grief identified by Dr. Elisabeth Kubler-Ross, a Swiss psychologist, may be seen in children after their parents' divorce. Examples of a child's thoughts, following the 5 stages are as follows:

1. **Denial**
   - "No, it's not true!"
2. **Anger**
   - "This shouldn't be happening to me."
3. **Bargaining**
   - "Maybe I can change things if I do better."
4. **Depression**
   - "I don't know how to keep going."
5. **Acceptance**
   - "I will be okay."

Effects on the Parents

Divorce can affect many areas of parents' lives. It is important for parents to foster a strong support system for themselves and their children during this time. The following are a few areas of life that are most commonly impacted by divorce. Remember that all families are unique and these effects may not affect all families in the same way.

Economic Stability

Economic Adjustments

Divorce usually requires an economic adjustment of lowering a single parent's standard of living due to the loss of financial support from a former spouse. Research shows that in order to maintain the same living standards as before, the average parent's income would have to increase by 30%.

Decrease in Overall Income

Studies have shown that the rate of women who live in poverty after divorce is four times higher than that of married couples because they are often paid less than men and may be responsible for a higher amount of the childcare responsibilities. Men also experience a loss in their standard of living, ranging from 10%-40%. This can be a result of the amount of child support required or a result of the lack of extra financial assistance from an ex-spouse who worked outside of the home.

Possible Economic Adjustments

- **Move into a smaller home**
- **Learn to keep a budget**
- **Switch to basic cable and internet**
- **Become aware of where money is being spent**
  - **Make sure lights are turned off when no one is in the room**
  - **Unplug appliances that are not in use**
  - **Turn up the thermostat when no one is in the house**
- **Save gas by walking or biking**
- **Utilize hand-me-down clothing and toys**
- **Shop at thrift stores**
- **Pool resources for expensive childcare items, such as strollers and cribs, with family and friends.**
- **Cook at home more**

Reach out to community services to help parents learn to adjust to the financial impact of divorce.

Financial Burden
The legal costs of divorce alone can be more than $20,000. Individuals will undergo many expenses to start over. Some of these expenses include rent deposit fees, moving costs, utilities deposits, etc.

Divorce can create a financial burden for both parties. Parents experiencing a divorce should use this information to prepare and prevent instability from occurring, which will protect the children.

Mental and Emotional Health

The emotional strain of asking for a divorce, or feeling blindsided by a divorce request, can take a toll on a person's mental health. Divorced individuals who need extra help should consider seeing a mental health professional to process their emotions and learn healthy coping skills. Below are some emotions commonly experienced by adults during a divorce:

Table 9.7
Mental and Emotional Health Concerns

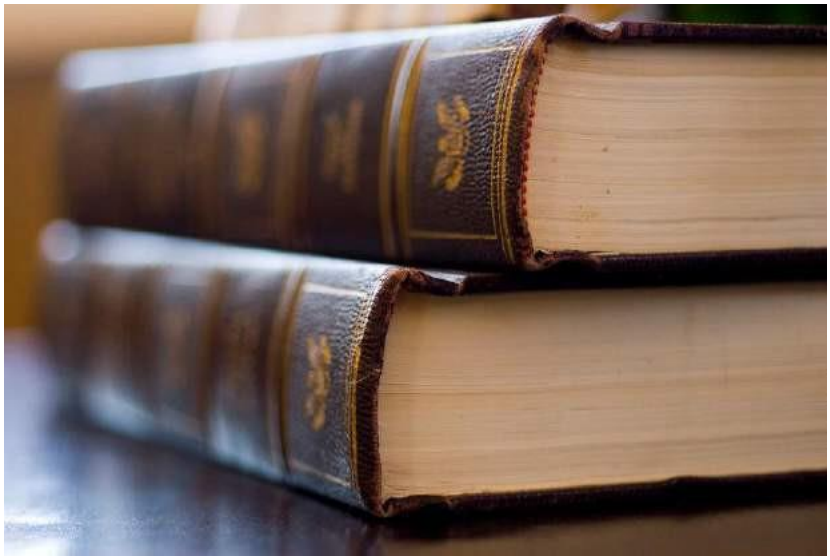
Lack of confidence	Feeling unworthy, not good enough, having low self-esteem
Depression	Overwhelming sadness, extreme fatigue, little desire to do anything
Difficulty focusing	Dwelling on the divorce and what went wrong in the marriage, unable to concentrate on other tasks; difficulty accomplishing things
Anger	Being upset at former partner, losing temper over little things, loss of control, severe frustration

Physical Health

Physical Manifestations of Stress
The stress of divorce can contribute to a weakened immune system, creating a greater likelihood of frequent illness. Some people experience depression and anxiety. Others engage in unhealthy risk-taking behaviors. Parents should pay attention to their own physical health during a divorce. They should get enough sleep, limit their alcohol use, and eat nutritious food, as well as consult a medical professional for help dealing with the physical effects of divorce.

Common Legal Terms of Divorce

The following list contains common legal terms used in divorce/separation cases.



Alternative Dispute Resolution or ADR - Alternative dispute resolution (ADR) refers to a variety of processes that help parties resolve disputes without a trial. Typical ADR processes include mediation, arbitration, neutral evaluation, and collaborative law. These processes are generally confidential, less formal, and less stressful than traditional court proceedings. Mediation is the form of ADR most common to divorce disputes.

Adjudication – adjudication or litigation refers to the process of taking a case through court and getting a final decision by a judge or jury.

STOP and Think

- **Why is it important for visit monitors to know common legal terms of divorce?**
- **What are ways you can help families by knowing legal terms?**

Child Custody Evaluation – is a process in which a mental health expert evaluates the family and makes a recommendation to the court for custody or parenting plan that is in the child's best interest.

Child Support - A court-ordered payment from one parent of a minor child to the other in order to assist in the expenses associated with raising the child.

Confidentiality – Generally, court proceedings are public matters in the vast majority of jurisdictions, including divorce proceedings. This means that unless the court agrees to file divorce records under seal, filings in divorce proceedings

become matters of public record. Exceptions to open court records exist including the identification of children and victims of sexual abuse, amongst others. In most places, however, to protect divorce records from being open to the public, one or both participants must ask the court to file records in the case under seal.
When a court files divorce records under seal, confidential or sensitive information within those records remains private and does not become a matter of public record.

Dissolution – the legal end of a marriage.

Jurisdiction – the authority of the court to rule on issues, relating to the parties, their children, or their property.

Mediation – is an alternative to litigation (the process of taking legal action) where a neutral third party facilitates the creation of a divorce agreement tailored to and agreed upon by the divorcing couple.

Parenting Plan - A document that establishes how parents will make decisions about their minor children. This must include a time-sharing schedule, and may also include other aspects of child-rearing such as education and the physical, social, and emotional well-being of the children. The document is developed by both parents or by the court in cases which the parents cannot agree or the plan they develop is not approved.

Time-Sharing Schedule - A schedule usually included in the parenting plan that specifies the time that a child will spend with each parent. The schedule must be agreed upon by both parents and include overnight stays and holidays. The court will determine the time-sharing schedule if both parents cannot agree.

Understanding Florida Laws

Who Can File for Divorce?

- To file for divorce in Florida, one of the spouses must have resided in Florida for at least six months before filing for divorce
- In Florida, either spouse can file for divorce

How to File for Divorce

- Florida has a no-fault divorce system
- In Florida, divorce is called "dissolution of marriage"

Either the husband or the wife can file for divorce by filing a petition for dissolution of marriage with the circuit court in the county where the couple last lived together or the county where either husband or wife lives

- If spouses do not have dependent or minor children together, file: Florida Supreme Court Approved Family Law **Form 12.901(b)(3)**, Petition for Dissolution of Marriage with no Dependent or Minor Child(ren) or Property
- If spouses do not have dependent or minor children together but they do have marital assets or liabilities, file: Florida Supreme Court Approved

Family Law **Form 12.901(b)(2)**, Petition for Dissolution of Marriage with Property but no Dependent or Minor Child(ren)

- If spouses have dependent or minor children together, file: Florida Supreme Court Approved Family Law **Form 12.901(b)(1)**, Petition for Dissolution of Marriage with Dependent or Minor Child(ren)

What is Co-Parenting?

The benefit of having two parents in a child's life is monumental. Every child deserves two healthy parents, and every family deserves to adjust to divorce and move forward. Divorce can be incredibly difficult for everyone involved, but if parents can learn new skills, it can help ease some of the stress and heightened emotions involved.

Here are the basic elements of co-parenting:

- Children have a good relationship with both parents.
- Both parents respond to the needs of their children.
- Parents rarely argue and never in front of the children.
- Parents do not place their children in the middle of conflicts.

Table 9.7
Benefits and Difficulties in Co-Parenting

Benefits of Co-Parenting	Difficulties in Co-Parenting
• The child has a relationship with both parents • Sense of stability, normalcy • Consistent rules and consequences • Shared responsibilities • Concern for child is the focus	• Communication issues between co-parents • Immature reactions • Co-parent knows how to get a reaction from the other parent • Difficulty compromising • Emotions can overwhelm the situation

If the visit monitor comes into contact with a family that is not practicing co-parenting skills, or have not heard about co-parenting, the visit monitor can give each parent more information about what co-parenting is and how it can help their child.

A Note about Violence

Monitors should be aware of the limitations of co-parenting in families with a history of domestic violence. Co-parenting, or shared parenting, is not a safe or appropriate situation for families with a history of serious domestic violence. Florida law allows judges to consider any history of domestic violence in determining the appropriate parenting plan. If there is a conviction of domestic violence (misdemeanor of 1st degree or higher), there is a rebuttable presumption against shared parenting.

See **Chapter 13 on Domestic Violence** to get more information about domestic violence and its impact on families in supervised visitation.

Positive Impact of Healthy Co-parenting on Children

- Feeling of stability, which allows for an easier adjustment to divorce and results in higher self-esteem.
- Continued relationships with both parents, freeing children from choosing a side on issues of conflict.
- Limit feelings of responsibility for the emotional and social needs of parents.
- Higher level of health, due to strong parental support.
- Higher grades, better social skills, and higher rates of high school graduation.
- Social competence and healthy communication skills due to parents who are sensitive to their needs and emotions.
- Lower likelihood to smoke, drink, and use drugs in adolescence due to higher level of parental involvement.

Types of Support Children Need from Both Parents

- ***Cognitive*** - Providing healthy interaction, including play and caregiving activities, helps children develop problem solving skills.
- ***Social*** - Social support can help children learn to interact with others in a healthy way.
- ***Emotional*** - Emotional support can help children develop the healthy attachments, self-esteem, and independence needed to explore the world.
- ***Physical*** - Providing more attention and care to children can impact their physical development by increasing their well-being and health.

Why do we need Co- Parenting?

- Research indicates that successful co-parenting relationships are beneficial for children's socio-emotional development.
- Well-coordinated co-parenting during the child's first year of life has been found to predict better child adjustment in later years, while distressed co-parenting predicts later child problems.
- Cooperative co-parenting relationships may be key to fostering positive nonresidential father involvement and lower levels of inter-parental conflict.

It is important for divorced parents to separate their emotions from their interactions with their children. Emotions are legitimate reactions to surrounding circumstances, but when it comes to children, a parent's emotions can get in the way of positive interactions. For example, stress, depression, anger, and shame can all affect the way parents relate to each other and their children. It is important for parents to learn how to regulate their emotions and be able to handle stress in a healthy way. If parents feel that their emotions are making it difficult to build a strong, positive relationship with their child, it is essential that the parents reach out to a friend, religious leader, or counselor. It is important for parents to learn stress-relief techniques and coping methods so that the main focus becomes the well-being of the children.

Co-Parenting Legal Issues

Creating a Parenting Plan

The "Parenting Plan" is a document describing the parents' agreement relating to decisions about the relationship between the parent and child and decisions about raising the child.

- The Parenting Plan must be approved by the court
- In Florida, joint or shared custody of the child is referred to as "time-sharing"

What must be in the Parenting Plan? (s. 61.13(2)(b), F.S.)

- Describe how the parents will share and be responsible for the daily tasks associated with raising the child
- A time-sharing schedule, which contains the specific times the child will spend with each parent

- Choosing who will be responsible for any forms of:
  - Health care,
  - School-related matters,
    - including the address that will be used for determining school location and registration
  - Other activities
- The methods by which the parent will communicate with the child
  - Example- by phone, email, text, etc.

The Parenting Plan must satisfy the "best interest of the child"

- The court will approve the Parenting Plan if it is in the "best interest of the child."
- Court can look to a variety of factors to determine whether the parenting plan is in the best interest of the child; factors are listed fully in s. 61.13(3), F.S.; examples:
  - Parent's demonstrated capacity to encourage a close and continuing parent-child relationship and comply with time-sharing schedule
  - Moral fitness of parent
  - Physical and mental health of parent
  - Reasonable preferences of child

DISPUTES ABOUT THE PARENTING PLAN

Parenting Coordination (s. 61.125, F.S.) "Parenting coordination" is a child-focused alternative dispute resolution

- The court may appoint a "parenting coordinator," who is a qualified neutral third person, to help the parents create or implement a Parenting Plan by helping resolve disputes between the parents
- The court cannot refer parties to parenting coordination if there is a history of domestic violence unless both parents agree
  - Further information on parenting coordination can be found elsewhere in this manual
  - If the parents cannot agree on a Parenting Plan that the court will approve, then the court will create the Parenting Plan.

PARENTING PLAN MODIFICATIONS

- A person asking the court to modify a parenting plan may do so by filing a signed and notarized **Florida Form 12.905a** Supplemental Petition to Modify Parenting Plan/Time-Sharing Schedule and properly serving it upon the other parent. If the other party is in the military service, additional steps for service may be required. See, for example, Memorandum for Certificate of Military Service, Florida Supreme Court Approved Family Law Form 12.912(a). If personal service is used, the other party has 20 days to answer after being served with your form 12.905a supplemental petition.

REMINDER:

Supervised visitation monitors must not provide legal advice to parents or families.

This information is included so that visitation monitors will be better educated on the issues children and families may be facing in the midst of divorce.

CHILD SUPPORT

Both parents are legally obligated to provide child support for their minor children

Determining the Amount of Child Support Owed

- Child support guidelines are set forth in section 61.30, F.S.

- The minimum amount of child support needed is determined by using the "child support guidelines," which is based on the parents' combined net income estimated to have been spent on the child as if the parents were living together
  - Each parent's percentage share of child support is determined by dividing each parent's net monthly income by the combined net monthly income

- Florida Family Law Rules of Procedure **Form 12.902(e)** provides the Child Support Guidelines Worksheet that should be filed with the court
  - This form allows you to determine the amount of child support owed based on a specific formula
  - The form provides a chart containing the guideline amounts that should be used when calculating child support. The amount is based on the combined net income of the parents and the number of children they have, divided between the parents in direct proportion to their income or earning potential.

- If the parent requests more or less minimum child support than the amount provided by the guidelines, the parent must file a Motion to Deviate from Child Support Guidelines
  - This motion is filed by completing and filing Florida Supreme Court Approved Family Law **Form 12.943** along with the Child Support Guidelines Worksheet (Form 12.902(e))

- The court may adjust the minimum child support, or the percentage of the parents' share of the total minimum child support, based on the following deviation factors:

- Extraordinary medical, psychological, educational, or dental expenses
- Independent income of the child (excluding any moneys received by child from supplemental security income)
- The payment of support for a parent which has been regularly paid and for which there is a demonstrated need
- Seasonal variation in one parent or both parents' income or expenses
- The age of the child, taking into account the greater needs of older children
- Special needs, such as costs that may be associated with the disability of a child, that have traditionally been met within the family budget even though fulfilling those needs will cause the support to exceed the presumptive amount established by guidelines
- The total available assets of the parents and the child
- The impact of the Internal Revenue Service Child & Dependent Care Tax Credit, Earned Income Tax Credit, and dependency exemption and waiver of that exemption. The court may order a parent to execute a waiver of the Internal Revenue Service dependency exemption if the paying parent is current in support payments.
- An application of the child support guidelines schedule that requires a person to pay more than 55% of his or her gross income for a child support obligation for current support resulting from a single support order
- The particular parenting plan, a court-ordered time-sharing schedule, or a time-sharing arrangement exercised by agreement of the parties, such as where the child spends a significant amount of time, but less than 20% of the overnights, with one parent, thereby reducing the financial expenditures incurred by the other parent; or the refusal of a parent to become involved in the activities of the child
- Any other adjustments that are needed to achieve an equitable result which may include, but not be limited to, a reasonable and necessary existing expense or debt. Such expense or debt may include, but is not limited to, a reasonable and necessary expense or debt that the parents jointly incurred during the marriage

Modification of an Existing Child Support Order

- Parents can seek to modify an existing child support order by proving a **substantial change in circumstances**

- The modification of child support must result in a change of at least 15% or $50 (whichever is greater) from the existing monthly child support obligation

- Parent seeking to modify an existing child support order should file with the court a Supplemental Petition to Modify Child Support
  - Florida Supreme Court Family Law **Form 12.905(b)**, Supplemental Petition for Modification of Child Support
    - Parent must serve other parent with notice of petition

Child Support Solutions

Visitation monitors can help low-income families increase economic opportunities and improve child support outcomes through referrals and education. Many single-parent families, unmarried or divorced, are predominantly low-income and have difficulty with the child support system. The Florida Department of Revenue (DOR) has administered the Child Support Enforcement Program to provide child support services in most Florida counties.

The purpose of the Child Support Enforcement Program is to:

- Make it easy for parents to provide support for their children,
- Serve customers with respect, concern, and professionalism,
- Ensure families can depend on their child support payments, and
- Work with parents, partners, and the community to continually improve the child support program.

Supervised visitation program staff should understand the services and functions of the local Child Support Enforcement (CSE) office. The CSE offices can help parents establish paternity, establish child support payments, enforce support orders, locate parents, and modify orders. Such services increase family economic stability and alleviate poverty. It is valuable for visitation programs to be able to provide meaningful linkages to families for assistance with financial improvement and sustainability strategies.

The Florida Office of Child Support Enforcement can be reached using the contact information below.

Florida Department of Revenue
Child Support Services
Phone: 800-622-5437
http://dor.myflorida.com/dor/childsupport

Facilitation Strategies

There are many ways for visit monitors to support children in divorce or separation cases. These can be achieved by the using various facilitation strategies when monitoring visits. Below are suggestions to assist in facilitating visits:

1. Review the case file to attempt to determine the depth of the relationship between the child and the visiting parent. 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.
3. 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.
4. Ask the custodial parent if a young child has a special comforting toy and blanket (or pacifier) that might make him or her feel more secure during the visit. Be sure that the child does not leave the toy at the end of the program when he or she leaves.

Note

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.

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 experienced a great amount of transition during the separation or 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 or partners are part of the visit, the program should conduct an intake with these persons also, to determine whether a relationship already exists with the child and how the child might be affected by having the additional person at the visit.
12. If a visit ends before the activity is finished (e.g. if a game is not finished), make note about this on file and ask the child and parent at the beginning of the next visit if they want to continue that same activity or move on to another one.

Relevant Materials and Activities for Children

The following books and videos are materials that are helpful for assisting children who are struggling with parental divorce. It can be helpful for supervised visitation centers to have some of these materials on site and to provide this information to parents who are searching for tools to help in their child's coping process.

Table 9.8 Books for Children of Divorce

0 – 18 months

Tots are Nondivorceable by *Sara Bonkowski*

18 months – 3 years

1. Teach Me About Separation *By Joy Berry*
2. We're Having A Tuesday *By DK Simoneau*
3. Two Homes *By Claire Masurel*
4. It's Not Your Fault, Koko Bear: A Read-Together Book for Parents and Young Children During Divorce *By Vicki Lansky*
5. Good-Bye, Daddy! *By Brigitte Weninger*

4 – 7 years

1. My Mom and Dad Don't Live Together Anymore: A Drawing Book For Children of Separated or Divorced Parents *By Judith Aron Rubin*
2. How I Feel: A Coloring Book for Kids During and After Divorce *By Alan D. Wolfelt*
3. I Don't Want to Talk About It *by Jeanie Franz Ransom*
4. Was It the Chocolate Pudding? A Story For Little Kids About Divorce *By Sandra Levins*
5. When Mom and Dad Separate: Children Can Learn to Cope with Grief from Divorce *By Marge Heegaard*

8 – 12 years

1. Divorce Is Not the End of the World: Zoe's and Evan's Coping Guide for Kids *By Zoe and Evan Stern*
2. A Smart Girl's Guide to Her Parents' Divorce: How to Land on Your Feet When Your World Turns Upside Down *By Nancy Holyoke*
3. Mom's House, Dad's House for Kids: Feeling at Home in One Home or Two By *Isolina Ricci*
4. What in the World Do You Do When Your Parents Divorce? A Survival Guide for Kids *By Kent Winchester*
5. My Parents Are Divorced Too: A Book for Kids by Kids *By Melanie, Steven, and Annie Ford*

13 – 17 years

1. The Divorce Helpbook for Teens *By Cynthia MacGregor*
2. Surviving Divorce: Teens Talk about What Hurts and What Helps *By Trudi Strain Trueit*
3. Divorce Can Happen To The Nicest People *By Peter Mayle*
4. The Kid's Guide To Divorce *By J.P. Brogan and V. Maiden*
5. Coping When Your Family Falls Apart *By Diana Booher*

Table 9.9 ***Videos for Children of Divorce***

0-5 years

1. **Little Children, Big Challenges: Divorce**
   http://www.sesamestreet.org/parents/topicsandactivities/toolkits/divorce

6-12 years

1. **Don't Divorce Me! Kids Rules For Parent on Divorce**
   http://www.hbo.com/documentaries/dont-divorce-me-kids-rules-for-parents-on-divorce/video/dont-divorce-me-trailer.html#/documentaries/dont-divorce-me-kids-rules-for-parents-on-divorce/index.html
2. **SPLIT: A Film for Kids of Divorce (and their Parents)**
3. **Kids On Top of Divorce**
   https://www.youtube.com/watch?v=kKPFGSluvHA
4. **Divorce: A Journey Through the Kid's Eyes** (6-16 years)

13-17 years

1. **Divorce: A Journey Through the Kid's Eyes** (6-16 years)
2. **TeenBetween: Caught up in You Parent's Divorce**
   https://www.youtube.com/watch?v=K9Pv2inG05U
3. **How to deal with your parents' divorce & my experience**
   https://www.youtube.com/watch?v=fokIlXeoqgM
4. **Parents Divorcing**
   https://www.youtube.com/watch?v=TG8zPgeG6fg
5. **Dealing With Divorce**
   https://www.youtube.com/watch?v=Neb0ZGqUOIs

STOP and Think

- **How can reading specific books on divorce and separation help children cope with what they are feeling?**
- **What are ways that parents can get involved when the child engages with books or videos about divorce and separation?**

PRACTICE EXAMPLES

Case Scenario 1

Emilia had a long day at her new job and was feeling frustrated and irritable by the time she arrived at home. Earlier in the day, she had asked Johnathan, her 14-year-old son, to clean his room and have it done before he watched TV. When she returned home, Johnathan was watching TV on the couch and his room was still dirty. Emilia stormed into the living room, grabbing the remote from her son and shut the TV off. She pulled him off of the couch by the arm yelling at him, "I said no TV until your room was clean! You are so incompetent, just like yourfather!"

Discussion Questions:

1. Did Emilia overact?

2. How might Johnathan be feeling?

3. What could Emilia have done differently?

4. What can Emilia do to repair the parent-child relationship with Johnathan?

Case Scenario 2

Karen and Adam Phillips were married for eight years and have two children, Sarah, age 5 and James, 7. Over two years Karen and Adam have scheduled nine court hearings for temporary relief, emergency relief, and clarifications 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 Sarah told the monitor "Mom says we don't have tovisit Dad if we don't want to." James asked his Dad 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 or visit monitor 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?

4. What, if anything should staff write in the visit report about this exchange?

Quiz Yourself!

1. Divorce can affect parents in which of the following ways?

A. Physical Health
B. Mental Health
C. Economic Stability
D. All of the above

2. Emotional long-term effects of divorce on children can include:

A. Increased anxiety and depression
B. Early engagement in sexual relationships
C. Long-term feelings of anger, hostility, and loneliness
D. Less satisfaction with their lives overall
E. All of the above

3. The following are effects of divorce on toddlers *except*:

A. Clinginess with caregivers
B. Aggressive behavior
C. Problems making new friends
D. Problems with sleeping

4. What are some emotions that children can feel when experiencing divorce as loss?

A. Anger
B. Depression
C. Denial
D. Apathy
E. All of the above

Answers: 1. D; 2. E; 3. C; 4. E

MATCH THE TERMS & CONCEPTS

This activity allows you to test your knowledge of relevant terms to this chapter. Draw a line to match the words to their correct definitions.

Co-parenting	The process of taking a case through court and getting a final decision by a judge or jury.
Parenting Plan	A process in which a mental health expert evaluates the family and makes a recommendation to the court for custody or parenting plan that is in the child's best interest.
Adjudication	The legal end of a marriage.
Child Custody Evaluation	Both parents are involved in the child's life and respond to the child's needs.
Custodial Parent	A document that establishes how parents will make decisions about their minor children.
Dissolution	A schedule usually included in the parenting plan that specifies the time that a child will spend with each parent.

Step-Parenting and Blended Families

http://www.helpguide.org/articles/family-divorce/step-parenting-blended-families.htm.
This article provides parents with information on how to bond with stepchildren and deal with typical issues that can come up with step and blended families.

The Importance of Self Care for Health and Stress Management

http://stress.about.com/od/lowstresslifestyle/a/selfcare.htm.
It is important for single parents to practice self-care after a divorce, in order to maintain physical and emotional health.

Coping with a Breakup or Divorce

http://www.helpguide.org/articles/family-divorce/coping-with-a-breakup-or-divorce.htm. The article provides useful tips and information for individuals who are having a hard time dealing with the difficulties that are associated with their divorce.

11 Rules for Helping Your Child Deal With Divorce.

http://www.parents.com/parenting/divorce/coping/helping-child-deal-with-divorce/?page=2. This resource can help parents who are currently going through a divorce in which there has not been violence or abuse understand how to respect boundaries and help children get through the experience as positively as possible.

Long-term Effects of Divorce on Children

http://www.ces.ncsu.edu/depts/fcs/pdfs/fcs482.pdf. This handout goes through common long term effects that children may face when their parents experience divorce and offers suggestions for parents.

Handouts

The following exercises can be given to parents in order to help them maintain positive self-esteem and perspective. If a visitation monitor notices that a parent is being self-critical during a visitation, especially if it is affecting the child, he or she can give the parent the "Positive Parent" handout.

Positive Parenting

Think about what you were like before you had children. How have you changed by being a parent? Below are some different ways you may have changed as you raise your children. Read each statement and underline any you feel are true. Then write down the top three ways you feel you have grown.

Personal Development

- I have found that I am stronger than I thought I was.
- I am better able to solve problems.
- I have more confidence.
- I am more reliable and dependable.
- I have greater courage when facing new situations.

Relationships

- I can count on others in times of trouble.
- I am more caring.
- I value my friends and family more.
- I show support to others.
- I put more effort into relationships.

New Meanings

- I have a better understanding of what I believe.
- What I think is important has changed.
- I can take on difficulties.
- I have a stronger religious faith.
- I believe my life is important.

New Possibilities

- I am more likely to change things that need to be changed.
- I have found new interests and hobbies.
- I am able to do better things with my life.

The #1 way I have grown: _____

The #2 way I have grown: _____

The #3 way I have grown: _____

Supervised visitation monitors can give this exercise to parents who are having difficulty coping with their divorce and are adversely affecting their child through their negative self-outlook. The "I am Strong" handout can help parents recognize their strengths and help them relate those strengths to their parenting.

I am Strong

Having children often makes parents want to be a better role model. Raising children makes parents stronger. Parents should use the list below to identify their strengths by circling those that most apply to them below. Then parents should list the top three strengths they feel most confident in the lines provided below.

Creative	Fair	Confident	Eager to Learn	Positive
Passionate	Focused	Forgiving	Don't give up	Healthy
Trustworthy	Calm	Loyal	Very Patient	Loving
Hard-working	Humble	Spiritual	Imaginative	Kind
Lots of Friends	Happy	Supportive	Goal-oriented	Striving
Want to do better	Funny	Sensitive	Understanding	Hopeful
Dependable	Caring	Leader	Self-controlled	Curious

Strength #1: _____

Strength #2: _____

Strength #3: _____

On a separate sheet of paper, parents should answer the following questions below based on the about the strengths they identified:

1.) Is there a strength you feel you have developed that surprised you? Why do you think you were not able to recognize it before?

2.) How would you describe yourself if someone asked you about your life? What strengths would come to mind in your description? Do you feel a particular strength is central to your personal identity?

3.) Think of a situation you did not handle well, and identify what strengths could have been useful during that time. How might this have changed the outcome of the situation?

4.) Was there strength you do not feel you currently have, but would like to develop in your life? What are some ways you could start to practice this strength?

Coping Methods for Parents

After a divorce, parents may notice feeling more stressed with their responsibilities. The following list provides different strategies that can help parents effectively handle that stress.

Coping Method	How it Helps	Examples
Relaxation	Relaxation can help slow your breathing rate, relax your muscles, and reduce blood pressure, limiting the harmful effects of stress.	This can involve simply breathing slowly, meditation, yoga, or resting in a quiet space.
Physical Recreation	Exercise has been proven to be a helpful de-stressor for many people and can help you sort out your emotions. The endorphins you feel will also help to give you a more positive outlook on life.	Go for a run, join a sports team, stretch, or find a yoga class to plug into.
Writing	Journaling your feelings and thoughts can be a healthy release from the situation at hand. It can give you a new perspective on the situation that you may not have had before.	Start a new journal, create a blog, or write notes to a loved one about your struggles.
Healthy Distractions	Engaging in a healthy distraction can help provide a break to reevaluate the conflict, but remember to evaluate what triggered your emotional response later on.	Read a book, take a bath, or watch a movie to relax and give your mind a breather.
Reach Out	Seeking support can help you identify and manage your emotions, while feeling a boost in self-assurance.	This can mean simply talking to a friend, taking the step to join a support group, or reaching out for professional help.

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CHAPTER 10

THE IMPACT OF PARENTAL MENTAL ILLNESS, SUBSTANCE ABUSE, AND DUAL DIAGNOSIS

Case Scenario

Sean Winters regularly attends supervised visitation with his 12-year-old daughter Lisa Winters. He was originally referred after serving a 30-month tour of Iraq serving in the military. He has been diagnosed with PTSD and depression and was recently arrested as a result of allegedly threatening the police. In addition, Mr. Winters was ordered to receive substance abuse treatment for his excessive use of alcohol and marijuana. Mr. Winters arrives for his weekly visitation but appears to be extremely sluggish, which is different from his regular presentation. In the lobby, Mr. Winters has a discussion with another client and his mood appears to be unstable – his voice is fluctuating from loud to soft, and his conversation revolves around people he thinks are following him. A staff member overhears from the conversation that he is agitated about issues that occurred earlier in the day with his roommate. The staff member states, "I'm pretty sure he's under the influence. Look at how bizarre he's acting." The director allows the visit to occur. After about 15 minutes into the visit, Lisa tells her father about her history class and what she has learned about the Vietnam War. Lisa begins probing her father with questions about his time serving in the military, asking if it was similar to what she has read. Mr. Winters becomes extremely agitated and defensive. He yells "You don't understand war!" He begins to snap at Lisa and then yells at her to stop apologizing. Lisa becomes frightened and looks to the monitor in distress.

After completion of this chapter, you will be able to answer the following questions:

- After hearing the statement from the other monitor, how would you determine if Mr. Winters was intoxicated or unable to continue with the visit?
- Besides substance abuse, what else could be causing Mr. Winters change in behavior?
- What is the best time to address irregular behavior? Before the visit starts? In the middle of the visit? Once a client becomes aggressive?
- How might have mental illness affected his ability to parent or participate in the visitation?
- How would you deal with the incident of aggression during the visitation? What protocol or safety measures would you take?
- What precautions could have been in place to avoid the situation with Lisa completely?
- Do you have to be a mental health professional to provide adequate services to clients at a supervised visitation program? If not, what baseline information should you have?

Introduction

This chapter is divided into three sections:

Mental Illness

Substance Abuse

Dual Diagnosis

Mental illness and substance abuse can have negative effects on parenting, children, and supervised visits. In addition to the effects of mental illness or substance abuse alone, half of individuals with a mental illness also suffer from a substance abuse disorder. The co-occurrence of these two issues is called dual diagnosis and can have its own set of concerns for visitation monitors. It is important for supervised visitation providers to know the effects of these issues on families and how to work with these issues in supervised visitation. This chapter will discuss mental illness, substance abuse, and dual diagnosis separately as visit monitors may encounter clients with any one of these issues. Monitors can use the information in this chapter to support families coping with mental illness, substance abuse, or dual diagnosis.

DID YOU KNOW?

Approximately half of the population that suffers from a mental illness has at least one substance abuse disorder.

Mental Illness

Mental illness affects approximately one-fifth of the total adult population in the United States. Approximately two-thirds of women and one-half of men with mental illness are parents. Due to reportedly high incidents of custody loss with this particular population, conducting supervised visitations with families and parents living with mental illness is becoming more common. Mental illness encompasses many different categories, including substance abuse, and the symptoms from these illnesses may affect supervised visitation.

Substance Abuse

Substance abuse accounts for a significant percentage of supervised visitation cases. The symptoms of parental substance abuse can impact parenting capability directly and can lead to multiple consequences for the children involved. According to the American Psychiatric Association, substance abuse is considered a mental disorder due to changes in the brain that cause symptoms similar to those of mental illness. While substance abuse disorders are different from other mental illnesses, it is important to understand how mental illness and substance abuse relate to and impact each other.

Dual Diagnosis

Historically, mental health and substance abuse have been separate systems of care. Over time, researchers have discovered that there is an emerging population that suffers from both conditions concurrently. With increasing numbers, it is likely for visitation centers to work with parents suffering from co-occurring disorders.

As visitation monitors interact with parents and families coping with mental illness and/or substance abuse, it is important to understand the unique challenges that may be faced with this sensitive and complex topic.

What will I learn in this chapter?

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

- Understand mental illness and its effects
- Understand common diagnoses of mental illness and their symptoms
- Identify commonly abused drugs and their effects
- Understand the impact that mental illness and substance abuse have on parenting, children, and supervised visitation
- Identify and understand the relationship between mental illness and substance abuse
- Understand the prevalence of dual diagnosis and the risks and consequences associated with it
- Identify techniques to work with parents of mental illness and substance abuse
- Identify how mental illness and substance abuse are intertwined with domestic violence
- Understand the limitations of being a visitation monitor regarding mental illness and substance abuse
- Identify screening and risk assessment techniques to ensure safety of all parties

Snapshots and Facts

- In 2012, there were an estimated 43.7 million adults aged 18 or older in the U.S. who had experienced a mental illness in the past year. This represented 18.6 percent of all U.S. adults.
- Almost one-third of American women and one-fifth of American men provide evidence of a psychiatric disorder annually.
- Mothers with schizophrenia have higher rates of reproductive loss, e.g. miscarriages, stillbirths, and induced abortions.
- Parents with mental illness may be quite vulnerable to losing custody of their children, some studies reporting rates as high as 80%.
- Parents with mental illness often feel responsible or blamed for their children's maladaptive behaviors, which are more prevalent than in children whose parents have no mental illness.

Part 1

Mental Illness

Mental illness is a broad term used to describe psychiatric disorders that impair a person's cognitive abilities, emotional reactions, behaviors, and abilities to perform activities of daily living (e.g. feeding, dressing). There is a broad spectrum of mental illnesses, and they differ in their characteristics, symptoms, prevalence, outcome, and duration. While some mental illnesses may occur in an episodic fashion, others may impact the individual chronically. The treatments of mental illness are vast and can include medications, mental health counseling, family and community support, and psychosocial therapies.

The Diagnostic and Statistical Manual V (DSM-V) is the official manual used to classify, categorize, and diagnose mental disorders in the United States. Mental health professionals use the DSM-V as a guideline for diagnosis and treatment of individuals with mental health issues. While there are numerous categories of mental illness, this chapter will discuss high prevalence mental illnesses and disorders that may impact supervised visitations.

DSM-V Categories

- **Neurodevelopmental**
- **Schizophrenia Spectrum**
- **Bipolar and Related**
- **Depressive**
- **Anxiety**
- **Obsessive-Compulsive**
- **Trauma and Stressor**
- **Dissociative**
- **Somatic Symptom**
- **Feeding and Eating**
- **Elimination**
- **Sleep-Wake**
- **Sexual Dysfunctions**
- **Gender Dysphoria**
- **Disruptive, Conduct**
- **Substance-Related**
- **Neurocognitive**
- **Personality**
- **Paraphilic**

Considering the immense amount of information to be covered on mental illness, the following section will provide insight to some of the major categories of mental illness and their symptoms. For complete access to information on mental disorders please visit www.dsm.psychiatryonline.org

Table 10.1 *Categories of Mental Illness*			
Category	**Description**	**Symptoms**	**Disorders**
Depressive Disorders	Presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function.	• Depressed mood • Diminished pleasure/interest • Weight loss • Fatigue • Loss of energy	• Major Depressive Disorder • Persistent Depressive Disorder • Disruptive Mood Dysregulation
Schizophrenia Spectrum	Abnormalities in one or more of the following domains: Delusions, hallucinations, disorganized thinking (speech), grossly disorganized/ abnormal motor behavior, or negative symptoms (morbidity).	• Fixed beliefs • Perception-like experiences that occur without an external stimulus • Social withdrawal • Disturbances in thought and perception	• Schizophrenia • Delusional Disorder • Schizotypal Personality Disorder
Trauma and Stressor Disorders	Psychological distress following a traumatic or stressful event.	• Anxiety or fear-based symptoms • Externalizing aggression • Dissociative features	• Posttraumatic Stress Disorder • Acute Stress Disorder • Adjustment Disorder
Bipolar and Related Disorders	Serves as the bridge between Depressive and Psychotic	• Manic episodes of euphoric, expansive, or irritable mood.	• Bipolar I • Bipolar II • Cyclothymic Disorder

	disorders. Many experience extreme mood swings and impairment in daily functioning.	• Depressive episodes • Mood swings	
Anxiety Disorders	Excessive fear and anxiety, often stress-induced.	• Extreme sense of fear and worry • Somatic symptoms; trembling, shaking • Difficulty concentrating	• Social Anxiety Disorder • Panic Disorder or Attacks • Generalized Anxiety Disorder • Phobias
Personality Disorders	Pattern of behavior and experiences that deviates from the expectations of culture. The behavior is pervasive and inflexible and can lead to distress or impairment.	• Difficulty with relationships • Lack of empathy • Problems with social skills • Personality traits are inflexible and maladaptive/ inappropriate	• Paranoid Personality Disorder • Borderline Personality Disorder • Narcissistic Personality Disorder
Substance Use Disorders	Cluster of cognitive	• Impaired control • Social impairment • Secretive behaviors	• Alcohol Use Disorder • Substance Intoxication • Substance Withdrawal

STOP and Think

After reading this section, you should be able to answer the following question regarding the case scenario at the start of the chapter.

Besides substance abuse, what else could be causing Mr. Winters' change in behavior?

Impact of Parental Mental Illness on Parenting

Mental illness impacts everyone differently, and it may affect one's parenting abilities. For many supervised visitation cases, mental illness may have played a role in custody, shared time decisions, or visitation agreements. Depending on the condition, parents with mental illness or substance abuse issues are faced with added challenges in coping with their condition and parenting. Mental illness alone is insufficient to establish parental unfitness, and many parents with mental illness have and continue to avoid issues with the support of others around them. Many parents with mental illness have the desire to be good parents and can work to improve their parenting skills and reduce any risk to their children. It is valuable to understand what impact mental health and/or substances has on a parent's ability to parent or participate in supervised visitation.

DID YOU KNOW?

A 2007 study by Cleaver & Nicholson revealed that parents were not adequately ensuring their child's safety in 93% of cases where children lived with substance- abusing parents.

In order to promote the welfare of children, parents must provide the following:

- Basic care
- Safety
- Emotional warmth
- Appropriate stimulation
- Guidance and boundaries
- Stability

Mental illness and substance use can affect parents' capacity to address these issues adequately.

- A higher proportion of parents with mental illness lose custody of their children than parents without mental illness. There are many reasons why parents with mental illness risk losing custody.
- The major reason for the loss of custody from parents with mental illness is the severity of the mental illness and the lack of support from other competent adults within the family.

Several aspects of parenting are examined below.

Parenting Skills

Mental illness symptoms may play a role in one's ability to provide healthy parenting to children. For example, apathy and listlessness can create difficulty in organizing day-to-day living activities. In most cases, parents with mental illness may see the following in their parenting skills:

- Unpredictability
- Inconsistency
- Ineffectiveness

These problems may also affect parents who do not have a mental illness.

Some detrimental effects of parental mental illness and substance abuse include:

- Leading a disorganized lifestyle
- Difficulty establishing routines
- Difficulty coping adequately with unexpected life events
- Lack of attention to children/leaving children unsupervised
- Inability to provide basic care
- Inability to ensure child's safety
- Apathy, inability to provide child with emotional warmth

REMINDER:

Mental illness alone does not establish parental unfitness. Many parents are able to overcome the added stresses of illness and can develop strong relationships with their children. Your role as a monitor is to support parents in the development and continuation of the relationships with their children.

Parents' Perception

In some cases, mental illness or substance use can result in parents having a warped view of the world. Distorted parental perceptions can impact parenting in several ways:

Negative Self-Perceptions: A parent suffering from mental illness or substance use issues may see themselves as inferior parents. They could feel less competent and adequate than other parents. This could result in parents providing inadequate care to their children.

Distorted Views: Sometimes parents with mental illness can have a distorted view of their children. They could perceive behavior problems or could place blame on children for their distress.

These issues with perception can affect the parent's capacity to provide adequate guidance and boundaries.

STOP and Think

- **How can you support parents with negative self-perceptions?**
  - Provide affirmations
  - Build on parent strengths
  - Provide educational materials
  - Discuss referrals that may offer professional services

Mental Illness and Control of Emotions

Some mental illnesses may cause parents to be irritable or angry, while others may influence the ability to control emotions. When parents are coping with a whirlwind of emotions, it can be difficult for them to connect with their children.

NOTE

Mood swings are difficult for children to understand and can impose stress and distance on relationships.

- Disorders with psychosis can cause parents to have inappropriate and intense affective responses to children.
- Mood disorders can lead to mood swings and the inability to control impulsive, rapid emotions.
- When parents are preoccupied with their own feelings, they may experience greater difficulty when responding to their child's needs.
- Parents can miss their children's cues, and can appear withdrawn and disengaged.

Consider This…

Neglect is not limited to infants and young children. Some people may reserve money that is usually used for children's and household essentials to be diverted to satisfying the needs of the parent or parent's substance use. This can cause difficulty in providing older children with essentials (i.e. clothing and food) and can strain family relationships.

Neglect of Physical Needs

Some of the effects of mental illness can lead parents to neglect their own and their children's physical needs. Most parents, despite the problems they're facing, are still able to look after their children. Unfortunately for some, there are periods of despair or intense symptom response which can cause them to lose sight of their children's needs. Neglect occurs when a parent fails to provide children with basic care. It is important to recognize when a parent's mental health impairs the ability to care for his or her children.

Parent-Child Attachment Relationships

When parents suffer from mental illness or substance use, it can be difficult to engage in relationships with their children. For some parents, symptoms could result in the parent being emotionally unavailable to the child. Parents with substance use problems can be less responsive to their children and less willing to engage in activities or play with their children. Parents with mental illness may not readily recognize their children's cues or sufficiently understand how to respond to such cues. Preoccupation with substances or mental health issues can lead to parents becoming emotionally distant, unavailable, or critical of their children. These concerns impact the parent-child relationship and can lead to insecure attachments. Monitors should be aware of how these mental health issues may impact parent-child interactions during visitations.

STOP and Think

After reading this section, you should be able to answer the following question regarding the case scenario at the start of the chapter.

How might Mr. Winters' mental illness have affected his ability to parent or participate in the visitation?

Impact of Parental Mental Illness on Children

The effect of a parental mental illness on children is varied and unpredictable. It has been found that parental mental illness poses biological, psychosocial, and environmental risks for children; despite these findings, not all children will be negatively affected or affected in the same way. A parent with a mental illness is not solely responsible for problems with the child or family. It is important to consider how mental illness affects a parent's behavior, which in turn affects relationships and may cause risk to the child(ren). Some important factors to consider in determining the level of risk to a child include:

- Child's age at time of onset of parental mental illness
- Severity of parent's mental illness
- Duration of parent's mental illness
- Degree of stress in the family resulting from illness
- Extent to which symptoms interfere with positive parenting
- Child's age and stage of development

Looking more closely at the child's age and developmental stage, Table 10.2 notes the connection between parental behaviors and impact on children. Use this table to identify the negative impact parental mental illness may have on your client's ability to parent. If you see these behaviors, note the potential for negative effects on children and think of ways that your work as a monitor can help.

Table 10.2

Impact of Parental Mental Illness on Children

Age of Child	Parental Response	Impact on Children
Infants - *Birth to 18 months*	• Inability to focus on child's needs • Unawareness of infant's crying • Inability to bond with child • Distraction in caring for child	Child may: - Be neglected - Experience tension and anxiety - Have accidents - Show lack of response - Fail to meet benchmarks in development
Toddlers and Preschool – *18 months to Age 5*	• Inadequate time devoted to caregiving • Misread cues from child • Lack of consistency • Experience extreme stress • Model inappropriate behavior • Provide too much or too little control	Child may: - Experience neglect - Experience tension - Have a lack of supervision - Experience over-stimulation or deficits in stimulation - Be a victim of abuse
School Age – *Ages Six to Twelve Years of Age*	• Inability to assist with child's academic and social development • Inconsistency with discipline • Be unavailable to child • Emotionally unstable and unpredictable • Create a disorganized lifestyle	Child may: - Feel shame and self-doubt - Begin to become aware of social stigmas - Have difficulty with trust - Experience anxiety - Experience emotional neglect - Feel isolated
Adolescence – *Ages Thirteen to Eighteen Years of Age*	• Intolerance of child's moods or needs • Disengagement due to stress • Difficulty in setting boundaries • Inflexibility in meeting adolescent's needs • Restricting adolescent to care for parent or other children	Child may: - Experience loss or disorganization - Feel anxious - Be sensitive to social stigma and peers - Have anger toward parent - Have difficulty concentrating - Experience problems in relationships and/or school performance - Be at risk for substance use

Risk Factors

Children of parents with mental illness are at risk for developing social, emotional, and/or behavioral problems. Factors that place children at risk, especially children of parents with mental illness include:

- Poverty
- Occupational or marital difficulties
- Poor parent-child communication
- Parent's co-occurring substance use disorder
- Aggression or hostility by a parent
- Single-parent households (without a support system)
- Inconsistent and unpredictable family environment

A combination of these factors increases the vulnerability of a child, and visitation monitors should consider how these factors may affect the children with whom they work. Many of these factors can be reduced through preventative strategies. For instance, monitors may provide referrals to outside professionals (substance counseling, mental health professionals) or monitors can work with parents and children to strengthen their relationship during visitation with skill building and communication techniques.

Protective Factors and Mental Illness

One of the most important protective factors for children of parents with mental illness is for the parent to secure treatment. With numerous treatments available, parents can gain control of their symptoms or at least insight into their diagnosis. This will permit communication and strengthen the relationship a parent has with their child.

Other factors that play a role in protecting children from risks include:

- Knowledge that they are not to blame
- Help and support from other family and monitors
- Positive self-esteem
- A sense of being loved by parent with mental illness
- Positive peer relationships
- Interest in school or activities
- Healthy engagement with adults outside the home
- The ability to communicate and articulate feelings

In many cases, families, professionals, and society pay more attention to the parent with mental illness and tend to overlook the children within the family. Monitors can provide more attention and support to children and help them develop healthy coping mechanisms.

STOP and Think

After reading this section, you should be able to answer the following question regarding the case scenario at the start of the chapter.

How might Mr. Winters' illness affect Lisa? What are the risk factors (if any) for Lisa's wellbeing?

Monitoring Parents with Mental Illness in Supervised Visitation

Working with a parent with a mental illness can be challenging, and it is important for the supervised visitation monitor to have some basic knowledge about working with individuals with mental illness. There are many strategies and techniques that can be used to help facilitate a visit between a parent and child. This training offers information about working with parents suffering from mental illness in supervised visitation, what to do in emergency situations, and the importance of documenting incidents.

General Practice Skills for Use with Parents with Mental Illness

Many skills are transferable for all clients, but when working with parents with mental illness, it is important to be mindful of a few specific strategies.

Learn about Mental Illness. This chapter has provided you with a base-level of knowledge about mental illness. Remember, though, the chapter does not make you a professional clinician. When you receive a new referral, be sure to review the file thoroughly. If a mental health professional has been involved in the case, be sure to read his or her notes. Do this to determine whether there is any specific behavior that you should be aware of or on the lookout for.

A Note on Strengths-Perspective:

Using global compliments is a great way to make parents feel comfortable in supervised visitation. An easy global compliment to use is, "Participating in visitation shows how resilient and compassionate you are. It can be difficult to balance all of the things in your life, but you are still determined to be here."

Avoid Stigmatizing Mental Illness. While this may go without saying, it is important for monitors to reflect on their own biases and opinions about mental illness. One thing to consider is that people with mental illness have long faced stigmatization and discrimination. Each person is different and would most likely appreciate our patience and willingness to support their parent-child relationship at visits.

Maintain Confidentiality When Appropriate. Confidentiality is held with all clients, but specifically with parents of mental illness. Sensitivity should be given to their illness. Only essential information should be shared with other professionals. In addition, parents may be concealing their mental illness for their own privacy. Not all factors of one's mental illness is relevant to the safety or work with supervised visitation. Be mindful of the information you share with others in order to maintain trust and privacy.

Focus on Strengths. It may be easy to focus on the problems that an individual is facing, but it is crucial to look past these to work in supervised visitation. Focusing on strengths can help build confidence in the parent and lead to more positive interactions during visits. Despite the severity of mental illness, there are always strengths to highlight and embrace. One parent may express great love for his or her children while another may be honest and kind. Reminding parents and families of their strengths will benefit everyone involved; also, parents may be more compliant and willing to receive assistance with their parenting skills.

Treat Everyone as a Person First. Aside from gathering more information on the client's mental illness, you should approach parents with mental illness the same way you would any other parent. The basics of respect and understanding benefit all individuals. It is okay to discuss parenting strategies and visitation expectations, and to hold parents to the same accountability standard as all other parents. Some mental illnesses may make it more difficult to work with a parent, but using the

People-First Language

Refrain from speaking about a client with disorder-leading terms; People-first language comforts individuals and allows a safe space for services. Example: You should say, "He has been diagnosed with schizophrenia" rather than calling the client "the schizophrenic dad."

parent's strengths as a starting point will help in the communication process. In addition, when determining if a parent is capable of participating in visitation, **remember** that mental illness does not disqualify one from being a parent.

Identifying and Assessing Risks

Many parents may be fully able to interact in an appropriate manner during scheduled visits despite their mental health issues, hospitalizations, or concerns with medication. Some parents with mental illnesses, however, may experience severe disorders in which their thinking or behavior is impaired. Other problems, such as medication management, may reveal 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. The purpose of identifying risks regarding parental mental illness includes:

1) Determining whether mental health status may impair a parent's ability to interact effectively with his or her child during a scheduled visit.
2) Determining whether the child is endangered or upset over the parent's behavior, emotional response, or impaired thinking.

In your initial observations with the parent, you should consider the following:

<u>Parenting</u>

- Is the parent able to attend to the child's physical, intellectual, social and emotional needs during the visit?
- Does the parent have age-appropriate understanding and expectations of the child?
- Does the parent have the capacity to initiate or follow through and participate in child-centered activities?
- Is there a history of physical of sexual abuse in the family between the visiting parent and child(ren)?
- Can the parent follow directions and respect the child's boundaries?

Parent's Mental Status

- What is the apparent level of disturbance, instability, and violent tendencies or impulse control?
- Does the parent exhibit specific behavioral or psychiatric symptoms that impact his or her parenting abilities?
- Does the parent have a sense of responsibility for self, child, and family?
- Does the parent have the capacity to recognize risks to the child?
- Is the parent paranoid? If so, what is the level of paranoia? The greater the level of paranoia, the greater the risk to others.
- Does the parent comply with medications or other clinical interventions that are known to you?
- Is the parent able to form or engage in trusting relationships with visitation staff?

The Child of the Parent with Mental Illness

- Is the child acting developmentally appropriate?
- Does the child exhibit appropriate attachment to parent and to other caregivers?
- Does the child have the capacity for self-protection?
- Does the child exhibit any unusual behaviors or characteristics?
- Is the child highly anxious or fearful of seeing parent?
- Has the child been harmed by the parent?
- Does the child understand the status of the parent's mental illness?
- Is the child embarrassed by the parent's appearance or behavior?
- Does the child blame himself/herself for the parent's condition?

Mental Health Checklist

This is a guide that monitors and program directors may use in determining mental health status and thus risk factors present during a visit. This guide provides a framework to document observations in a consistent manner. Visitation monitors and directors can use this checklist to determine if visits should be held or not. Most monitors routinely look at these categories in their interactions with clients.
Reminder: This is not a comprehensive mental health assessment but should be used at the discretion of the provider to conduct objective assessments. If further assistance is needed, contact a mental health professional.

Appearance

- Disheveled ☐
- Motor Status ☐
  - Tremors ☐
  - Awkward gestures ☐
  - Very slowed ☐
- Bizarre dress ☐
- Exaggerated hair ☐
- Exaggerated makeup ☐
- Other: Appearance ☐

Behavior

- Posture
  - Slumped ☐
  - Tense ☐
- Facial Expressions
  - Fearful ☐
  - Angry ☐
  - Bizarre ☐
- Movement
  - Can't sit still ☐
  - Restless ☐
  - Lethargic ☐
- Voice/Speech
  - Very loud ☐
  - Demanding ☐
  - Scattered ☐
  - Threatening ☐
  - Low Response ☐

Feeling or Mood

- Appears fearful ☐
- Appears depressed ☐
- Elated ☐
- Excited ☐
- Agitated ☐
- Angry ☐
- Tearful ☐
- Perception
  - Hallucinations
    - Visual ☐
    - Auditory ☐

Thinking

- Orientation
  - Confusion ☐
  - Can't identify self ☐
  - No relation to time ☐
- Memory
  - Can't recall info ☐
  - Can't recall visits ☐
  - Can't recall past events ☐
- Thoughts
  - Expresses:
    - Suicidal thoughts ☐
    - Homicidal thoughts ☐
  - Delusions ☐
  - Expresses bizarre beliefs ☐

Staff Limitations

While most staff may not object to identifying possible signs of parental mental illness when those signs seem obvious, some staff members will not be comfortable deciding whether some more subtle signs make a visit untenable. In addition, supervised visitation monitors should not label a client with a mental illness because others may treat them differently and they could become subject to stigma. You should discuss whether or not you feel you can monitor the full array of cases referred to the supervised visitation program with a supervisor. This discussion would provide you with insight on your limitations in working with parents with mental illness. It is important to understand what is appropriate and within your training and skill set during your work with parents with mental illness. The purpose of a monitor is not to diagnose, shame, or counsel a parent, but rather to ensure the safety of the child while interacting with the parent. As you continue to learn about mental health and its impact, consider what situations are beyond your ability to address or work with.

REMINDER:
Monitors DO NOT diagnose or treat mental illnesses. It is important for staff to understand how to work with families coping with parental mental illness and how to respond to escalated situations due to mental illness.

When to Seek Supervisor Assistance

When interacting with parents with mental illness, many observations or symptoms may be complex. With such a sensitive and complex subject, it is best to use supervisor expertise to assist in situations where you may be unsure.

- If parent is acting differently than normal but does not appear dangerous
- If you feel that you are not making objective observations
- If the parent's record indicates the presence of a mental illness that you are unfamiliar with
- If you feel uncomfortable or uncertain in any case
- If the illness presents an unmanageable risk to the visitation.

When to End the Visit

In some cases, symptoms from mental illness may cause problems or discomfort in a visit. To ensure the safety of the child, it is important for monitors to check-in with children throughout the visit. Several situations in which a visit should be terminated are listed below.

- If parent becomes aggressive or insulting to child
- If parent is unable to refocus from delusions or hallucinations
- If parent has delusions or hallucinations that appear dangerous or violent
- If behaviors endanger the child's emotional or physical safety
- If recommended by the supervisor.

Worried you don't have training on observations?

Don't worry, Chapter 15 of this manual will help prepare you for observing and recording during visits.

Just keep reading!

When to Contact Law Enforcement or Security

In some rare cases, a parent may behave or react in a way that would require the intervention of law enforcement. In these cases, parents may be reacting to a medication stabilization, traumatic event, or the overwhelming symptoms of their mental illness. When law enforcement is called for a person whom is mentally ill, a Baker Act may occur. The Florida Mental Health Act of 1971 (Florida Statute 394.451-394.47891 (2009 rev.)), commonly known as the "Baker Act," allows the involuntary institutionalization and examination of an individual. The Baker Act allows for involuntary examination (what some call emergency or involuntary commitment).

The Baker Act is initiated by law enforcement or mental health professionals when an individual presents to be a danger to themselves or others and refuses voluntary treatment. When considering this option, it is important to remember that a Baker Act is a last resort option that leads to involuntary hospitalization. Calling law enforcement can also lead to a situation that is over-escalated; and unfortunately not all law enforcement officers are trained to work with persons with mental illness. It is recommended by mental health professionals to avoid the involvement of law enforcement unless absolutely necessary. Despite this recommendation, you must know when it is appropriate to involve law enforcement for the protection of clients and staff at your program.

- If parent becomes a danger to him/herself or others
- If parent threatens child or staff with violence
- If parent has a weapon of any kind
- If parent threatens harm to him/herself

STOP and Think

When these problems present, monitors must file a critical incident report and may consider termination of the case which are both covered in Chapter 11 of this manual.

When to Make Referrals

As stated earlier, visit monitors may or may not be aware of presenting mental illness in clients. There may be cases when a visit monitor is not aware of any mental health history. Providing any treatment or assessment of clients is unethical and outside of visitation staff's realm of work, but there may be times when staff can make referrals to professional mental health or substance abuse services. It may be appropriate to make a referral in the following situations:

- If parent engages in unusual behavior over extended period of time
- If parent appears to be struggling with changes
- If symptoms appear to interfere with visitation and parent/child relationship
- If parent does not have a case manager or other assistance

When making a referral to parents that may need mental health services, remember that it is important to address the issue sensitively. Parents may be faced with changes and challenges in life and there are many community resources available to help parents with coping skills or other specialized services to address mental health or substance use concerns.

Guidelines for Making Referrals to Outside Services

1. Identify the most appropriate staff member to facilitate the referral process; this will likely be the program director or lead staff member. A supervisor with a good relationship with the parent will be trusted and the parent may be more likely to accept the recommendation. This staff member must have an understanding and respect for the parent's culture such as beliefs, values, norms, and symbolism are all pieces of one's cultural identity. This understanding will help match appropriate services to the parent and the parent will be more likely to participate in services that reflect their values, culture, and preferences.

2. Ensure that staff has knowledge of mental health and substance abuse services available in the local community. Important information to include is who offers services; cost for services; and what type of services are offered (i.e. psychotherapy, support groups, family therapy).
3. Engage parent in a discussion about the benefits of receiving services and what type of help my best match their needs. Also, it is important for monitors to understand relevant barriers that may interfere with a parent seeking services. Barriers can include:
   a. The cost of services
   b. Transportation barriers
   c. Cultural and linguistic competence of providers
   d. Fear of losing other services
   e. Stigma or unpleasant past experiences with mental health services
4. Document referral in client's file. When a referral has been made, monitors must document all relevant information in the file. Also, any referrals or other interaction with parents with case managers must go through the case manager first. A case manager may be able to provide a referral or has already initiated the process of meeting the client's needs.
5. Follow-up with parent. This is important because monitors may need to understand if a parent accepted or denied the referral. A parent may need a different referral or may not be interested in seeking services.

Community Resources

Visitation staff are encouraged to become familiar with services available in the community. Staff can expand their knowledge by exploring a few of the following…

- Mental Health Consultants
- Local Community Mental Health Centers
- Private practitioners (LCSW/LMHC, etc.)

Table 10.3 What Can You Say?	
"I know we've had to reschedule several of your visits this month. It is not uncommon for problems to trickle down into our lives. I was wondering if maybe you'd be interested in working with a social worker from Park Community Services to help with some of the issues you're facing."	"I've noticed you've been going through some difficult times lately. It can be hard to cope with so many challenges at one time. I want you to know that there are services available that might be able to help you through this troubling time. Have you heard of the Stronger Parents Support Group available at Sunrise Community Center? I think you would be able to connect with people with similar experiences to you."
"I know you've been working with your case manager, but we continue to have issues with you arriving for visits intoxicated. Do you think it would be helpful to have more help from someone who specializes in substance use? I can talk to your case manager about possibly providing you with a referral to the Starting Over Treatment Center."	"You are so strong and resilient and you continue to give your best effort. I was wondering if you called the referral I gave you a couple of weeks ago? I hope it was helpful or if not I can find another center that might be a better fit for you."

Strategies for Working with Parents with Mental Illness

During a visit, it is the monitor's job to facilitate a safe interaction between a parent and child. In order for this interaction to be safe, the monitor must be aware of any reports of parental mental illness. It is the monitor's job to be alert, aware, and conscious of the interactions in the visit. Below are some strategies for working with families with a parent who suffers from a mental illness.

Before the Visit

- Review your case file and be aware of any potential mental illness or areas of concern.
- Avoid misinformation or myths regarding mental illness. Research potential diagnosis for a general background about the parent's illness.
- Meet with the parent before scheduling a visit to better understand how he or she acts and is affected by the mental illness. Discuss how the parent is feeling, if they are compliant with their medication, and what other treatment they may be receiving.
- Prepare the visiting parent of expectations during the visit and how their children may react to seeing them and their behavior.
- Meet with the children before the visit to better understand what they may be feeling. Allow them to voice any concerns they have. Assure them that you will be there to make sure the visit is safe.
- Inform the children in an age appropriate manner why their parent may be acting different because of their illness or medications.
- Reduce any excess noise or distractions in the room where the visit will be taking place. Avoid televisions, radios, cell phones, hand held games, etc.

During the Visit

- If the parent becomes agitated or upset, ask the parent if he or she needs to take a break. If the parent takes a break, see if time away provides the necessary opportunity to continue the visit. If the parent is still upset after the break, ask if the parent would like to terminate the visit.
- If the children become agitated or upset, ask if they need to take a break. If the children are still upset after the break, ask if they would like to terminate the visit.
- If the parent expressed delusional thinking or hallucinations, DO NOT deny or affirm these. Try and refocus the parent on the visit and the children.
- If the parent engages in behavior that compromises or endangers the emotional or physical safety of the children, end the visit.

After the Visit

- Document the case. Include any objective information about behavior or appearance on the part of the parent. (e.g. "Parent stated that aliens were a threat," rather than "parent disclosed abnormal beliefs about aliens.")
- Check in with the children and see how they are feeling after the visit. If they are uncomfortable with visiting their parent in the future, give them alternatives such as having a shorter visit, drawing a picture, or writing a letter.
- Consult the case manager to ensure that therapy or treatment is offered to the client.
- Make sure everyone leaves the facility safely and separately.

Interacting with Children of Parents with Mental Illness

As you've read in earlier sections of this chapter, children of parents with mental illness are at a much higher risk for numerous social, behavioral, emotional, and psychosocial issues. When working with children of parents with mental illness, it is important to recognize how parental mental illness may affect them; and how your interactions in supervised visitation can support children of parents with mental illness.

REMINDER:

Every family and child is different. Some parents may choose not to share information about their mental illness with their children. Honesty and information is important if the child asks or if there are obvious issues during visitation related to the parent's mental illness.

Speak with a supervisor and the parent prior to the visit regarding what is appropriate to discuss with a child.

Guidelines to Interaction with Children of Parents with Mental Illness

1) **Reassurance** is a key part of working with children. It is important for children to know that they're not alone. Dealing with issues related to mental illness during visitation can cause a lot of confusion for children. In some cases it may be appropriate and necessary to refer the child or family to support groups about coping with parental mental illness. The opportunity to talk with others facing similar situations is comforting and healing.
2) **Honest acknowledgement** of the difficulties facing parents and children is important. This helps to dispel any secrecy or shame related to mental illness. While some may think it is preferred to protect children from harsh

topics, this can lead to resentment and misunderstandings. It is important to talk openly about problems to avoid adding stress or shame to the problems.

3) **Information about the illness** can help children understand what is happening to their parent and themselves. Talking openly about these issues helps reduce the stigma and encourages children to have comfort in supervised visitation.
4) **Remind children they are not to blame** to relieve guilt and shame. It's reassuring for children to be told they didn't do anything wrong and problems are not their responsibility.
5) **Allow kids to be kids** especially in supervised visitation. There may be preoccupation with the parent's mental illness and even added burdens or responsibilities. Time in visitation should focus on the relationship and not the parent's mental illness.
6) **Offer a safe space** for children to talk. For monitors, this includes making referrals to community groups,
school counselors, or religious leaders. A positive adult to talk to is key to better outcomes for children of parents with mental illness.

STOP and Think

After reading this section, you should be able to answer the following questions regarding the case scenario at the beginning of the chapter.

- What is the best time to address Mr. Winters' irregular behavior? Before the visit starts? In the middle of the visit?
- How would you deal with the incident of aggression during the visitation? What protocol or safety measure would you take?
- What precautions could have helped to avoid the situation with Lisa?

Part 2
Substance Abuse

Looking more closely at mental illness, it is important to understand that substance use and abuse are categorized by the American Psychological

Association as a mental illness. Substance use, abuse, and addiction can cause fundamental changes in the brain, which can disturb a person's cognitive abilities, behaviors, and emotions. Because of this brain disturbance and the symptoms that come from substance use and abuse, a definition of a mental disorder is given. The substance- related disorders are separated into two categories including substance use disorders and substance-induced disorders. Monitors will be able to understand mental illness and substance abuse as separate bodies and also how they relate to and impact each other.

Substance abuse disorders account for many referrals to supervised visitation programs. Frequently, substance abuse disorders include alcoholism, prescription abuse, and other drug use. Sixty percent of the world's illegal drugs are consumed by drug users in the United States. This consists of two million Americans who use heroin, six million who use cocaine, and eighteen million who have alcohol abuse problems. Children who witness parental substance abuse are more likely to experience physical, sexual, and emotional abuse and neglect. Substance-related disorders are separated into two categories and monitors should understand how the characteristics of each differ. Not all parents with substance-related disorders will use the same substance or display similar symptoms. Understanding the variety of substances used will provide insight for monitors working with parents with substance-related disorders.

Substance use disorders include a pattern of behaviors related to the use of the substance. Symptoms of substance use are separated into four categories.

1) ***Impaired control*** – Taking larger amounts of substance than intended; most daily activities revolve around substance; intense desire for substance; great deal of time spent obtaining, using, or recovering from effects of substance.
2) ***Social impairment*** – Failure to fulfill major role obligations at work, school, or home; continued use despite social problems; important activities may be given up for substance; withdrawal from family activities and hobbies.
3) ***Risky use*** – an individual's failure to abstain from using the substance despite the difficulties caused; continued use in dangerous situations or despite the negative effects of use.
4) ***Pharmacological criteria*** – built tolerance to substance;

withdrawal occurs after prolonged heavy use of the substance.

Substance-induced disorders include intoxication and withdrawal of substances. These disorders have symptoms that are attributable to the physiological effects of the substance on the central nervous system and develop shortly after use of a substance. The overall categories for substance-induced disorders includes:

1) Intoxication
2) Withdrawal
3) Substance/medication-induced mental disorders (e.g., substance-induced psychotic disorder, substance-induced depressive disorder)

These are only general definitions of how substance disorders are categorized; and understanding the complexity of substance disorders will assist monitors when faced with diverse parents experiencing unique symptoms or disorders. In addition, it is important to understand the different substances parents may use and their effects.

NOTE

Pull out a piece of paper and read each of the substance categories listed in Table 10.4. For each category, try to write down as many street names as possible for each substance.

You might be surprised at how many you can list! The matching activity at the end of the section may have some street names you don't know.

Commonly Abused Substances

Substances are placed into categories for classification purposes. Within these categories, there are numerous substances used and abused by individuals. Monitors should be aware of the substances that are used by individuals as well as the many labels or street names given to these substances. In addition to natural substances, there are many man-made or synthetic drugs being produced continually. These new drugs, along with all substances, can go in and out of style; these trends are important to note and understand their impact on visitations or clients.

Table 10.4
Commonly Abused Substances and Their Effects

Substance	Effects of Intoxication	
Alcohol	• Reduced inhibitions • Slurred speech • Motor impairment • Breathing problems	• Confusion • Memory problems • Concentration problems

Cannabis (Hashish, Marijuana)	• "High" feeling • Euphoria • Grandiosity • Sedation • Sensation of time passing slowly	• Lethargy • Impairment in short-term memory • Impaired judgment • Distorted sensory perceptions • Impaired motor performance
Hallucinogens (LSD, PCP, Mushrooms)	• Distorts a person's perception of reality • Seeing images, hearing sounds, and feeling sensations that seem real but are not. • Rapid, intense emotional swings	• Sweating • Tremors • Palpitations • Blurring of vision • Reduced coordination
Inhalants (Propane, paint thinners, glue)	• Feeling of euphoria • "High" feeling • Dizziness • Incoordination • Slurred Speech • Lethargy	• Tremors • Muscle weakness • Belligerence • Severe mood swings • Loss of consciousness
Opioids (Codeine, Heroin, Morphine, Opium)	• Small pupils • Slowed breathing • Absent breathing	• Extreme fatigue • Changes in heart rate
Sedative, Hypnotic, Anxiolytic Drugs (Depressants, Barbiturates, Ativan, Valium)	• Slurred speech • Incoordination • Impairment in attention	• Stupor or coma • Impairment in memory
Stimulants (Amphetamines, Cocaine)	• Auditory hallucinations • Paranoid ideation • "High" feeling • Euphoria • Hyperactivity	• Restlessness • Anxiety • Alertness • Grandiosity • Repetitive behaviors • Impaired judgment

Continuum of Substance Use

The DSM V recognizes substance use disorders on a continuum of mild, moderate, or severe. An individual moves along this continuum in regard to the frequency of their substance use. Monitors should understand the different categories of substance use and recognize the impact of each category on the individual. It is also important to note that not all individuals move progressively from one stage to the next. Some individuals may skip stages or remain in stages for long periods of time.

Table 10.5

Continuum of Substance Use

Stage	Description of Stage
Non-use	-Individual has chosen not to use a substance for personal, religious, or cultural reasons
Experimental Use	-Individual begins to explore a substance and may be pressured by friends, family, or social pressures -May lead to long term damage, continued use, and problematic health effects
Casual Use (Mild)	-Use to experience effects, reduce anxiety, stress, or to socialize -May be common to use in social situations; can increase due to reliance of using substance in a social setting
Frequent Use (Moderate/Dangerous)	-Routine of heavy or binge use -Changes in behavior may be apparent -May feel symptoms of non-use
Severe Substance Use	-Compulsive use of substance; user cannot cease usage despite attempts -Daily functioning and health status deteriorate -Social isolation occurs

Substance Abuse Recovery and Treatment

Treatment for substance-related issues can 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 the person using substances, motivation of abuser as well as other factors. It is important for monitors to understand that treatment is different for every person and how to make referrals when necessary.

Because enabling is a common problem with substance abuse, the entire family may need to be involved in the treatment program. Enabling is when a person, such as a family member, allows, tolerates, or even facilitates the person's, using substances, destructive behavior. Enabling comes in many forms and is not just the act of helping a person using substances acquire substances. For example, an enabling family member may cover for the person's, using substances, bad behavior, such as making excuses for a missed visitation appointment. When the entire family participates in recovery, trained professionals will be able to help the abuser and enablers.

REMINDER:

As with any mental illness, monitors DO NOT provide treatment of any kind for substance use disorders. Rather, monitors should be aware of the resources available in their communities to assist with such issues and make referrals if appropriate and necessary.

Treatments are available through a variety of interventions, such as:

- Assessment and treatment planning
- Prescription of specific medications
- Crisis intervention
- Detoxification and other medical assistance
- Case management
- Family therapy
- Individual and group psychotherapies
- Integrative therapies: acupuncture, diet, exercise, yoga, meditation

- Self-help groups (AA, NA)

Staff should routinely be alert to alcohol and drug use in parents or caregivers referred to the program. While substance use 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.

Monitoring Parents with Substance Use Disorders in Supervised Visitation

Visit monitors will encounter parents in varying stages of substance use and recovery. This section describes the reaction of substance-using parents to seeing their children in supervised visitation settings. These reactions may include anger, depression, hostility, denial, and/or aggression. Likewise, this section will describe the broad spectrum of reactions that children may experience when visiting a parent with a substance-related disorder. It is important for monitors to understand substance use to provide a safe setting for visits and to reduce the risk to children or other program participants.

Parental Substance Use and Parenting

A parent's substance use may affect his or her ability to function effectively in a parental role. When parents provide ineffective parenting it can be due to some of the following:

- Physical or mental impairments cause by alcohol or other drugs
- Reduced capacity to respond to a child's cues and needs
- Difficulties regulating emotions and controlling anger and impulsivity
- Disruptions in healthy parent-child attachment
- Spending limited funds on alcohol and drugs rather than other essentials
- Spending time seeking out, manufacturing, or using alcohol or other drugs
- Incarceration, which can result in inadequate or inappropriate supervision
- Estrangement from family and other social supports

Parents with substance use disorders may experience a chaotic or unpredictable home life and this may impact their ability to provide adequate and appropriate care for their children. In addition, different substances may have different effects on parenting and safety. Moreover, risks for children's safety may differ depending upon the level and severity of parental substance use.

NOTE

Threats to a child of a parent who becomes sedated and inattentive after drinking excessively differ from the threats posed by a parent who exhibits aggressive side effects from methamphetamine use.

Impact of Parental Substance Use on Children

Children of parents with substance-related disorders typically experience negative consequences of their parents' abuse. Parental substance use negatively affects a child's development, causing increased risk of long-term problems for a child including greater risk for child abuse and neglect. Some consequences of parental substance-use include the following:

- Disruption of the bonding process
- Emotional, academic, and developmental problems
- Lack of supervision
- Children become caregivers
- Social stigma
- Adolescent substance use and delinquency

Behavior – Children in substance-using 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 classes, to transfer schools frequently, to experience economic problems, to be aggressive, and to have encounters with law enforcement. Children may also be more at risk for both physical and sexual abuse than children in non-substance abusing homes.

Medical – 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

hazardous accidents. Additionally, significant alcohol use by women during pregnancy can increase the risk of Fetal Alcohol Syndrome or Fetal Alcohol Effects in infants, which in turn results in lifelong, dysfunctions for children. Further, children of substance users may exhibit "failure to thrive" syndrome because of their experience with neglect.

Educational – 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 – A large proportion of children who have been exposed to parental substance use 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 lead to eating disorders, anxiety/depressive disorders, and drug or alcohol use.

Identifying Parental Intoxication

Visitation staff may be called upon to determine whether a parent is intoxicated during intake or for visitations. Beyond the commonly described signs of intoxication, there are other observable signs to be noted. 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 may use breathalyzers or other tools to assess parental intoxication or even use security staff to make this assessment. Other programs may require a drug test to be administered preceding a scheduled visit. In these programs, visits may be cancelled if the test returns positive results. While it may be beyond a monitor's expertise to confirm whether a parent is intoxicated, a visit monitor can determine by the parent's presenting behavior whether the visit should proceed.

Monitors should focus on the parent's behavior and whether it justifies terminating or canceling a visit.

The table below will assist monitors with assessing if a parent is intoxicated. It is recommended for monitors to review intakes or case files to know what a parent's primary substance(s) is before seeking out observable symptoms of intoxication.

Table 10.6
Observable Symptoms of Intoxication

Substance	Observable Symptoms of Intoxication	
Alcohol	• Odor on breath • Flushed skin • Difficulty focusing	
Narcotics	• Constricted pupils • Euphoria • Drowsiness/sleepy • Nausea	
Tranquilizers and Sedatives (Barbiturates)	• Dilated pupils • Decreased alertness • Disorientation • Loss of coordination • Confusion	• Slurred speech • Sleepiness • Dizziness • Withdrawal
Cannabis	• Dilated pupils • Bloodshot eyes • Disorientation	• Dry mouth/throat • Unusually talkative • Unusually quiet
Hallucinogens	• Dilated pupils • Hallucinations • Panic	• Unpredictable behavior • Paranoia • Exhilaration
Inhalants	• Exhilaration • Irrational behavior • Drunk appearance • Confusion	• Runny nose • Watery eyes • Substance odor
Stimulants	• Increased alertness • Agitation • Excitement • Euphoria	• Activeness • Runny nose • Dry mouth
Opioids	• Constricted pupils • Euphoria • Nausea	• Drowsiness • Sleepiness

Symptoms that Mimic Intoxication

Monitors should be observant and aware of parental intoxication for safety; although, there are many problems unrelated to substance use that may mimic symptoms of intoxication. This can place monitors in difficult situations to determine if symptoms impede upon the ability to conduct a visitation. With this consideration, monitors should be aware that parents may face a number of conditions that can lead to unusual behaviors. To avoid conflict when determining if a visit should proceed with unusual parent behavior, monitors must focus on the behaviors presented and determine if such behaviors will affect the visit negatively. When in doubt, a monitor should consult with a supervisor about the conduct of a visit. Monitors should become familiar with some of the conditions that may reflect symptoms of intoxication; this will assist with dispelling confusion around parental conditions and behaviors.

Consider this…

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 or substance use conditions unless their behavior threatened the safety and well-being of others.

Review the risk assessment and mental health checklist to determine if a parent can participate in visitation.

Over-the-counter medicines (OTC) – OTC's are used to treat many conditions from the common cold to weight issues. Some people may experience unusual effects from these medicines. For example, antihistamines may make users drowsy; decongestants and diet formulations can make users agitated and/or dazed.

Prescription medications –Medication that has been properly prescribed may have side effects that mimic intoxication. For example, some anti-nausea pills make users sleepy, as do medically prescribed and legitimately used barbiturates, tranquilizers, and painkillers. Some antipsychotic medications make users appear to be lethargic.

Physical disabilities/health conditions – Some health conditions like diabetes may lead to symptom similar to intoxication. For diabetes, a condition called ketoacidosis can cause a person's breath to smell of alcohol, and at times the person can feel faint or woozy; this condition may be easily mistaken for drunkenness. Meneire'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 illness – As stated throughout this chapter, many symptoms of substance use and mental illness overlap. It is important to focus on the parent's behavior, instead of trying to determine exactly what has caused that behavior.

STOP and Think

After reading this section, you should be able to answer the following question regarding the case scenario at the start of the chapter.

After hearing the statement from the other monitor, how would you determine if Mr. Winters was intoxicated or unable to continue with the visit?

Strategies for Working with Parental Substance Use

Parental Behaviors

Monitors may face various parental behaviors and characteristics that are associated with substance use. These behaviors can have an effect on staff and children involved with the visitation. Parental behaviors include:

- Denial of abuse
- Anger
- Aggressiveness
- Verbally aggressive
- Poor impulse control
- Physically ill
- Poor hygiene
- Threatening behavior
- Poor reliability

How does this affect children?

- **Children in families facing parental substance use may demonstrate:**
  - **Frustration**
  - **Anger**
  - **Mistrust**
  - **Fear**
  - **Embarrassment**
  - **Self-blame**
  - **Uncertainty**
  - **Anxiety**
  - **Guilt**
  - **Sadness**

Refer to *Guidelines for Interacting with Children of Parents with Mental Illness*

Interacting with Parents

If a worker has observed parental behavior that indicates substance use may be a problem, 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. Some general tips for working with parents with substance use concerns include:

NOTE

If you must end a visit, it is important to use simple and direct language.

"I'm sorry Mr. Jacobs, the visit won't be held today. We will reschedule for next week"

- Use assertive communication skills
    1. Avoid lecturing
    2. Use "I" statements rather than "You" statements
    3. Keep verbal communication simple and direct
- Separate the parent from other clients
- Focus only on disruptive behavior at the moment it occurs – avoid any past issues with the parent
- Assess for medical need – if the parent passes out, has difficulty breathing, exhibits signs of withdrawal, or appears to be an immediate danger to himself or others, call for medical or law enforcement help
- End the visit
- Document the termination after the parent has left the premises
- Provide reports pursuant to program policy

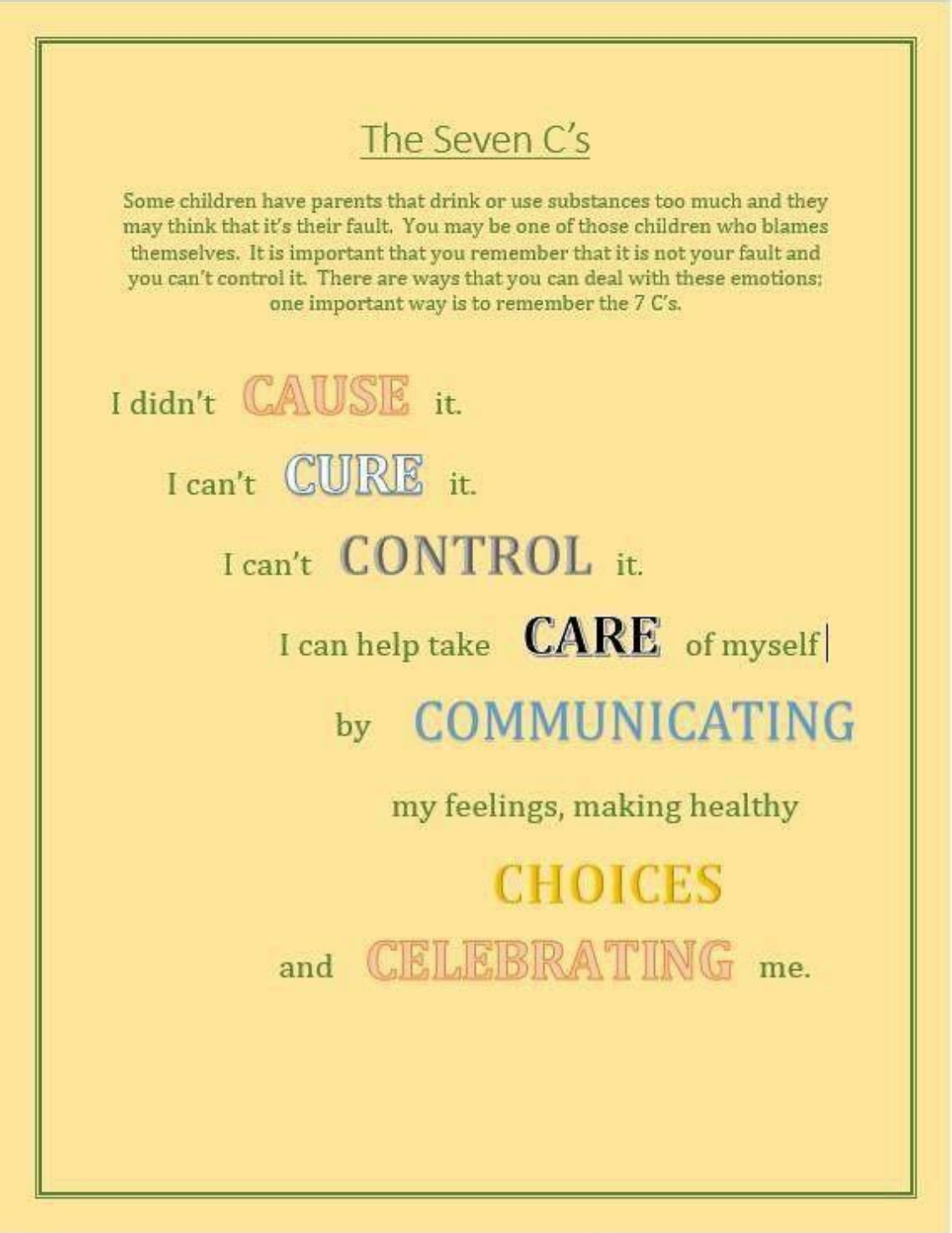
When parents express negative behaviors, staff may be affected in the following ways: feelings of frustration/annoyance with parent, fear of physical harm, being yelled or cursed at, need to seek medical attention for parent, and may need to reschedule or cancel visits. When these occur, it is important for monitors to refer back to the section on *Monitoring Parents with Mental Illness in Supervised Visitation.*

Interacting with Children of Substance-Using Parents

Children living with parents with substance use problems need support and constructive strategies for coping with their life situations. Some general interactions that can help children in these situations include:

- Recognize a child's resiliencies
- Encourage problem-solving skills
- Assist them in building relationships with positive adult role models
- If appropriate, remind children that they are not to blame for parent's addiction
- Let children know that they are cared about in your program
- Encourage children to ask for assistance during visits, if needed
- Try to provide consistency during visits
- Emphasize to older children that addiction is a disease and that parent behaviors may be unpredictable when using substances.

See Seven C's Handout



Talking with Children About Substance Use

It can be difficult to talk to children and adolescents about drug use. However, studies show that children who are properly informed about drug use and the risks involved are less likely to experiment with drugs. Parents who are educated about drugs can talk to children about the risks in case a child is ever in a situation to use drugs.

The old saying "just say no" does not provide adolescents and children with the reasons why they should not use drugs, the safety concerns with drug use, or the legal consequences of drug use. Instead of just saying no, consider the information below before talking about drug use.

How to Talk about Drug Use

How you talk to children about drug use depends on his/her age and level of understanding. Review the following chart for tips on how to talk about drug use with a child. These conversations should happen early and often to reinforce facts and ideas and to let children know that he/she can ask about drugs in a judgment free zone.

Age	How to Start the Conversation	Physical Risks	Legal/Social Risks
4-7	Find moments to start the conversation, like when giving the child medicine for a cold, or at the doctor. Talk to your child about how he/she should only take medicine that you, a specific caregiver, or a doctor provides, and never take medicine from a stranger, a friend, or other adults.	Let the child know that taking medicine he/she is not supposed to take can make him/her really sick. If the child is mature enough, explain that it can even cause death.	Focus on building trust between you and the child, and make sure he/she knows he/she needs to ask before taking any medicine from anyone other than a parent or doctor.
8 – 12	Begin a conversation by asking child what he/she thinks or knows about drugs. Ask questions in an open, non-judgmental way to get an honest	Talk to child about specific drug names. Let them know drugs can cause addition,	Discuss how some people may think drugs are safe, but that drugs are not safe in any amount.

Age	How to Start the Conversation	Physical Risks	Legal/Social Risks
	response from the child. You do not want the child to think he/she is in trouble. Use examples in the news to help introduce the topic.	illness, and/or death. Ask child if he/she has any questions.	Explain to child that using drugs is against the law.
13-18	At this age, children are more likely to be exposed to drug use within their peer group. Talk to child about specific scenarios, asking "what would you do?" Provide your child with ways he/she can leave an uncomfortable situation and say no to using drugs.	Talk to the child about specific drug names. Let him/her know drugs can cause addition, illness, and/or death. Ask child if he/she has any questions.	Talk about how drug use can affect a person's ability to think, learn, go to college, drive, and live. Discuss the child's goals and how drug use will impede his/her goals.

What Would You Do?

The following scenarios can be shared between a parent/caregiver/ and child to facilitate a conversation about drug use and how to say no. Remember that just telling a child to say no will likely not yield results. It is important for children to have practice in how to say no and how to respond to certain situations.

Age	Scenario	Answers
4 – 7	"What would you do if a teacher gave you pills at school?"	Call a parent/caregiver to ask permission before taking the pill.
	"What would you do if grandma gave you medicine?"	Discuss with your child if this person is allowed to give him/her medicine.

Age	Scenario	Answers
8-12	"What would you do if you saw drugs near you?"	Find a parent/caregiver or teacher and let him/her know
	"What would you do if a friend said he/she knew where to find drugs?"	Say drugs are not safe and that he/she should leave them alone.
13-18	"What would you do if you were at a party where people were doing drugs?"	Leave the room safely and do not use the drugs.
	"What would you do if a friend offered you drugs?"	Say that you do not use drugs and leave the situation safely.

Part 3
Dual Diagnosis

Mental illness and substance abuse often co-occur – they affect people at the same time. The co-occurrence of these conditions is often called dual diagnosis; though, there is some debate about the usefulness of this term. Within the supervised visitation setting, monitors will likely have clients that are known to have one of these issues. Therefore, monitors should be knowledgeable about the co-occurrence of these conditions.

What is Dual Diagnosis?

For the purposes of this training, dual diagnosis is when a person suffers from both a mental illness and a substance abuse problem. The individual has a diagnosis under two categories: mental illness and substance abuse. It may refer to individuals with more than one mental health or substance abuse diagnosis. Dual diagnosis covers all forms of co-occurring substance abuse problems and mental

illnesses defined by the American Psychiatric Association. Some common examples of mental illnesses included in dual diagnosis are depression, anxiety, schizophrenia, and bipolar disorder. Under dual diagnosis, substance abuse refers to any alcohol abuse, illicit drug abuse, prescription drug abuse, or dependence. Though dual diagnosis concerns the co-occurrence of two conditions, either condition may develop first. For example, a person with a mental disorder may turn to substance abuse as a coping mechanism, or a person with a history of substance abuse may develop emotional and mental problems due to the abuse.

What is the Relationship Between Substance Use and Mental Illness?

The relationship between mental illness and substance use is complex. The relationship can be discussed in a few ways:

- For people with mental illness, drugs and alcohol can be a form of self-medication. Many people with mental illness go untreated because they have developed a coping mechanism with substances. Even if substance use alleviates problems in the moment, they do not treat the underlying condition and can, in fact, make it worse.
- Drugs and alcohol worsen underlying mental illnesses; especially during acute intoxication and during withdrawal from a substance.
- Drugs and alcohol can induce the onset of mental illness symptoms in a person with no previous mental health history.

While recent research and popular literature have seen the growing use of the term dual diagnosis, some argue against using the term because:

- The term has been used to refer to people with other combinations of illnesses, such as individuals with mental illness and developmental disabilities, or with more than one mental illness, like depression and anxiety.
- Some individuals experience more than two disorders, such as substance abuse, bipolar disorder, and anxiety.

Why do Mental Illness and Substance Abuse Often Co-occur?

- Mental illness and substance abuse frequently co-occur for a variety of reasons, including stress, trauma, genetics, and brain deficits.
- Clients with mental illness, stress, or trauma may use substances to self-medicate. In turn, self-medicating can increase vulnerability to mental illnesses.
- Research has shown that addiction and mental illness share common genetic traits. Thus, some people are at risk for developing either condition from birth.

Examples of the Dual Diagnosis Relationship

- **A person with depression can become suicidal when under the influence of alcohol.**
- **A person with panic attacks experiences worsening symptoms during heroin withdrawal.**

- Mental illness and substance abuse affect similar areas of the brain. Because similar brain areas and functions are affected, the development of either mental illness or substance abuse can substantially impact the development of the other.
- Some people use alcohol and other drugs as a coping mechanism for events in their life. A victim of, for example, child sexual abuse or domestic violence may numb his/her feelings with alcohol or drugs. At the same time, that individual may experience depression, anxiety, or other disorders like PTSD as a result of the same traumatic experiences. The substance use and mental illness may be caused by trauma from the past.

How Do Dual Diagnoses Affect Clients?

Dual diagnosis affects many aspects of a person's life, including feelings, mood, behavior, and social interaction. When one member of a family has dual diagnoses, that member can cause strain on the entire family relationship due to difficulties with finances, maintaining employment, physical health issues, and social functioning problems. It is important for supervised visitation personnel to be able to identify this issue to assist the person in getting help, which will improve the family relationship. Supervised visitation personnel should also be proactive for safety reasons. Persons with dual diagnoses have been identified as being more likely to commit violence than persons without such diagnoses. Substance abuse paired with mental illness can increase risk of frequent or lethal violence.

Symptoms of Dual Diagnosis

The symptoms of mental illness and substance abuse overlap, which can make identifying dual diagnosis difficult. Symptoms such as depression, paranoia, anger

issues, erratic behavior, social withdrawal, and sudden mood swings are shared characteristics. These symptoms may lead a parent to:

- Fail to make visitation visits
- Become forgetful
- Hide or lie about substance use
- Continue substance use despite negative consequences
- Be unable to maintain employment

Helping Clients with Dual Diagnosis

As a monitor, you won't diagnose mental illnesses or dual diagnoses. You may wonder how you will know that a client is diagnosed with co-occurring disorders. You may become aware of a client's mental health or substance abuse status through use of the following:

- Mental health records
- Case manager alerts monitor
- Previous arrest records
- Allegations from the other party

Your job as a supervised visit monitor is to create a safe environment, to report potential problems, and to improve the family relationship. The best way you can do this for a family with a member suffering from dual diagnoses is to alert the case manager, refer the client to a treatment facility, and/or encourage the client to seek help. Dual diagnoses require professional treatment.

Your role as a supervised visit monitor is critical to the success of the family because research has shown that the more risk factors a family is exposed to, the higher the risk to the child's welfare. When a parent suffers from just one condition, such as substance abuse, mental illness, or domestic violence, the child is at risk, but that child's risk increases when multiple factors are present. Therefore, being aware of dual diagnosis is one way you can be a part of the family's success.

Dual Diagnosis: What Does Treatment Look Like?

In the past, when service providers worked with individuals with a dual diagnosis, they treated each diagnosis separately, working with one disorder first and then the other. It soon because obvious this method of treatment wasn't working, as people with substance abuse problems were denied treatment for their mental health disorder because of their addiction; however, they could not receive treatment for substance abuse because of their mental health disorder. Additionally, some substance abuse treatment programs believed that those with mental health disorders should stop taking all medicine including mental health prescriptions, as total detox was needed for rehabilitation.

New Treatment Methods

Counselors have struggled with treatment and have begun exploring new treatment methods**. Parallel treatment**, treating each diagnosis at separate facilities at the same time, was thought to be a solution for dual-diagnosis services, however, the difference in treatment locations and methods made the process difficult for patients.

Integrated Treatment

Integrated treatment is the most accepted method of treating individuals with dual-diagnoses.

Integrated treatment involves getting treated for mental health disorders and substance abuse at the same program, often by the same counselors (or counselors who work together to provide improved services). Though integrated service can be difficult, integrated models of treatment for dual-diagnosis are more successful than other treatment options.

Successful integrated treatment programs usually involve the following:

- Multidisciplinary treatment teams (psychologists, social workers, medical professionals, etc.)
- Interventions based on an individual's stage in treatment
- Access to services (housing, employment assistance, food assistance)
- Service without time restrictions

- Assertive outreach (i.e. rehabilitation counselors extend help without waiting to be asked)
- Motivational interventions (improve and inspire)
- Substance abuse counseling
- Group treatment
- Educating the family regarding the individual's mental health and substance abuse disorders
- Participation in alcohol & drug self-help groups
- Pharmacological treatment (medication for the mental health disorder)
- Interventions promoting healthy choices

Variations by Client

Treatment for a dual-diagnosis may look different than treatment for those with a substance abuse problem. Clients with dual-diagnoses may go through treatments more slowly than others; they may be dealing with their dual disorders and may not complete their treatment as quickly as individuals with one diagnosis.

As a visitation supervisor, you likely won't be designing dual-diagnosis treatment programs; however, you will certainly work with adults with dual-diagnoses and will likely supervise parents undergoing treatment for their dual-diagnoses. It is important to be respectful of their treatment and the ways treatment may impact visitations. Additionally, it is important to emphasize the positive impacts of treatment by recognizing progress the individual may have made. By providing positive reinforcement and understanding difficulties, you will be able to support positive visitation experiences.

The Interface Between Mental Illness and Domestic Violence

The vast majority of abusers do not have a mental illness. Mental illness does not cause domestic violence, nor should it be considered a justification or excuse for violence. Victims of domestic violence, however, are more likely than non-victims to develop a mental health disorder at some point in their lives. Domestic violence is associated with many mental health concerns such as depression, anxiety, panic attacks, substance abuse, and posttraumatic stress disorder. Monitors should be aware of the impact violence may have on victims and consider the role it may play in visitation.

NOTE: BE AWARE

Perpetrators will often use the victim's anxiety or depression to "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 decline when the victim feels that she and her children are safe.

Victims of domestic violence may exhibit behaviors that can be mistaken for mental illness. Adult victims of domestic violence commonly experience depression and symptoms of posttraumatic stress disorder, including sleep disorders, anxiety, hyper-vigilance, stress, and fear. A victim exhibiting these symptoms may appear disorganized or even paranoid. This may simply be frustration expressed with a system that is difficult – and dangerous – to navigate. If monitors do not understand how domestic violence may affect behaviors, they may make the situation more dangerous by deciding that the parent is delusional, paranoid, or unreasonably angry. The Clearinghouse recommends that supervised visitation programs receive cross training by staff of certified domestic violence centers to learn about victim dynamics and the services offered by the centers. Remember, the best local resource for victims of domestic violence are those local advocates, who can conduct private risk assessments, provide safety planning, and connect victims to legal and social services assistance.

Substance Use and Domestic Violence

Research tells us that these two issues are correlated and that substance use is a risk factor for more severe domestic violence; however, substance use does not cause domestic violence. Because of the close association, it is important to be aware of both domestic violence and substance use when they co-occur.

Blaming the violence on the substance inappropriately shifts responsibility from the perpetrator to the substance or addiction.

Table 10.7

What to Remember about Domestic Violence

Control – Domestic violence is a pattern of behavior with the intent of asserting power and coercive control over one's partner. Each act of abuse, threat, or control tactic is chosen deliberately by the abuser to gain control over the victim.

Awareness of Actions – The abuser is abusive and violent both when sober and when under the influence. Intoxication and addiction are used as excuses for the abusive behavior.

Choice – Domestic violence perpetration is a choice, not a disease or mental health/psychological problem. The individual is choosing to be violent and harm others in order to be in control, and usually the perpetrator feels justified in his/her ways.

Accountability and Education –Court-ordered programs for abusers should focus on accountability and changing violent attitudes and behavior. All re-offending is viewed as unacceptable, as it inherently harms the victim and children.

Effects on Perpetrators and Victims

Some domestic violence victims may begin to use or abuse drugs/alcohol as a means of coping or self-medicating. Victims who abuse substances may be sabotaged in their recovery efforts by the abuser, who may prevent them 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 keeping themselves and abuser intoxicated may prevent further abuse. The abuser may threaten to harm children or victim if the use of substances does not continue.

Refer to Chapter 13 for more information on the dynamics of domestic violence and how they may play a role in supervised visitation.

PRACTICE EXAMPLES

Case Scenario 1

Wanda brings her three children to a scheduled visit to see their father. There is a history of domestic violence and the court has ordered supervised visitation. The children appear unwashed and wear dirty clothing. Wanda is very tearful and upset, confiding in staff that she has been unable to sleep, is anxious, can't concentrate, and is unable to tend to her children's needs. There are no mental health issues listed on the intake and screening forms.

Discussion Questions:

1. What issues could Wanda be facing?
2. How could a visitation monitor help Wanda?
3. How might a visit monitor facilitate a visit in this case?
4. How should a monitor respond to Wanda's behaviors?
5. What role can the local certified domestic violence center play in helping Wanda?

Discussion Questions:

1. How might Fred's children react to his condition?
2. What issues could come up during supervised visitation with the children? How should you prepare for it?
3. What resources could you provide the custodial parent?
4. How would you address questions from the children about Fred's condition?

Case Scenario 2

Fred is the father of two children, ages ten and twelve. He has a long history of depression and six months ago, attempted suicide. 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. At intake staff meet Fred, who is extremely quiet and sad, saying very little. His medication adds to his lethargy. He wants to see his children, but can express no enthusiasm. He does not smile or make eye contact.

Test Your Knowledge!

Take this quiz to see what you have learned from the training.

1. **TRUE or FALSE: Mental illness impacts every person in the same way, including one's children and environment.**

2. **Focusing on a client's_____can help build confidence of the parent with mental illness and lead to more positive interactions during visits.**
   a. **Disorder**
   b. **Strengths**
   c. **Opinions**

3. **All of the following should happen before a visit with a parent with mental illness EXCEPT:**
   a. **Review a client's file**
   b. **Risk Assessment**
   c. **Give parent suggestions for medication**
   d. **Reducing excess noise and distractions**

4. **If a parent describes violent or aggressive hallucinations/delusions, what should a monitor do?**
   a. **Baker Act parent**
   b. **Terminate visit and contact law enforcement**
   c. **Ignore parent's hallucinations/delusions**
   d. **Tell parent that the delusions are not real**

5. **There are many other conditions that mimic intoxication including:**
   a. **Diabetes**
   b. **Mental illness**
   c. **Prescription of Valium**
   d. **All of the above**

6. **TRUE or FALSE: Parental mental illness does not affect children and should be ignored for the safety of the child.**

Answers: 1. False 2. B 3. C 4. B 5.D 6. False

- **Tips for Parenting with a Mental Illness** *http://psychcentral.com/lib/tips-for-parenting-with-a-mental-illness/* A short article to help cope with mental illness and face the multiple challenges of parenting.
- **Practice Notes: Working with Parents with Mental Illness** *http://www.practicenotes.org/vol4_no2/working_with_adults.*htm A resource for working in child welfare; Offers tips and guidelines for working with persons with mental illness. Provides simple and generalist skills to be applied during the visitation process.
- **Children of Parents with Mental Illness** *http://www.copmi.net.au/* **Keeping Families and Children in Mind** from Children of Parents with Mental Illness, a national initiative in Australia, is a terrific work force development resource available online. Many people contributed to the development of the resource, including parents, children, family members, providers, and other experts.
- **Family Options: An Innovative Program for Parents Living with Mental Illness** *http://www.parentingwell.org/archives/417* . A brief (13 minute) presentation that provides the rationale behind the Family Options intervention, and a description of the program. The Discussion Guide is useful in training situations.
- **Coping** *http://www.mhasp.org/coping* . This interactive site is for children to learn how to cope with their parent's mental illness. This would be a good site to give to parents and children to help with understanding and coping strategies.
- **Helping Children Understand Mental Illness: A Resource for Parents and Guardians** *http://coping.mhasp.org/guardians.html#3* . This site offers tips and suggestions to parents and guardians to discuss mental illness, to build child's self-confidence, and answers commonly asked questions. When parents are struggling to discuss or open up to their child about mental illness, tips from this resource could be beneficial to breaking the ice.
- **Dual Diagnosis Toolkit: A Practical Guide for Professionals and Practitioners** *http://www.scshare.com/downloads/dualdiagnosistoolkit.pdf* . This toolkit is written for frontline staff working with adult clients who have a combination of substance misuse and mental health problems. The toolkit is both a practical guide and a reference source. It provides a basic introduction to key issues, service models and good practice in both substance misuse and mental health. The material is arranged so that busy practitioners can quickly identify the information they need without having to read the whole document.

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CHAPTER 11

THE IMPACT OF CHILD NEGLECT ON SUPERVISED VISITATION

Case Scenario

At the age of 17, Jordan Burns was raped by three boys at a party. Five years later, Jordan was diagnosed with schizophrenia. Jordan learned to take her medication responsibly and began a heathy intimate relationship with John. Two years into the relationship with John, Jordan became pregnant. After having the baby, Jordan stopped taking her medication. John ended their relationship soon after. Jordan began leaving the baby home alone for hours without checking in on him. John came to Jordan's home and found his son lying in a crib covered in feces. The baby had no food and a fever. DCF filed a petition for Dependency after John gave up his parental rights. Jordan agreed to supervise visitation twice a week as part of her case management plan.

After completion of this chapter, you will be able to answer the following questions:

- How has the parent neglected the child in this case?
- What are some parental and child characteristics that may have been causes of child neglect?
- What are some social-situational factors that may have contributed to child neglect?
- What specific techniques can visit monitors employ to help facilitate effective visits in this case?
- What are some parental resources and referrals that may be helpful to the parent in this case study?

Introduction

Supervised visitation monitors need to understand how to identify cases of child neglect and learn to help parents build healthy parenting skills so that children can thrive.

What will I learn in this chapter?

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

- Define child neglect
- Identify types of child neglect and give examples of each
- Discuss the signs of child neglect
- Discuss common theories regarding causes and risk factors of child neglect
- Discuss mediating or protective factors for child neglect
- Discuss intellectual, physical, social, and psychological consequences of child neglect
- Identify risk factors and determine necessary interventions during visits
- Understand the strategies for preparing a neglected child for visitation
- Employ effective techniques to facilitate visits between a neglectful parent and their child
- Understand the impact of neglectful parents on supervised visitation
- Be aware of parental resources and referrals that may be helpful for neglectful parents
- Understand mandatory reporting laws regarding child abuse and neglect
- Appropriately report child neglect

Snapshots

- The overall national child victim rate for abuse and neglect was about 10 victims per 1,000 children in 2011.
- Although children of all ages experience abuse and neglect, it is the youngest children that are the most vulnerable – about 70% of children who died as a result of abuse or neglect in 2012 were younger than three years of age.
- According to the National Council on Child Abuse and Family Violence, children whose parents abuse alcohol and other drugs are more than four times more likely to be neglected than children from non-abusing families.
- 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.
- The estimated rate of neglect among families with four or more children is almost double the rate among families with three or fewer children.
- Living with married biological parents places children at the lowest risk for child abuse and neglect, while living with a single parent and a live-in partner increases the risk of abuse and neglect to more than eight times that of other children.

Defining Child Neglect

Florida Statutes §827.03 defines child neglect as:

A) A caregiver's failure or omission to provide a child with the care, supervision, and services necessary to maintain the child's physical and mental health, including, but not limited to, food, nutrition, clothing, shelter, supervision, medicine, and medical services that a prudent person would consider essential for the well-being of the child.

B) A caregiver's failure to make a reasonable effort to protect a child from abuse, neglect, or exploitation by another person.

According to the Department of Children and Families, neglect is defined 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."

REMINDER:

A person who willfully or by culpable negligence neglects a child and in so doing causes great bodily harm, permanent disability, or permanent disfigurement to the child commits a felony of the second degree. A person who willfully or by culpable negligence neglects a child without causing great bodily harm, permanent disability, or permanent disfigurement to the child commits a felony of the third degree.

- Florida Statutes §827.03

These definitions are evidence that organizations and policies – and those who work within both – define child neglect differently. It is crucial for monitors to consider understand the way in which these definitions play a role in their work in supervised visitation.

In general, definitions of neglect look at the failure of a caregiver or parent to act in ways to fulfill responsibilities for the development of a child as a form of maltreatment. This includes failure to provide for physical needs (such as basic physical care, health care, supervision and proper nutrition) as well as other needs (such as emotional or educational support), although the caregiver is able to do so. Child neglect may also be characterized as an ongoing pattern of inadequate care.

When monitors are evaluating whether or not a case may include child neglect, it is important to consider the following:

- **What are the basic needs of the child?** Every child is different, and their needs are likely to change based on their age or developmental stage. While one 11-year-old may need considerable emotional attention, another may be fiercely independent by nature and ask for less from a parent. Consider how a parent's behavior does or does not meet that specific child's basic needs.
- **What actions or failures to act on the part of parents or caregivers may constitute neglectful behavior?** Examine the situation carefully and determine where neglect may be occurring. Consider also *why* these acts are considered neglectful, and where the motivation (or lack thereof) comes from which causes the parent or caregiver to engage in this behavior.
- **Are the parent's actions or inactions intentional?** There is a distinct difference between a parent's unwillingness to provide for their children and an *inability* to do so. Additionally, many first time parents are simply unaware of certain needs children may have. Critically evaluate whether or not the circumstances are a result of willful neglect, or if they may be a lack of resources, understanding, or capabilities.

STOP and Think: Identifying Child Neglect

Read the following cases and identify which case(s) constitutes child neglect as identified by Florida's statutory definition.

A. ***Five-year-old Bobby falls off of his bike and scrapes his elbow and knee. Bobby's mom, Jane, cleans his cuts and put bandages on them. Jane does not believe that Bobby was seriously injured so she doesn't take him to the hospital.***
B. ***12 years old Joe fell off of his bunk bed after wrestling with his brother. Although Joe and his brother were just playing, Joe was seriously injured. Joe's mother, Catherine, notices that there is severe bruising around Joe's leg and is afraid that it may be broken because of the fall. Although Joe cries and expresses to his mom that he is in a lot of pain, Catherine bandages his leg instead of taking him to the hospital.***
C. ***Three-year-old Stephanie, who is still in diapers, is regularly cared for by her six-year-old sister, Karey, while their mother, Joan, works. Karey can feed Stephanie jarred baby food.***

Types of Child Neglect

This chapter will cover five forms of child neglect: physical neglect, inadequate supervision, emotional neglect, educational neglect, and medical neglect.

Physical Neglect

Physical neglect is the most common form of neglect. It refers to the failure to provide a child with the basic necessities of life, such as adequate food, clothing, and shelter. The table below further explains the different kinds of physical neglect which may occur.

Table 11.1
Types of Physical Neglect

Type of Physical Neglect	Definition
Refusal of Health Care	Failure to provide or allow needed care in accord with the recommendations of competent health care professionals 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	Leaving a child for an extended period of time without arranging for reasonable care and supervision.
Expulsion	Refusal of custody of a child; kicking a child out of the home without adequately arranging for his/her care by others, or the refusal to accept custody of a returned runaway.
Shuttling	Moving a child repeatedly from place to place to avoid custody; leaving a child with others for long periods of time.
Miscellaneous Physical Neglect	Other types of physical neglect can include inadequate housing, nutrition, clothing, or attention to hygiene, as well as general disregard for a child's safety and welfare.

Inadequate Supervision

Inadequate supervision can include leaving a child of inappropriate age alone for extended periods of time, leaving a child alone with inattentive or inappropriate adults, or exposing a child to hazards such as second-hand smoke, violence, or other conditions that could potentially harm the child.
See the table below for a more detailed explanation of inadequate supervision.

Table 11.2
Types of Inadequate Supervision

Type of Inadequate Supervision	Definition
Lack of Appropriate Supervision	A child is left unsupervised or inadequately supervised for extended periods of time, or allowed to remain away from home without a parent knowing the child's whereabouts. The amount of supervision needed may vary according to the child's age, development, or situation.
Exposure to Hazards	This includes but is not limited to exposure to safety hazards such as second hand smoke and other drugs or drug-related environmental hazards, weapons, unsanitary household conditions, or lack of car safety restraints.
Inappropriate Caregivers	Leaving a child in the care of someone who is either unable to or should not be trusted to provide care for a child.
Miscellaneous Forms of Inadequate Supervision	Other types of inadequate supervision may include leaving a child with an appropriate caregiver but without proper planning or the caregiver's consent, or leaving the child with a caregiver who is not adequately supervising the child. It may also include permitting a child (or simply not keeping them from) engaging in risky, illegal, or harmful behaviors.

Emotional Neglect

Emotional neglect can include a failure to provide emotional support (such as emotional security and encouragement), or being unresponsive to a child's basic emotional needs. Emotional neglect can have severe consequences, so much so that failure to nurture and stimulate infants can result in the infant failing to thrive or even infant death. See the table below for more information about the various types neglect.

Table 11.3
Types of Emotional Neglect

Type of Emotional Neglect	Definition
Inadequate Nurturance / Affection	Marked inattention to a child's needs for affection, emotional support, or attention.
Isolation	Denying a child the ability to interact or communicate with peers or adults, inside or outside the home.

Chronic Extreme Abuse or Domestic Violence	Chronic or extreme spousal abuse or other domestic violence in the presence of a child. If there is, under most circumstances, the child welfare agency will work to help the victim parent to create safety for herself/himself and the child. The perpetrating parent should be held accountable and the victim parent and child should be protected.
Permitted Alcohol / Drug Abuse	Encouraging or permitting drug/alcohol use by a child.
Other Forms of Permitted 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 problems.
Delay in Psychological Care	Failure to seek or provide needed treatment for a child's emotional or behavioral problems.
Miscellaneous Emotional Neglect	Other inattention to the child's emotional/developmental needs.

Educational/ Developmental Neglect

Educational/developmental neglect is the failure to provide a child with necessary experiences for growth and development either by neglecting to send a child to school or by failing to provide a child with needed educational training. Educational neglect can have a negative impact on the child's cognitive capacity, language development, and academic achievement. Educationally neglecting a child robs the child of his or her potential and can lead to serious developmental consequences. The table below defines some types of educational neglect which monitors may encounter.

Table 11.4
Types of Educational Neglect

Type of Educational Neglect	Definition
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 Needs	Refusal to allow, or failure to obtain recommended remedial educational services for a child's diagnosed learning disorder without reasonable cause.

Medical Neglect

Medical neglect is when caregivers do not meet a child's basic health care needs. Even in non-emergency situations, failure to provide treatment can result in worsened health. The table below defines some types of medical neglect.

Table 11.5
Types of Medical Neglect

Type of Educational Neglect	Definition
Denial of Healthcare	Failure to provide or to allow needed care as recommended by a health care professional for a serious physical injury, illness, impairment or any other reasonable medical condition.
Delay in Healthcare	The failure to provide appropriate medical care in a timely fashion for a serious health problem

Reasons for medical neglect include but are not limited to:

- Fear or anxiety about a medical condition or treatment;
- Religious beliefs;
- Financial issues.

It is important to remember that although there is a correlation between medical neglect and poverty, there is a difference between *inability* and *refusal* to provide medical treatment to a child. Services such as Medicaid may be offered to help families with low income and limited resources provide healthcare for their families.

Signs of Neglect

The following situations may indicate the presence of child neglect:

- When a child lacks adult supervision.
- When a child is frequently left alone or allowed to play in unsafe situations and environments.
- When a child's clothes are ill-fitting, dirty, or inappropriate for the weather.
- When a child's hygiene is consistently bad.
- When a child lacks needed medical or dental care, immunizations, or glasses.
- When a child has untreated illnesses and physical injuries.
- When a child has not received help for physical or medical problems brought to the parents' attention.
- When a child is frequently late or missing from school.
- When a child is frequently begging for or stealing food or money.
- When a child consistently comes to school or other activities early, stays late, and/or does not want to go home.
- When a child abuses alcohol or other drugs.
- When a child is consistently engaging in delinquent behavior.
- When a parent is frequently unaware of their child's whereabouts.
- When a parent appears to be indifferent to their child.
- When a parent or caregiver is abusing alcohol or other drugs.

STOP and Think

Which of the following may be an indication of child neglect?

A. David was late for school twice this week.

B. Jane didn't take her daughter to the hospital to treat a common cold because she figured over the counter medicine would be sufficient.

C. Dorothy allows her 12-year-old son to roam the street without any knowledge of his whereabouts.

D. Ten-year-old Brittany is always hungry and consistently wears dirty clothes to school.

Causes and Risk Factors of Child Neglect

Research on child neglect has found that there are multiple causes and risk factors of child neglect, some of which include child risk factors, parental or family risk factors, social-cultural factors, social-situational and environmental factors, and religious risk factors.

Child Risk Factors

There are certain characteristics a child may possess that are factors or stressors associated with parental neglect. These characteristics include:

- Children with cognitive, physical, or emotional disabilities;
- Children exposed prenatally to drugs and other toxins;
- Children who are born premature, have low birth weight, or are born with anomalies;
- Children with chronic health illness;
- Children with emotional or behavioral problems;
- Children with attention deficits;
- Children with temperaments that make them difficult to bond with;
- Children who are younger (children under the age of 2 are more likely to be neglected compared to any other age group under the age of 18).

Parental or Family Risk Factors

Research indicates that there are certain characteristics of parents and families that are associated with child neglect. These include:

- Low academic achievement;
- Impaired intellectual functioning;
- Unemployment or underemployment (poverty);
- History of substance abuse;
- History of mental illness;
- Poor social skills;
- Poor parenting skills;
- Family structure (single parent home, large number of children in the home, divorce, cohabitation)
- History of victimization; and
- Young parents.

Social-Cultural Factors

Social-Cultural factors are values or norms held by a culture regarding child-rearing practices that may have an impact on neglect. For example, in some cultures, children are asked to care for their younger siblings, whereas in other cultures this would be unacceptable and viewed as a form of child neglect.

Cultural considerations include:

- The culture's child-rearing norms (e.g. usage of corporal punishment);
- The culture's view of traditional medical care (e.g. some cultures have concerns regarding medical treatments provided by Western physicians and may prefer other forms of treatment such as herbalism);
- The culture's expectations regarding childhood experiences (some cultures may assign more responsibility to children than other cultures).

Social-Situational and Environmental Factors

Certain situations or dynamics within a family's community may contribute to child neglect. These can include:

- Neighborhoods of low socioeconomic status (poverty);
- Limited employment opportunities;
- Social isolation;
- Domestic violence;
- Lack of stable child care;
- Overcrowded neighborhoods;
- Residential instability;
- High unemployment rates;
- High density of alcohol outlets;
- Lack of informal and formal social support and networks;
- Single-parent families with children who have different fathers; and
- Poor accessibility to or availability of health care, child care, or social services.

Religious Factors

Parents may refuse medical care for their children on the basis of a particular religious belief. This alone is not considered neglectful under Florida State Statute §39.01, which states that "a parent or legal custodian who, by reason of the legitimate practice of religious beliefs, does not provide specified medical treatment for a child may not be considered abusive or neglectful for that reason alone." However, this *does not* mean that the case should not be reported, that it will not be investigated, or even prevent the court from ordering that medical services be administered by a physician when the health of the child requires it. Monitors should be respectful and mindful of these factors when considering a potentially neglectful situation, and make a report to 1-800-96-ABUSE if they suspect neglect.

STOP and Think

Instructions: *After reading the following case scenario, identify which risk factors are present.*

Fred and Lauren are 24 years old with a 6-year-old boy named Kane. Both parents dropped out of high school so that they could find a job to support their son. Since both Fred and Lauren's parents refused to allow them to stay at home after having Kane, they applied for public housing and got a two-bedroom apartment. Lauren and Fred are not married and are currently unemployed. Kane was diagnosed with ADHD and has a difficult temperament. Fred and Lauren frequently complain about being stressed over parenting Kane.

Interactional Patterns

Research indicates that the parent-child relationship between neglectful caregivers and their children can be characterized by specific interactional patterns.

Neglectful parents usually interact less with their children overall, and are more negative than average parents when they do interact with their child. Neglectful parents are also more likely to make more requests of their children, but tend to be less compliant with the requests their children make of them. Neglected children often have a difficult time developing emotional intimacy with their parents because of the rejection and because of their parents' emotional distance. Some young parents are immature and uninformed and are therefore more likely to treat their children like a playmate, friend, or adult. Young parents have less knowledge of their children's needs and the appropriateness of their expectations.

Neglectful parenting is characterized by the following:

- Few demands, low responsiveness, and little communication;
- Little or no supervision;
- Little warmth, love, and affection;
- Refusal to attend school events, parent-teacher conferences, or other important events involving their children;
- Intentionally avoiding their children;
- Being emotionally distant from the children.

As a result, neglected children fear becoming dependent on others; they feel that they must learn to provide for themselves. Neglected children often feel fear, anxiety, or stress due to the lack of family support, and have an increased risk of substance abuse. They are emotionally withdrawn, and exhibit more delinquency during adolescence.

Child Neglect Protective Factors

Protective factors are characteristics in children, families, and communities that, when present, reduce the risk of child neglect. These protective factors include the following:

Child Protective Factors

- Positive attachment to parents;
- Nurturing relationship with parents;
- Supportive social connections with peers and extended family;
- Productive hobbies and/or interests.

Parental/Family Protective Factors

- Warm parent-child relationships (healthy interaction style between child and parent);
- Extended family support;
- Knowledge of child developmental stages;
- Social support;
- High academic achievement;
- Parental resilience;
- Good coping skills;
- Household rules/structure.

Community/Societal Protective Factors

- Mid-to-high socioeconomic status;
- Consistent parental employment;
- Accessible social services, healthcare, and child care;
- Adequate housing;
- Supportive adults outside of the family involved in the child's life.

Test Your Knowledge!

Identify whether each example is a risk factor or a protective factor.

1. **Parents with a college degree**
2. **Low-income families**
3. **Healthy babies**
4. **A child with a good temperament**
5. **A parent with a history of victimization**
6. **Extended family support**
7. **Adequate child care**
8. **Young parents**
9. **Employed parents**

Effects of Child Neglect

Child neglect has a profound impact on children's growth, development, and well-being. Certain factors (such as appropriate interventions, the length of time the child has been neglected, the age of the child, and the type of neglect) can affect the severity of these effects. Some children will have profound issues that are immediately apparent, while others may suffer from subtler effects that many may not realize are related to early life neglect. It is important to keep in mind the various consequences that neglected children may display in supervised visitation. These consequences include:

DID YOU KNOW?

Neglect can have short-term and long- term consequences.

Cognitive Effects of Neglect on Children

- Language delays;
- Academic delays;
- Less prepared for learning;
- Lower brain function;
- Lower scores on measures of school performance;
- Lower scores on measures of cognitive capacity; and
- Increased risk of dissociative disorders and memory impairments.

Physical Effects

- Greater risk of death from accident or lack of supervision;
- Failure to thrive;
- Persistent hunger;
- Poor hygiene;
- Malnutrition and chronic anemia;
- Weight loss or inadequate weight gain;
- Chronic or persistent digestive/intestinal disorders; and
- Persistent cradle cap or severe diaper rash.

Social Effects

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

- Lack of trust and other relationship difficulties;
- Isolation or social withdrawal;
- More likely to experience problems such as teen pregnancy and drug use; and
- More likely to engage in sexual risk-taking, thereby increasing their chances of contracting a sexually transmitted disease.

Psychological/Emotional Effects

- Low self-esteem;
- Poor coping skills;
- Affective disorders (i.e. anxiety disorders, depressive disorders);
- Psychiatric symptoms;
- Poor impulse control;
- Lack creative initiative;
- Primitive soothing behaviors;
- Core feelings of being "worthless" or "damaged".
- Trouble regulating emotions;
- Safety-seeking behaviors with unfamiliar adults; and
- Mental illnesses.

Impact of Child Neglect on Supervised Visitation

Three important practical issues must be considered when a program accepts a neglect case for supervised visitation: 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;

- An identification of the family's cultural understanding of neglect.

In the event that a referring agency has already completed a formal assessment of the parent and/or child who will be engaging in visits, supervised visitation staff should review the assessment prior to scheduling visits to ensure they have a more complete view of the issues present. While this cannot replace information gathered during intake, it can provide guidance in what may or may not need to be probed into during intake and in determining the level of assistance that a particular family may need.

If a formal risk assessment has not been conducted, programs may be able to refer the case for assessment to social service agencies with which they are affiliated if they feel it necessary.

Exercise: Responding to Child Neglect

Instructions: Think of some forms of neglect that have been referred to the supervised visitation program in the past or that have appeared in the newspaper or on television. Answer the following questions:

- Do you have any biases about neglectful parents? In what ways can you combat these biases?
- What feelings do you think you will have to overcome in order to facilitate visits between neglectful parents and their children?
- Do you believe neglectful parents should have the right to supervised visitation with their children?
- Do you believe neglectful parents love their children?
- Do you believe that neglectful parents can one day become responsible caregivers?

Strategies for Preparing a Child for Visitation

It is important for supervised visitation monitors to take steps to ensure that children are adequately prepared to engage in visits with their parent(s). There are a number of strategies monitors can employ to accomplish this, including:

- Understand or anticipate parents' reactions to seeing the child.
- Help the child express his/her feelings about seeing the parent.
- Anticipate that some children may express sadness, exhibit temper tantrums, be argumentative, or refuse to discuss a pending visit.
- Understand that children may try to back out of a pending visit with the parent because of feelings of being hurt due to past neglect.
- Children may refuse to meet with their parent because of a fear that the parent may not show up to the visit.

- Visit monitors should direct foster parents or relatives caring for the child to anticipate possible acting-out behavior before or after a visit.
- Help the child recognize their mixed emotions toward the parent.
- Understand that the child may express fear over continuous rejection by the parent.
- Offer a nurturing environment where the child can experience unconditional positive regard.
- Help the child express his/her feelings about the visit.
- Inform the child of his/her rights and control over the visit. For example, the child can choose to end a visit and set parameters for physical contact.
- Educate the child about the parent's responsibilities and the role of the visit monitor.
- 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.

Effective Techniques for Facilitating Visits

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

Use Your Resources!

The Institute has published a Family Skill Builder e-book which outlines several parent/child interactions which encourage healthy child development. A variety of suggested interactions are described for all age groups.

View the e-book here: http://familyvio.csw.fsu.edu/wpcontent/uploads/2012/06/FINALFamilySkillBuilder.pdf

- Help the parent understand the child's level of development and their needs;
- Encourage more parent/child interactions to strengthen positive attachments;
- Ensure that a variety of toys, games, or materials are available during a visit to maximize choices for play or interaction, and that the parent is able to use them with the child either alone or with assistance from a monitor;
- Prepare parents for what may be a very emotional reaction or behavior on the part of the child, especially in early visits;
- Recognize that the parent may need to be guided more often than others when interacting with their children;
- Be prepared to model interaction or behavior for parents who need extra help connecting with their children, or to suggest activities for parents and children to engage in;
- Use positive feedback to reward parents for initiating play or positive communication with their child;

- Check in with parents about their feelings, impressions, or frustrations before or after visits to encourage them to make their visits consistent.

The Impact of the Characteristics of Neglectful Parents on Supervised Visitation

Parents with a history of neglect may require assistance from visitation staff in order to have effective interaction with their children during supervised visitation services. The table below outlines some common characteristics of neglectful parents, and how monitors may adapt, in order to minimize their negative impact on the visit.

Table 11. 6
The Impact of Neglectful Parents on Supervised Visitation

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 model good parenting – show them how to play, discipline, and interact with the child. Staff may have to assist the parent in giving the child medication or feeding the young child during the visit.
Lack of Education/Intellectual Deficits	Staff may need to assist the parent in filling out forms and may need to read program rules to them.
Substance Abuse	Staff may need to screen for use of substances prior to visits.
Social Isolation	Staff may not be able to readily contact the parent if the family lacks phone service. Staff may have to reschedule visits due to the family's lack of transportation.
Depression	Staff may have to assess the impact of the parent's depression upon the child during the visit – if the parent is weeping, the child may become upset.

Problems with Social Support	Staff may have to anticipate other family members or friends coming to visits if the parent relies on others for transportation. Likewise, the parent may rely on unreliable friends/neighbors to get to visits.

Monitoring Visits

Monitors facilitating visits between a neglectful parent and child can engage in a number of techniques to assist the visit. Examples include:

- Anticipate a range of emotional reactions by both the parent and child such as detachment, depression, anger, and/or guilt.
- Ensure that the parent does not assign "blame" or responsibility for the neglect of the child, and that they do not try to minimize or deny that the neglect occurred.
- Be aware of emotionally abusive statements made by the parent during visits.
- Allow the child to discuss the neglect if he or she pleases.
- Be aware of any contact between a parent and child.
- 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. 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.

Following a Visit

- Discuss suggestions the child may have for making the visit better or more comfortable.
- Discuss any concerns or problems that arose during the visit that may affect the child later in the day with their caregiver.
- Allow the custodial parent or foster parent to report any unusual behaviors or problems.

Following a visit, discuss plans for future visits with the child and allow them to disclose their feelings or concerns regarding the visit.

Parental Resources and Referrals

When facilitating visits between a neglectful parent and their child, a visit monitor must always be prepared to think outside the scope of their agency and employ a variety of techniques to make the visit more effective. This often means identifying community resources that will benefit the family as a whole. While the role of a typical visit monitor may not include some of these suggestions, depending on the structure of their program, it is important to keep in mind that no matter who actually provides the resource, the family will benefit more if they have access to them. These include:

- **Concrete resources:** these may include help with housing, transportation to visits, medical care, or child care.
- **Social support:** supervised visitation programs may make referrals to parenting groups, support groups, parent education programs, or suggest making connections with religious groups.
- **Developmental remediation:** this can mean referrals to mental health services, encouraging the family to engage in cultural activities, or suggesting parent education materials or programs.
- **Individual interventions:** parents may need referrals to substance abuse counseling, adult education, mental health services, or health care providers.
- **Family focused:** supervised visitation programs can refer families to legal assistance programs, or help them apply for public assistance.

Reporting Child Neglect

This toll free number is available 24/7; counselors are waiting to assist you.

(800) 962-2873

The Florida Department of Children & Families provides comprehensive protective services for children, and vulnerable adults, who are abused, neglected, or at threat of harm in the state, by requiring that reports be made to the Florida Abuse Hotline.

Telephone: 800-962-2873

Fax: 800-914-0004

Florida Relay 711

TTY: 800-453-5145 Report

Online: https://reportabuse.dcf.state.fl.us/

Reporting child neglect is mandatory under Florida law. The identity of the reporter of child neglect, abuse, or abandonment will be kept confidential. When contacting the Florida Abuse Hotline, please have as much of the information listed below available as possible before you call:

- Name, date of birth (or approximate age), race, and gender for all adults and children involved.
- Addresses or another means to locate the subjects of the report, including current location.
- Information regarding disabilities and/or limitations of the victim(s).
- Relationship of the alleged perpetrator(s) to the child or adult victim(s).
- Any other relevant information that would expedite an investigation, such as directions to the victim and/or potential risks to the investigator.

If you are unable to obtain some of this information, you may still call the Hotline and a counselor will determine if the information presented meets statutory criteria for the Department of Children and Families to initiate a protective investigation.

If you know or suspect that a child or vulnerable adult is in immediate danger, call 911

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CHAPTER 12

THE IMPACT OF CHILD PHYSICAL AND SEXUAL ABUSE ON SUPERVISED VISITATION

Case Scenario

In the summertime, a young mother, Maggie dropped off her two young children, Angie age 5, and Matthew age 8, for a weekly visitation with their father. The children arrived in sweatshirts and long pants and were visibly sweating. The visitation monitor notices and asks the children if they are hot and offers to lower the temperature of the air conditioning. In response, Angie silently nods her head and lowers her eyes while Matthew remains completely quiet and looks over towards the corner. After the visit, the monitor then asks Maggie to speak and she inquires politely about why the children are bundled up and points out that they seem to be sweating. The mother responds by barking back, "that is none of your business lady!" The monitor is somewhat confused but concedes and Maggie and the children leave the visitation center.

After completion of this chapter, you will be able to answer the following questions:

- *Were there any red flags that the monitor should have identified?*
- *Was there anything unusual about the children's behavior?*
- *Was there anything unusual about the mother's behavior?*
- *Should the monitor take any further action?*

Introduction

Families may be referred to supervised visitation programs for many reasons. Children may have been removed from their homes because they have been abused, or they might enter into supervised visitation for a different reason and program staff may suspect abuse. As such, it is imperative that visitation monitors be adequately educated in the dynamics of child abuse should they be working with a family where abuse has, or is suspected to have, occurred.

Child abuse can be physical or sexual in nature, and may manifest in many different ways. This chapter aims to provide visitation monitors with the knowledge base and skills to both identify, and appropriately respond to child abuse in visitation services. Child abuse is complex, and will often result in more than just physical injuries. There are many other mental, emotional, and behavioral consequences surrounding abuse, which will impact children in different ways.

Additionally, it is important for visitation monitors to understand the complex factors that influence an adult to become abusive toward a child. Parents who have abused their children may be unable to cope effectively with their own prior trauma or other stressors. It is important for a visitation provider to remain sensitive to the complex nature of abuse, and to behave professionally during the provision of services.

What will I learn in this chapter?

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

- Define physical and sexual abuse
- Identify different types of child abuse
- Understand and explain the impact abuse has on childhood victims
- Identify common injuries associated with abuse
- Reference Florida Statute definitions of abuse
- Identify different risk factors for child abuse
- Identify and encourage the development of protective factors within families
- Anticipate possible reactions to visitation
- Adequately prepare for, monitor, and follow-up on visitation where child abuse is present or suspected
- Report child abuse

Snapshots and Facts

- Child abuse occurs at every socioeconomic level, across ethnic and cultural lines, within all religions, and at all levels of parental education.
- About 30% of abused and neglected children will later abuse their own children.
- As many as 14% of men and 36% of women in prison were abused as children.
- As many as two-thirds of people in treatment for drug abuse reported being abused or neglected as children.
- According to the 2013 Child Maltreatment report, in all cases of substantiated child maltreatment, 18% were victims of physical abuse.

Part One

Child Physical Abuse

Child Physical Abuse

Physical child abuse is an adult's physical act of aggression directed at a child that causes injury, even if the adult didn't intend to injure the child. Acts of physical abuse may include:

- Striking a child with the hand, fist, or foot or with an object
- Burning the child with a hot object
- Shaking, pushing, or throwing a child
- Pinching or biting the child
- Pulling a child's hair
- Cutting off a child's breathing

Abuse is any willful or threatened act that results in any physical, mental, or sexual abuse, injury, or harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired. Abuse of a child includes acts or omissions.

Florida Statute 39.01(2)

Other Kinds of Child Physical Abuse:

- **Shaken Baby Syndrome** involves a frustrated caregiver shaking a baby, in an attempt to make the baby stop crying. Since the baby's neck muscles cannot properly support its head, the baby's brain bounces around inside its skull causing brain damage which often results in severe neurological problems and even death.
- **Munchausen's Syndrome by Proxy** involves a parent intentionally causing the child to become ill, rushing them to the doctor and convincing them that the child is sick. This behavior on the part of the parent is likely motivated by a desire for attention and sympathy.
- **Corporal Punishment** is an antiquated form of disciplinary action for children, which involves the use of physical force with the intent of inflicting bodily pain, without injury, for the purpose of correction or control of a child.

"Corporal discipline of a child by a parent or legal custodian for disciplinary purposes does not in itself constitute abuse when it does not result in harm to the child."

FL Statute 39.01(2)

Impact of Child Physical Abuse

Physical Impact

As illustrated above, there are many physical consequences of abuse. While the severity of injuries can vary greatly, the consequences of abuse abound. Below are some other documented consequences of physical abuse on children.

DID YOU KNOW?

According to one study, in the three years following maltreatment investigation, 28% of children reportedly had a chronic health condition.

- *Abusive Head Trauma:* Head trauma resulting from shaking and blunt impact to the head is the most common cause of traumatic death for infants. Although related injuries may not be immediately noticeable, this kind of injury impedes healthy brain development in children.
- *Impaired Brain Development:* Child abuse and neglect have been shown to significantly impact brain development. Some regions fail to form properly causing long-

term consequences for cognitive, language, and academic abilities, and have also been tied to mental health disorders.

- *Poor Physical Health:* Child abuse also affects long-term physical health by increasing the likelihood of chronic disease such as cardiovascular disease, lung and liver disease, hypertension, diabetes, asthma and obesity. Specifically, physical abuse has been shown to increase the risk of diabetes and malnutrition.

Psychological Impact

Apart from the psychical impacts of child abuse, there are also many psychological consequences that arise as a result of childhood trauma. These can manifest as behaviors like isolation, fear, and the inability to trust others. If left unattended these behaviors have the potential to have long-term consequences on a person's mental health.

- *Difficulties during infancy:* When infants and young children enter out-of-home care due to abuse or neglect, the trauma of a primary caregiver change negatively affects their attachments. As a result, nearly half of infants in foster care who have experienced abuse exhibit some kind of cognitive delay and lower IQ scores, language difficulties, and neonatal challenges, when compared with children who have not been abused or neglected.

- *Poor mental and emotional health:* Childhood abuse is a risk factor for borderline personality disorder, depression, anxiety, and other psychiatric disorders. It also negatively impacts the development of emotional regulation which can carry on through adolescence and adulthood.

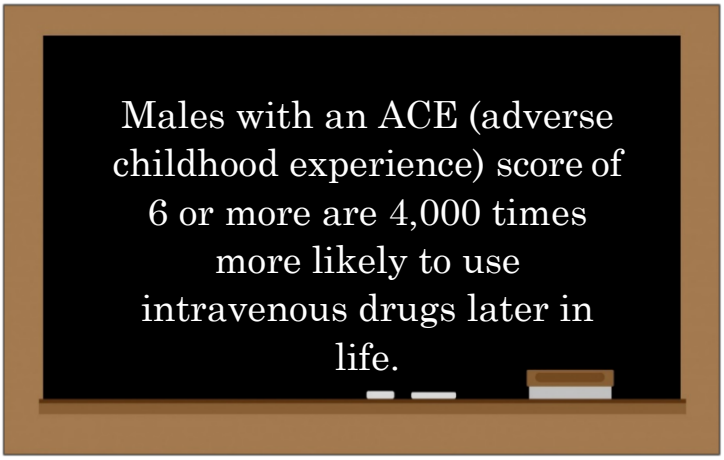
- *Cognitive Difficulties:* Child victims of abuse are also at risk for severe developmental and cognitive issues, including grade repetition.

Behavioral Impact

Although not all childhood victims of abuse manifest behavioral issues, they are certainly more likely to than their non-victimized counterparts to suffer negative consequences. They may experience any or all of the following:

- *Difficulties during adolescence:* Data has shown that children who have been abused often repeat grade levels in school, and engage in substance abuse, delinquency, and truancy. They are also more likely than their peers to engage in sexual risk-taking, which also increases their chances of pregnancy and contracting sexually transmitted diseases.

- *Juvenile delinquency and adult criminality:* Several studies have also documented a correlation between child abuse and future delinquency.



- *Alcohol and other drug abuse:* Research has also shown that victims of child abuse have an increased likelihood of abusing alcohol, smoking cigarettes, or taking illicit drugs during their lifetime.

- *Abusive behavior:* Studies have also shown that child victims of abuse often become abusive parents to their own children.

Societal Impact

- *Direct Costs:* According to a CDC study, the lifetime cost of child maltreatment and related fatalities over the course of a year totals $124 billion. By comparison, prevention programs have proven to be cost effective, providing a favorable cost/benefit ration at $47 benefits to society for every $1 spent on program costs.

- *Indirect Costs:* These long-term societal consequences of child abuse and neglect are varied and include costs associated with increased use of health care, criminal activity, mental illness, substance abuse, and domestic violence.

Signs and Symptoms

The co-occurring signs and symptoms of physical abuse can be overt, like a physical injury, or more insidious, like a change in behavior. As such, it is important to be vigilant of the physical signs of abuse as well as the behavioral and psychological signs that may not be obvious to the untrained eye. The table below outlines some physical and behavioral signs of abuse.

Table 12.1 Signs and Symptoms of Physical Abuse	
Physical *These visible injuries may or may not be visible to the monitor and can be covered by clothing.*	• Unexplained or frequent burns, bruises or other injuries • Black eyes • Bruises in areas of the body not typically injured by accidental or normal childhood activities • Faded bruises or healing injuries following absence from school • Human bite marks • Burns on the arms, legs, or areas covered by clothing • Cigarette burns • Bruises shaped like objects, such as a hand or belt buckle • Marks around the wrist or ankles, indicating someone may have tied the child up • Difficulty walking/sitting • Delays in normal physical development • Obvious need for medical care/personal hygiene
Behavioral *A child's behavior may suggest a history of abuse, especially in the presence of the abuser.*	• Depression/attempted suicide • Withdrawal from friends and social activities • Unbelievable or inconsistent explanations of injuries • Unusual shyness • Avoidance of eye contact with adults or older kids • Apparent fear of caretakers –parent(s)/caretaker(s) • Anti-social behavior in older kids such as truancy, drug abuse, or running away from home • Child seems overly watchful, on edge, as if anticipating something bad is going to happen • Expresses a reluctance to go home • Extreme changes in behavior/temperament • Delays in emotional development • Lack of emotional attachment to parent
Parental or Other Caregiver Behavior *The behavior of a parent or another caregiver may also indicate the presence of abuse.*	• Demeaning attitudes towards the child • Expresses the child is wholly bad and burdensome • Expresses little concern for the child and his or her life, such as their performance in school • Rarely displays physical affection toward the child • Thinks of the relationship as completely negative • Verbalized dislike for the child

Types of Injuries

There are many different types of injuries seen in children who have been physically abused. The table below, although not exhaustive, provides a list of common injuries resulting from physical abuse and their likely causes.

Table 12.2
Types and Examples of Physical Abuse

Injury	*Definition*	*Caused By*
Bruises	Injuries resulting from bleeding within the skin, skin is discolored but not broken	Some sort of blunt trauma such as hitting or punching
Cuts, punctures, or bites	A cut or break in the skin	Result from injury caused by a sharp object, or teeth
Burns/scalds	Tissue injury resulting from exposure to extreme heat or chemicals	Deliberately exposing a child to extreme temperatures or chemicals
Dislocation of bones	Displacement of a bone from its joint	May be caused by putting unnatural force on a joint, such as pulling or dragging a child
Fractures	Broken bone May be: Simple, Compound, Complicated, or spiral	May be caused by twisting or pulling an arm or leg, or by shaking or striking a child
Internal Injuries	Injury to the internal organs	Severe blow to the abdomen with a body part or object
Head Injuries	Broken bone in the skull, or injury to the nervous system or brain.	Can be caused by hitting or shaking a baby. Shaken-baby syndrome occurs when brain damage is caused by violently shaking a child
Asphyxiation (Suffocation)	Choking, smothering, or drowning, which interfere with a child's oxygen intake	Strangling a child with hands or object, or placing some object over a child's nose or mouth

Deadly Weapon	The use of a deadly weapon in the process of abuse can produce any of the injuries above	Use of a gun or knife to punish or illicit cooperation from a child. Can be an actual injury or threatened one
Beating and/or excessive corporal punishment	Striking a child in a manner that results in temporary or permanent disfigurement or injury.	Corporal punishment that results in injury

Bruises

Bruises are often the first sign that a child has been hurt, and depending on the location, may be an indication of physical abuse. They can present in many different ways, depending on the nature of the injury that caused it. Outlined below are some common kinds of bruises that are consistent with child abuse.

Strangulation: These kinds of bruises generally result from something being wrapped around a child's neck, and may present in a semi-circle shape. If the bruise appears to taper off to one side, it may indicate the use of a rope or similar object. If a strangulation bruise is suspected, the child's eyes may show red spots, which is an indication of lack of oxygen due to strangulation.

Fixed Object Bruises: These kinds of bruises are often caused by the use of blunt objects such as paddles, coat hangers, etc. These may resemble the shape of specific objects.

Bruises Caused by Aggressor's Body: These bruises generally occur when the abuser uses their bare hands or other body parts to inflict harm. They may appear around the neck, wrist, ankles, or shoulders in the shape of an open hand or fist.

In Infants and Children: It is uncommon for infants to have naturally occurring bruises before they are able to crawl or walk. It is also uncommon for bruises to appear on soft areas, such as the stomach or buttocks. If a visitation monitor notices bruises in these locations on infants, this should be considered a red flag and be investigated further.

If an unnatural or unusual bruise is identified, a monitor should ask the parent or child to explain where the bruise came from. Stories that are inconsistent,

unbelievable, contradictory, or have timelines that do not match the age of the bruise, are all indications of abuse. Visitation monitors should utilize appropriate avenues to report reasonable suspicions.

Identifying Signs of Physical Abuse on Darker Skin

Bruising is one of the earliest and most identifiable signs of physical abuse. However, bruises can be difficult to identify on darker skin, due to the lack of contrast between the color of the bruise and natural skin tone. In general, they appear fainter and are often less apparent compared to bruises on those with lighter skin tones.

When attempting to identify the age of a bruise on dark skin, refer to the following table.

Identifying Ages of Bruises on Dark Skin

Age	*Presentation*
0-2 Days	Typically red/pinkish
2-4 Days	Purple, blue, or black
5-10 Days	Yellow or green
10-14 Days	Light brown or faint yellow
14+ Days	Bruise tends to fade away

Current Research

Polyvictimization, Development, and Behavior

Current research has discovered that most children who experience one type of abuse often experience others, which is known as **polyvictimization**.

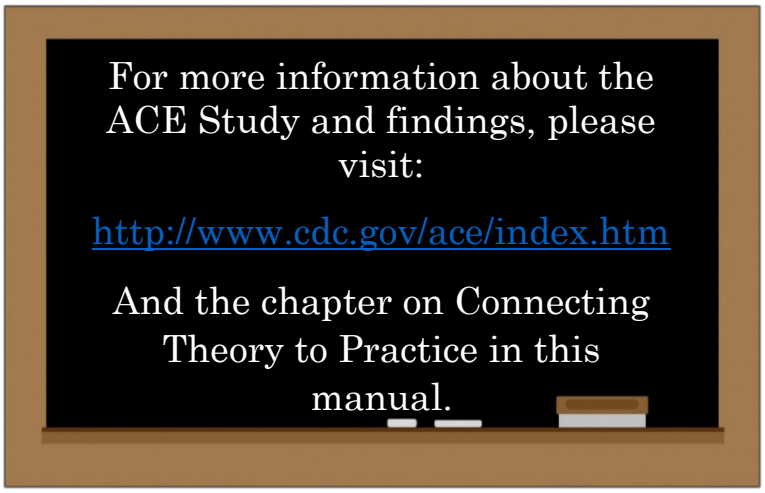
A recent national report showed that polyvictimized children are at an increased risk for losing the fundamental capacities necessary for normal development, successful learning, and a productive adulthood. Youth who have been victimized in multiple ways also show an increased risk of aggressive and destructive behaviors when compared to their non-victimized counterparts.

An estimated 1 in 10 children in the U.S. are exposed to multiple types of violence.

Current research has also uncovered the effects of abuse on children's brains. According to one study, physically abused children showed alterations in the

orbitofrontal volume when compared with typically developing children. Volume shrinkage in this particular part of the brain has been related to measures of family stress. Among physically abused children, those showing poorer academic performance and family functioning (family stress) also exhibited less volume in this region of the brain. This study, alongside a substantial body of scientific research, has demonstrated the effects of stressful environments on the developing human brain and associated behaviors (Davidson & McEwen, 2012).

A groundbreaking study called the Adverse Childhood Experiences (ACE) study compiled a multitude of cases to examine the correlation between childhood maltreatment and adult health and well-being.



Reactions in Visitation

Reactions to abuse can be as varied as the many manifestations of abuse itself. As such, it is important that visitation monitors be adequately prepared for any situation that might arise during visitation. He/she should be aware of their own emotional response to the disclosure of or presentations of abuse and be able to intervene or redirect as appropriate.

Children

Monitors should pay close attention to children's behavior during visitation, as it could be an indicator of abuse. Although not all children will react in the same way, their behaviors can run the gamut from quiet to loud and emotional. They may also exhibit fear of their parent or caretaker. Monitors should also be vigilant of any triggers that may make memories of abuse arise in children during a visitation. Triggers can also take on many forms, such as being in a similar setting where the abuse occurred, or the scent of cologne or other product used by the abuser. The fact that a child does not appear fearful could simply mean that he or she feels safe in the controlled environment of supervised visitation.

Parents

Much like children, parents who have abused their children can display a wide range of behaviors at visits. For instance, they may behave detached, depressed, angry, or even guilty. Although it is unlikely that a parent would blatantly physically abuse their child during visitation, there could be several other indicators of abuse. For instance, they may interact with the child in unusual ways, such as using coded messages to communicate, or physical contact that seems to trigger the child negatively and remind them of the abuse. Monitors should pay close attention to any and all possible signs of abuse, document them and take appropriate action.

Foster Parent/Family Members

Foster parents or family members who have temporary custody of children due to abuse may be understandably leery of visitation. They may express anxiety or fear about the potential harm of the child during or as a result of visitation with an abusive parent. Monitors should listen to their concerns and take them into consideration, while reassuring them that the child's safety is their priority and they will be vigilant to assure that the child is safe.

Staff Members

As mentioned earlier, visitation monitors should be keenly aware of their own feelings and reactions to the disclosure of or suspicion of abuse. They can have a range of emotional reactions, but should be able to manage those emotions and be prepared to respond appropriately and professionally. They may be the first to learn about past or ongoing abuse, so their response is of the utmost importance.

Risk and Protective Factors

Visitation monitors should be familiar with all of the identified risk and protective factors present in families in order to be effective in their duties and identify, intervene, and report abuse.

Risk Factors

Many different factors may increase a family's risk for child abuse and maltreatment. Having knowledge about these factors and being able to identify them is invaluable to the prevention of child abuse. Several identifiable risk factors are outlined in the table below.

Protective Factors

Much like risk factors, there are six identified protective factors in families and communities which reduce the likelihood that violence and/or abuse will occur. They are:

1. **Nurturing and attachment**
2. **Knowledge of child developmental stages**
3. **Parental resilience**
4. **Supportive social connections**
5. **Access to concrete community support**
6. **Social and emotional competence of children**

Below is a table which illustrates identified risk/protective factors for children, family, and society. Any combination could either lead to more risk or protection from abuse.

Table 12.3
Risk and Protective Factors of Child Abuse

	Risk Factors	Protective Factors
Child	• Developmental or physical disability • Under the age of 5 • Special needs that increase caregiver burden	• Age-appropriate development • Good health • Good peer relationships • Personality factors such as:

	• Mental illness • Chronic physical health problems • Temperament: slow or difficult to warm up to adults • Childhood trauma	Easy temperament, Positive disposition, Active coping system, Positive self-esteem, Good social skills, Internal locus of control, Balance between help-seeking and autonomy.
Family	*As seen in the abusive parent* • A history of being abused • Poor childhood experiences • Insecure attachment • Physical or mental illness • Family crisis or stress • Financial stress or unemployment • Social or extended family isolation • Poor understanding of child development • Lack of parenting skills • Alcoholism or substance abuse • Parent's immaturity • Large number of dependent children • Personality factors, such as: external locus of control, poor impulse control, depression/anxiety, low tolerance for frustration, feelings of insecurity, lack of trust	• Supportive family environments • Nurturing parenting skills • Household rule/structure and parental monitoring • Stable family relationships • Parental employment • Adequate housing • Access to health care and social services • Parents model healthy coping skills • Parent's level of education
Societal / Environmental	• Low socioeconomic status • Lack of access to adequate medical care, health insurance, child care, or social services • Parental unemployment or homelessness • Exposure to racism/discrimination • Lack of quality education • Community violence	• Access to healthcare • Consistent parental employment • Family's religious participation • Access to quality education • Caring adults outside the family who serve as role models or mentors

Strategies to Build Protective Factors

The table below provides suggestions for visitation monitors to employ with visiting or custodial parents, in order to develop protective factors and prevent child abuse.

For more in-depth information on developing protective factors, reference our E-book series, located on our website.

http://familyvio.csw.fsu.edu/clearinghouse/manuals-and-materials/

Protective Factor	Action
Nurturing and Attachment	Inform parent about the importance of being present in the child's life and encourage them to become more involved
	Remind parent to show affection when leaving and greeting his or her child at visitation
	Encourage parent to listen to his or her child when talking about visits etc.
	Provide parent with *Economic-Friendly Activities for Families*
	Provide parent with *Top 10 Strategies to Facilitate Child Communication*
	Discuss how parent can praise his or her child and provide tips from *Catching the Good and Praising Your Child* Handout

Knowledge of Child's Developmental Stages	Provide parent with information on child's age group and development
	Discuss age-appropriate consequences and punishments for children
	Inform parent of age-appropriate activities in the community
	Remind parent of ways that he or she can support child in new activities
	Provide parent with the *Every Child is Smart* Handout
	Provide parent with the *Family Development Guide*

Parental Resilience	Discuss parts of life that cause stress and recommend resources to help reduce that stress (low-cost child care services)
	Suggest positive coping skills and activities
	Inform parent of any free resources for physical health or medical services (yoga at the community center, free physicals at the clinic)
	Remind parent to practice self-care and coping skills
	Acknowledge when he or she makes it through a challenging time
	Remind parent that he or she is strong and resilient, provide parent with *10 Things Parents Do Great*

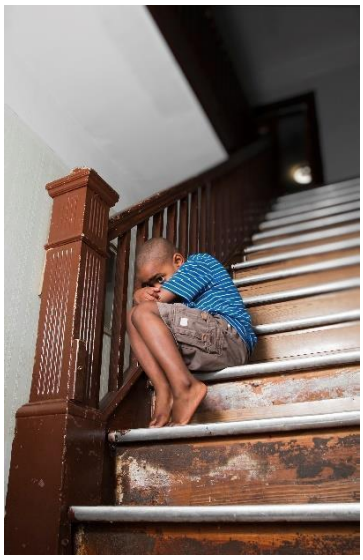
Supportive Social Connections	Check-in with parent and discuss their personal barriers to receiving support
	Educate parent about local support groups and programs
	Encourage parent to meet new people and refer him or her to a community event
	Help parent identify friends, neighbors, or acquaintances in his or her life who are supportive in times of need
	Look for barriers to social involvement for the parent (child care, transportation, or self-confidence)

Access to Concrete Community Supports	Discuss with parent what his or her specific needs are
	Provide parent with appropriate referrals to agencies that meet those needs
	Inform parent about free resources in the community (arts and crafts night, movie in the park, free health screenings, etc.)
	Where necessary, help parent in accessing services (referral form, signatures, etc.)
	Inform parent about any new resources that may be time sensitive (Tax-free week, free vaccinations, etc.)
	Follow up with parent concerning their access to supports and where they may still need assistance

Social and Emotional Competence	Ask parent how he or she deals with emotions such as anger, sadness, or frustration
	Ask parent about his or her feelings and child's feelings
	Provide parent with *Role Playing Emotions with Children* Handout
	Follow-up with parent on emotional intelligence
	Discuss how the parent approaches talking about emotions with their child

Missing the Signs of Child Abuse

At every meeting with children and caregivers, monitors should be alert to the presence of any of following, as they may be warning signs that child abuse might be present. Be sure to document and report any substantial concerns.



Signs of Physical Abuse

- The child verbally expresses that he or she has been abused.
- Frequent injuries that are attributed to the child being clumsy or accident-prone
- Inconsistency between stories from children and parents, such as:
    - Injuries that do not fit the story provided
    - Conflicting explanations between the adult and child's story
    - Unbelievable events given the child's developmental stage
- Habitual absence from school without legitimate reason(s)
- Long sleeve shirts or jackets being worn when it is hot outside
- Awkward movements or difficulty walking, consistent with healing injuries
- Cuts, burns, sprains, or injuries that have not been explained adequately

Part Two

Child Sexual Abuse

It can be very difficult to discuss child sexual abuse, but it is essential for supervised visitation staff to learn about the issue to help protect children. Child sexual abuse cases have many complex dynamics and the Clearinghouse will publish an updated Child Sexual Abuse Referrals Manual in 2018. The content of the new manual will explore all parts of child sexual abuse and will include topics such as human trafficking, best practices for working with sexual abuse cases, and juvenile sexual offenders. Provided in this chapter is a brief overview of child sexual abuse dynamics that all monitors should know.

Overview of Child Sexual Abuse

Much like physical abuse, the effects of child sexual abuse can have severe and long-lasting effects on children and families. The specific ways in which children respond to sexual abuse, as well as the long term consequences, are in many ways both similar to and unique in comparison to physical abuse.

Because of the numerous differences between physical and sexual abuse, it is important to discuss this topic separately and in depth. Visitation monitors should have a deep understanding of both definitions of abuse, as well as the differences that exist between the two.

DID YOU KNOW?

More than 90% of juvenile sexual abuse victims know their abuser in some way.

One important difference between physical and sexual abuse is the concept of a perpetrator's willfulness; one does not accidentally sexually abuse a child, nor does it occur as a result of an inability to control one's temper. When sexual abuse occurs, it is a willful act by a perpetrator.

According to Florida Chapter 39, sexual abuse can refer to any one or more of the following acts:

- Any penetration, however slight, of the vagina or anal opening of one person by the penis of another person, whether or not there is the emission of semen.
- Any sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person.
- Any intrusion by one person into the genitals or anal opening of another person, including the use of any object for this purpose, except that this does not include any act intended for a valid medical purpose.
- The intentional touching of the genitals or other intimate parts, including the breasts, genital area, groin, inner thighs, and buttocks, or the clothing covering them, of either the child or the perpetrator, except that this does not include:
    - Any act which may reasonably be construed to be a normal caregiver responsibility, any interaction with, or affection for a child, or;
    - Any act intended for a valid medical purpose.
- The intentional masturbation of the perpetrator's genitals in the presence of a child.
- The intentional exposure of the perpetrator's genitals in the presence of a child, or any other sexual act intentionally perpetrated in the presence of a child, if such exposure or sexual act is for the purpose of sexual arousal or gratification, aggression, degradation, or other similar purpose.
- The sexual exploitation of a child, which includes the act of a child offering to engage in or engaging in prostitution, provided that the child is not under arrest or is not being prosecuted in a delinquency or criminal proceeding for a violation of any offense in chapter 796 based on such behavior; or allowing, encouraging, or forcing a child to:
    - Solicit for or engage in prostitution
    - Engage in a sexual performance, as defined by chapter 827
    - Participate in the trade of human trafficking as provided in s. 787.06.

REMINDER:

Abusers do not always use physical force, instead they may use play, deception, threats, or other forms of coercion to engage children and maintain silence.

Table 12. 4 Sexual Exploitation Definitions		
Term	FL Statute	Definition
Performance	827.071(1)(b)	Any play, motion picture, photograph or dance or other visual representation exhibited before an audience
Sexual Performance	827.071(1)(h)	Any performance or part thereof which includes sexual conduct by a child less than 18 years of age.
Human Trafficking	787.06(2)(d)	Transporting, soliciting, recruiting, harboring, providing, enticing, maintaining, or obtaining another person for the purpose of exploitation of that person
	787.06(3)(g)	When a person who knowingly, or in reckless disregard of the facts, engages in, or attempts to engage in, or benefits financially by receiving anything of value from participation in a venture that has subjected a person to human trafficking.

The conceptualization of sexual abuse may be complex and the following table will help to illustrate the different acts that are sexual abuse.

Table 12.5 Understanding Child Sexual Abuse Dynamics		
Type	Definition	Example
Touching	Any fondling of sexual organs, sexual contact between genitals or penetration by genitals, digits, or other object.	Sexual intercourse of any kind (oral, anal, vaginal)
Non-touching	Exposing of the perpetrators genitals to the child, voyeurism, or exposing the child to explicit sexual material, such as pornography.	Masturbating in front of the child, or exhibition
Sexual Exploitation	Soliciting a child for the purposes of prostitution, or using the child to film, photograph, or model pornography.	Lending a child out to be used for sexual gratification by another.

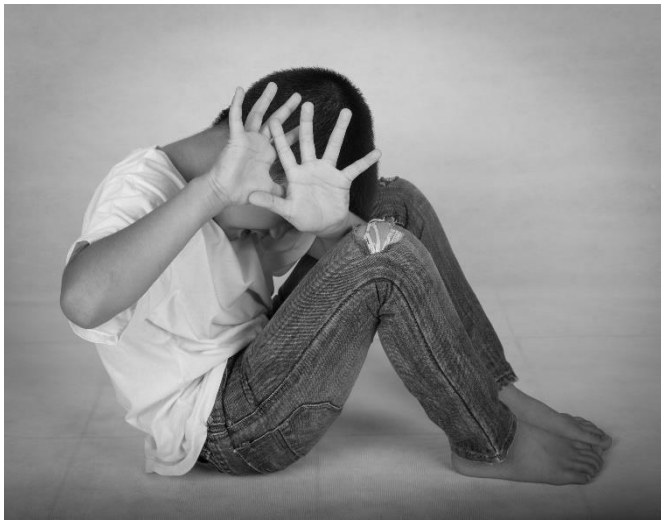
Impact of Child Sexual Abuse

Child sexual abuse is a traumatic experience and can have a lasting impact on the life of a child well into his or her adult life. Abuse can result in immediate symptoms, but also has long term physical, emotional, and psychological effects. The following section will focus on understanding the multifaceted impact of childhood sexual abuse on child victims.

Children who have been abused may begin to exhibit any of these behaviors again during or after visitation.

Signs and Symptoms

Identifying the signs and symptoms of child sexual abuse is important for monitors because in some cases, symptoms and signs can be very subtle and monitors should always be on high alert to protect children in visitation. There may be cases that are referred to programs as a result of sexual abuse findings and monitors should be aware of the dynamics that might be present during visitation. In other cases, there may not be pre-existing reports of abuse, and a child could be victimized while participating in supervised visitation. It is the responsibility of every visitation monitor to be aware of, notice, and report any inappropriate, re-victimizing, or alarming behaviors that take place during visitation.



There are patterns of behavior in children that can be identified as common (developmentally appropriate) and uncommon (red flags) in supervised visitation. It is important for supervised visitation providers to know the types of uncommon behaviors that should be considered red flags.

NOTE

It is important to note that any number of events could be potential triggers for children who have been abused. These could be as simple as being in the presence of the abuser or the smell of their clothes.

Table 12.6
Common and Uncommon Sexual Behavior

Common (may be developmentally appropriate)	*Uncommon (red flags)*
Preschool (0 to 5 years)	
• Sexual language relating to differences in body parts, bathroom talk, pregnancy, and birth • Self-fondling at home and in public • Showing and looking at private parts with other children	• Discussions of sexual acts • Sexual contact experiences with other children • Masturbation unresponsive to redirection or limits • Inserting objects into genital opening
School Age (6 to 12 years)	
• Questions about menstruation, pregnancy, and sexual behavior • Experimenting with same-age children, including kissing, fondling, exhibition, and role-play • Masturbation at home or other private places	• Discussions of explicit sexual acts • Asking adults or peers to participate in explicit sexual acts • Masturbating in public or excessively in private to the point of bleeding
Adolescence (13 to 16 years)	
• Questions about decision-making, social relationships, and sexual customs • Masturbating in private • Experimenting between adolescents of the same age, including open mouth kissing, fondling, and body rubbing	• Sexual interest in much younger children • Aggression in touching other genitals • Asking adults to participate in explicit sexual acts • The use of force, aggression, or drugs to obtain compliance

Best Practices

For visitation programs accepting referrals of cases involving child sexual abuse, there are specific visit rules that must be followed in order to protect the children involved. These rules should be already established and understood by all parties. In fact, they should be part of the visitation program agreement so that they are transparent. Monitors and program directors are responsible for ensuring all rules are followed.

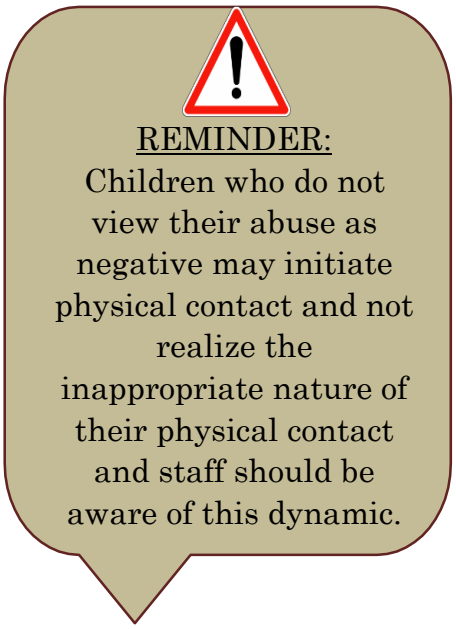
Know and understand all allegations. Prior to facilitating visits in any sexual abuse case, monitors should know what abuse has been alleged. Knowing what has previously happened is important when monitors are preparing for visits. It allows them to know what to look for during parent-child interaction. Monitors should review case files relevant to the abuse, and always document behavior that might be reason for concern. In addition, monitors should always consult with the supervisor or program director about parental or child behavior that raises concerns.

Ratio of staff to visiting families. In some programs, monitors may supervise more than one visit at a time. In sexual abuse cases, it is crucial to have one visit monitor for each visiting family. If the family is large, monitors should consider using more than one monitor to ensure that all family members are supervised adequately. This is important because it allows monitors to focus on one family, reducing distractions while remaining in the room at all times. It is crucial for monitors to be able to see and hear all interactions between parent and child. Upholding this ratio will help children feel protected, the visiting parent become aware of the close monitoring, and for the court system to know that the child is being adequately protected.

Language requirements. It is important for the monitor to have a fluent understanding of the language that the child and visiting parent will be using to communicate. If there is a need for sign-language interpreters or translation services, they should be scheduled and planned ahead of time. Language should be discussed during intake, and if the parent or child begins to use a language that is not understood by the monitor, an intervention should be made and a translator used

Physical contact. Due to the nature of child sexual abuse cases, it is important for physical contact to be closely monitored between parent and child. In addition, visiting parents should be aware that there will be restrictions on the physical

contact between parent and child during visits to protect the child from victimization and the parent from false allegations of abuse.



- Physical contact should be brief and should only be, if at all, initiated by the child. However, any physical contact which appears inappropriate or sexualized must be stopped by staff immediately, even if the child does not appear distressed.
- No objects – furniture, office equipment, toys, etc. – should block the view of the visit monitor.
- The following types of physical contact should be prohibited:

  - Tickling
  - Lap-sitting
  - Wrestling
  - Prolonged hugging or kissing
  - Kissing on any area below the face
  - Stroking
  - Hand holding
  - Hair combing
  - Changing diapers or clothes

These restrictions reduce the possibility of sexual abuse or physical abuse occurring during visits and of misinterpretations of parent-child contact. In addition, the following behaviors should also be avoided:

  - Whispering
  - Passing notes
  - Hand signals or body signals
  - Photographing the child
  - Audiotaping or videotaping the child
  - Exchanging gifts, money, or cards
  - Physical games (i.e. hiding toys or gifts in pockets, requiring child to touch toys or dolls)

This reduces the possibility of verbal threats, minimizes triggering events for the child, and enhances staff control of the environment. Monitors

should always be wary of unfamiliar behavior between the parent and the child and should make an effort to stop any communication that is not easily understood by others outside of the parent-child relationship. Secrets, private games between the parent and child, and other behavior that is unfamiliar to a monitor should trigger an intervention and re-direction. Whenever a monitor intervenes in a visit, the intervention should be recorded in the case notes.

Prohibitions on items brought to visits. Parents, custodial or visiting, should avoid bringing any items to the visit including:

- Toys, dolls, games, books
- Written material
- Food
- Additional clothing
- Photos
- Drinks
- Music
- Tapes
- Jewelry
- Pets (except service animals)
- Household items

IMPORTANT OFF-SITE VISITS

As part of the Clearinghouse's recommendations for child sexual abuse cases, off-site visits should NEVER occur for cases of child sexual abuse.

This reduces the possibility of a perpetrator bringing to the visit covert or overt reminders of the child's abusive experience. It also reduces the opportunity for the perpetrator to bribe the child or influence his or her testimony

Toilet rules and restrictions. Programs should have written rules relating to the use of toilet facilities during visits, and parents and children should be made aware of these rules prior to the first visit.

- Children MUST use the toilets on their own, or if a child is not old enough to use the toilet on his or her own, he or she should be accompanied by staff only. Parents may not accompany their children to the toilet in sexual abuse cases.
- Children may not accompany their siblings or other children to the bathroom in these cases.
- Babies who wear diapers or training pants should be changed by staff in a room separate from the visiting parent.

These precautions reduce the possibility of physical or sexual abuse incidents during visits or the misinterpretation of visiting parent's behavior during toileting.

Avoid discussion about abuse. Parents should never be permitted to blame, tease, or scold the child about alleged abuse. Further, monitors should not allow parents to discuss alleged or confirmed abuse with children during visitation.

Monitors should be mindful that additional precautions or rules may need to address specific dynamics in each case. Monitors should discuss sexual abuse cases with program directors to develop a case plan and rules for each case supervised in the agency. The most important safety precaution in sexual abuse cases is for monitors is to be continuously observant and to intervene in and record any suspicious behavior during visitation.

Statutory Requirements

Florida Statutes 753.05 specifically refer to rules regarding supervised visitation in cases of child sexual abuse:

Referrals Involving Child Sexual Abuse

- In order to accept referrals involving child sexual abuse, a visitation program must have an agreement with court and current affidavit of compliance on file. Additionally, the chief judge of the circuit in which the program is located must affirm that the program has agreed to comply with the minimum standards mentioned in 753.04.
- The program must also have a written an agreement with the court and with the department that contains policies specifically related to child sexual abuse that include provisions for the following:
    - Staff who supervises visits must have specific training on child sexual abuse by the clearinghouse and that training must be documented in personnel files
    - The program must have protocols on how to obtain background material on the family prior to starting services
    - The program can only accept referrals for which the staff already has background material, training, and security in place to safely monitor visits
    - The program cannot accept referrals when staff lacks the education, training, background material, and the security necessary to ensure safety of the child.
    - The program must cease visits if the child appears to be traumatized by the visits or when the visitor engages in inappropriate behavior or violates the program rules.

NOTE

Every program that accepts child sexual abuse referrals must have an agreement with the Department of Children and Families on file.

State of Florida
Department of Children and Families

Rick Scott
Governor

Secretary

AGREEMENT FOR SUPERVISED VISITATION PROGRAMS

Pursuant to s.39.0139 and s.753.05, F.S., this Letter of Agreement outlines specific requirements in the provision of supervised visitation services administered by the (Name):_____ Supervised Visitation Program in accordance with the agreement on file with the _____ Judicial Circuit.

The Florida Department of Children and Families (DCF) agrees:

1. To acknowledge the authority of the staff of the above-named Supervised Visitation Program to accept or decline referrals. Programs shall decline to accept a case for which they cannot reasonably ensure the safety of all clients, program staff and volunteers, for reasons including, but not necessarily limited to the following:

a. The volatile nature of the case or client;
b. Inadequate training of program staff and/or volunteers;
c. Inadequate facility security;
d. Insufficient resources;
e. Insufficient case background information;
f. Conflict of interest.

The (Name):_____ Supervised Visitation Program agrees that:

1. The program has an agreement with the court and a current affidavit of compliance on file with the chief judge of the _____Judicial Circuit affirming that the program has agreed to comply with the minimum standards contained in the administrative order issued by the Chief Justice of the Supreme Court on November 18, 1999.

2. The program will ensure that all program staff monitoring supervised visitation and other contact will have previously received special training in the dynamics of child sexual abuse provided through the Clearinghouse on Supervised Visitation; same training will be clearly documented in staff personnel files.

3. The program will have protocols established for obtaining background information on the family/case, prior to the initiation of supervised visitation services.

4. The program will accept only those referrals for which staff members have the requisite case background information, training, and security in place to safely monitor visitation and other contact.

1317 Winewood Boulevard, Tallahassee, Florida 32399-0700

Mission: Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency

5. The program will decline referrals of child sexual abuse cases when staff lacks the necessary training or education, when background information has not been received, or when lack of security may enable revictimization of the child.

6. The program will establish and train staff on procedures for staff to follow when supervising visitation and other contact, particularly in cases involving child sexual abuse.

7. The program will develop and follow policies for the handling and reporting of critical incidents.

8. The program will develop and enforce rules for appropriate interaction between the child(ren) and the parent(s)/individual(s) visiting during supervised visitation and other contact.

9. The program will suspend visits and subsequently notify the court in cases when the child appears to be traumatized by the visits, or when the parent/individual visiting or having other contact with the child engages in inappropriate behavior or otherwise violates program rules.

_____ _____
(DCF Representative Signature and Title) (Date)

_____ _____
(Supervised Visitation Program Director Signature) (Date)

For more extensive training on child sexual abuse, see the Clearinghouse's current training manual at http://familyvio.csw.fsu.edu/clearinghouse/manuals-and-materials/. A new Child Sexual Abuse Referrals Manual will be made available online in 2018. Topics to be included in this new training will include:

- The Impact of Child Sexual Abuse
- Human Trafficking
- Juvenile Sexual Offenders
- System Responses to Child Sexual Abuse
- Best Practices for Assessing Referrals
- Best Practices for Visits

Reporting Child Abuse

If, at any point during or following visitation, a monitor suspects or is made aware that a child has been abused or neglected by parents, caregivers, or any other adult in their life, they are mandated to report it to the Florida Department of Children and Families.

Information Needed for Report

When reporting abuse or neglect, it is necessary to gather relevant information which includes:

- Who is involved
- What happened
- When/Where it happened
- Extent of injuries
- What the victim disclosed
- Name, date of birth (or approximate age), race, and gender for all adults and children involved
- Addresses for all involved, including location at the time of report
- Relationship of the alleged abuse to their victim

3 Ways to Report:

Call
1-800-96-ABUSE (22873)

Fax
1-800-914-0004

Online
https://reportabuse.dcf.state.fl.us/

Definition of Abuse

The Florida Abuse Hotline will accept a report only when:

1. There is reasonable cause to suspect that a **child** (any born, unmarried person less than 18 years of age who has not been emancipated by order of the court)
2. Who can be **located in Florida**, or is temporarily out of the state but is expected to return in the immediate future,
3. Has been **harmed** or is believed to be **threatened with harm**
4. From a **person responsible for the care of the child** (such as a parent, legal custodian, adult household member, another adult, or another child who has taken responsibility for the child).

False Reporting

Any persons who make a report in good faith are immune from any civil or criminal liability. Any person who knowingly and willfully makes a false report has committed a felony in the third degree and are subject to up to 5 years in prison, five years of probation, and a $5,000 fine.

Failure to report known or suspected child abuse is now a third-degree felony offense.

False reports are those reports that are not true and are maliciously made for the purpose of:

- Harassing, embarrassing, or harming another person;
- Personal financial gain for the reporting person;
- Acquiring custody of a child;
- Personal benefit for the reporting person in any other private dispute involving the child.

Quiz

1. Which of the following is *not* required to report abuse?

A. Name, age, race, and gender of all involved
B. Location or address
C. Physical evidence or proof
D. A confession from a caregiver

2. TRUE or FALSE: Adults who were abused as children have an increased likelihood of abusing their own children.

3. What is one of the first signs that a child has been hurt, and may indicate physical abuse?

A. Bruising
B. Fractures
C. Burns
D. Cuts

4. Which of the following is considered to be a protective factor that universally reduces the likelihood violence will occur in a family?

A. Knowledge of children's developmental stages
B. Nurturing and attachment
C. Parental resilience
D. All of the above

5. TRUE or FALSE: Everyone has similar reactions to child abuse.

***Answers*: 1. C, 2. True, 3. A, 4. D, 5. False**

Online Resources

1. Child Welfare Information Gateway. *www.childwelfare.gov.* Provides resources on many topics concerning child welfare, and includes best practices, fact sheets, and other publications that visitation monitors and programs can utilize.

2. Healthy Children. *www.healthychildren.org.* American Academy of Pediatrics website providing parenting advice and resources for every stage of development. Topics range from prenatal care to parenting teenagers and young adults.

3. Florida Abuse Hotline. *www.myflfamilies.com/service-programs/abuse-hotline.* Additional information about reporting child abuse, including an online reporting portal.

4. NPR. *http://www.npr.org/sections/health-shots/2015/03/02/387007941/take-the-ace-quiz-and-learn-what-it-does-and-doesnt-mean*. At this site parents can take the Adverse Childhood Experiences (ACE) Quiz to learn more about childhood trauma, increased health risks and resilience.

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CHAPTER 13

DOMESTIC VIOLENCE AND SUPERVISED VISITATION

Case Scenario

Tristan has been visiting his ten-year-old son Cole for the past few weeks at the local supervised visitation program. Upon intake, Cole's mother Victoria expressed concern about her own safety, as well as Cole's while participating in the visits. Victoria has a protection order against Tristan due to the history of domestic violence in their marriage. During their marriage, Tristan threatened Victoria with his hunting knife many times. Victoria specifically recalls a time he waved his hunting knife at her, saying, "I'll make you look like the trophy on the wall." Under Florida law, if a Court enters a domestic violence final injunction protection order against an individual, it is illegal to possess any firearms, but Victoria told the monitor she was worried Tristan may not have gotten rid of his hunting knives.

At a visit, Tristan brings up hunting with his son and shows him pictures of his knives. Cole finds this story very exciting and asks his father if he can come hunting with him sometime. Tristan tells his son, "It's up to Mommy, so you go ask her, and tell her that she knows I'm good with a knife and you can be, too!" When Victoria picks her son up after the visit, Cole asks about hunting with his Dad. Victoria is very afraid because she knows that Tristan uses knives when he hunts and she is worried that he's using this as a way to threaten her. Victoria calls the supervised visitation program to see what she can do.

After completion of this chapter, you will be able to answer the following questions:

- What batterer characteristics are described here about Tristan?
- How should the supervised visitation monitor have handled this topic during the visit?
- What policies and procedures need to be in place in order to protect Victoria?

Introduction

In supervised visitation it is imperative that visit monitors understand the dynamics of domestic violence so that they can adjust their interactions with parents and children to enhance safety. Understanding the dynamics of domestic violence and how it affects children, victims, and perpetrators will allow programs to implement practices that best protect visiting families and staff members. This training will provide monitors with an overview of that information. Crucial local resources exist for victims/survivors across Florida. The Florida Coalition Against Domestic Violence has a listing of Certified Domestic Violence Centers. Their website is FCADV.org.

Supervised visitation services assist not only victims but also the court and law enforcement in ensuring safe contact between perpetrators and their children. It is important that monitors are attentive and observant of the interactions between family members who have experienced domestic violence. This training will help monitors hone their analytic skills in order to identify potentially harmful situations. In the case scenario above, the visit monitor could have stepped in at several points to prevent a potentially dangerous situation.

The CDC reports that two-thirds of female stalking victims were stalked by a current or previous intimate partner.

Many domestic violence perpetrators will try to find out where their victim is and may use children to find out that information.

It is up to the monitors to take preventative measures within the program to keep batterers from coming into contact with victim parents at visits. Many families that are referred to supervised visitation programs have an injunction or order of protection. There are different types of injunctions which you will learn about later in this chapter. As you continue throughout this chapter you will learn that many batterers use their children to gain important information about their victim; batterers may ask their children where they and the victim parent are staying or where the victim works. Thus, it is important for monitors to pay close attention to the dialogue occurring between a battering parent and a child. It should not be assumed that if an injunction is in place that the victim parent is now safe from the batterer. There is a very real threat of danger and fatality, and at the end of this chapter you will learn how recognize some of the risks involved.

What will I learn in this chapter?

Upon completion of this chapter, participants will be able to:

- Understand more about the complexities of domestic violence, its impact on supervised visitation, and local resources for victims
- Understand some of the myths and biases that perpetuate domestic violence
- Identify common characteristics of perpetrators and experiences of victims
- Recognize common behaviors of perpetrators that may impact supervised visitation services
- Understand the effects of domestic violence on children
- Understand how domestic violence affects a child's brain
- Understand the concerns that victim parents may have regarding supervised visitation
- Provide a safe and controlled environment for victims and children
- Implement policies that protect children, victims, other families, and staff
- Be aware that there are a variety of danger assessment tools used by victim advocates.
- Understand that the Local Certified Domestic Violence Center is an important community resource for victims.
- Identify some of the dynamics that indicate danger to the victim and be able to make referrals to the Local Certified Domestic Violence Center.

Domestic Violence Statistics

Released in 2010, the summary report of the National Intimate Partner and Sexual Violence Survey revealed several alarming statistics in regard to domestic violence.

- In 2010, the summary report of the National Intimate Partner and Sexual Violence Survey found that more than 1 in 3 women (35.6%) and more than 1 in 4 men (28.5%) in the United States have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.
    - *Center for Disease Control and Prevention & National Center for Injury Prevention and Control,* 2010

- Domestic violence can be fatal. In Florida's 2015 Annual Fatality Review Report, 64% of victims who were killed were separated from the perpetrator at the time of the murder

- *Report of the Attorney General's Statewide Domestic Violence Fatality Review Team,* 2015

•Combining local, state and the National Domestic Violence Hotline calls received more than 14 calls are made to hotlines every minute.

- *2013 Domestic Violence Count: A 24-Hour Census of Domestic Violence Shelters and Services,* 2013

Common Myths about Domestic Violence

Myth 1: Domestic violence is rare. Domestic violence is tragically common. Data collected from the National Crime Victimization Survey found that domestic violence accounts for 21% of all violent crime. 77% of domestic violence occurs behind the closed doors of the victim's home, and so if people cannot see the domestic violence while it is happening, they might not think that it is occurring.

- U.S. Department of Justice. (2014).

DID YOU KNOW?

- According to the CDC almost 1 in 4 women and 1 in 7 men have experienced severe physical violence by an intimate partner.

- The National Intimate Partner and Sexual Violence Survey, 2010

Myth 2: Alcohol and drugs causes domestic violence.
While alcohol and drugs can be involved during an episode of domestic violence, it certainly does not cause domestic violence. Many people who drink do not abuse their partners. Batterers may use alcohol and drugs as an excuse for being violent.

Myth 3: Victims have done something to cause the abuse, or they like the abuse. If they didn't, they would just leave.
Victim provocation is no more common in domestic violence than in any other crime. Battered women often make repeated attempts to leave violent relationships, but are prevented from doing so by the abuser's increased violence and control tactics. Other factors which inhibit a victim's ability to leave include economic dependence, few viable options for housing and support, unhelpful responses from the criminal justice system or other agencies, social isolation, cultural or religious constraints, a commitment to the abuser and the relationship, and fear of further violence.

Myth 4: Men cannot be abused

Although domestic violence disproportionately affects women, men can be victims of abuse as well. The CDC reports that 1 in 7 men have been severely assaulted by an intimate partner. In 2013, 13% of calls to the Domestic Violence Hotline were from male victims calling for assistance. Due to myths that reinforce traditional ideas of masculinity, male victims may be hesitant to report abuse due to the societal repercussions.

- National Center for Injury Prevention and Control, & Centers for Disease Control and Prevention. (2010).
- National Domestic Violence Hotline. (2014).

Myth 5: Religious families do not experience domestic violence.

The "National Declaration by Religious and Spiritual Leaders to Address Violence Against Women" acknowledges that domestic violence exists in all communities, including the church, and that too often sacred texts, traditions, and values have been misused to condone abuse.

- Faith Trust Institute, 2006

Myth 6: Domestic violence is usually a one-time event, or an isolated incident.

Battering is often a pattern of coercion and control that one person exerts over another. It typically includes the repeated use of a number of tactics including intimidation, threats, economic deprivation, isolation, and psychological and sexual abuse. Physical violence is just one of these tactics. The various forms of abuse utilized by abusers help to maintain power and control over their spouses and partners. Sometimes an abuser can control a victim by threatening violence, even if actual physical violence has not been used for some time.

What is Domestic Violence?

Legal Definition

Florida Statute Chapter 741.28

- "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. 741.28(2), Florida Statutes.

DID YOU KNOW?

The Florida annual fatality review report found that 64% of abuse victims who were murdered were separated from the perpetrator.

- *Faces of Fatality, Report of the Attorney General's Statewide Domestic Violence Fatality Review Team*, 2015

- "Family or household member" means spouses, former spouses, persons related by blood or marriage, persons who are presently residing together as if a family or who have resided together in the past as if a family, and persons who are parents of a child in common regardless of whether they have been married. With the exception of persons who have a child in common, the family or household members must be currently residing or have in the past resided together in the same single dwelling unit. 741.28(3), Florida Statutes.

A Non-legal definition

From The National Domestic Violence Hotline:

- "Abuse is a repetitive pattern of behaviors to maintain power and control over an intimate partner. These are behaviors that physically harm, arouse fear, prevent a partner from doing what they wish or force them to behave in ways they do not want. Abuse includes the use of physical and sexual violence, threats and intimidation, emotional abuse and economic deprivation. Many of these different forms of abuse can be going on at any one time."

Another term for domestic violence is *intimate partner violence* which is inclusive of couples who do not or have not lived under the same household but have or had an intimate relationship. As a visitation monitor, it is important to understand that the parents you work with may not have ever lived together but had a violent relationship. Do not assume that mere separation of the victim from the perpetrator will end the violence. Most homicides that occur happen after the victim has left the abuser.

Types of Domestic Violence

Table 13.1
Types of Domestic Violence

Physical Abuse

- Slapping
- Burning
- Mutilating
- Kicking
- Threatening with a knife, gun, or other weapon

Destroying loved objects or pets

Emotional Abuse

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

Economic Abuse

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

Sexual Abuse

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

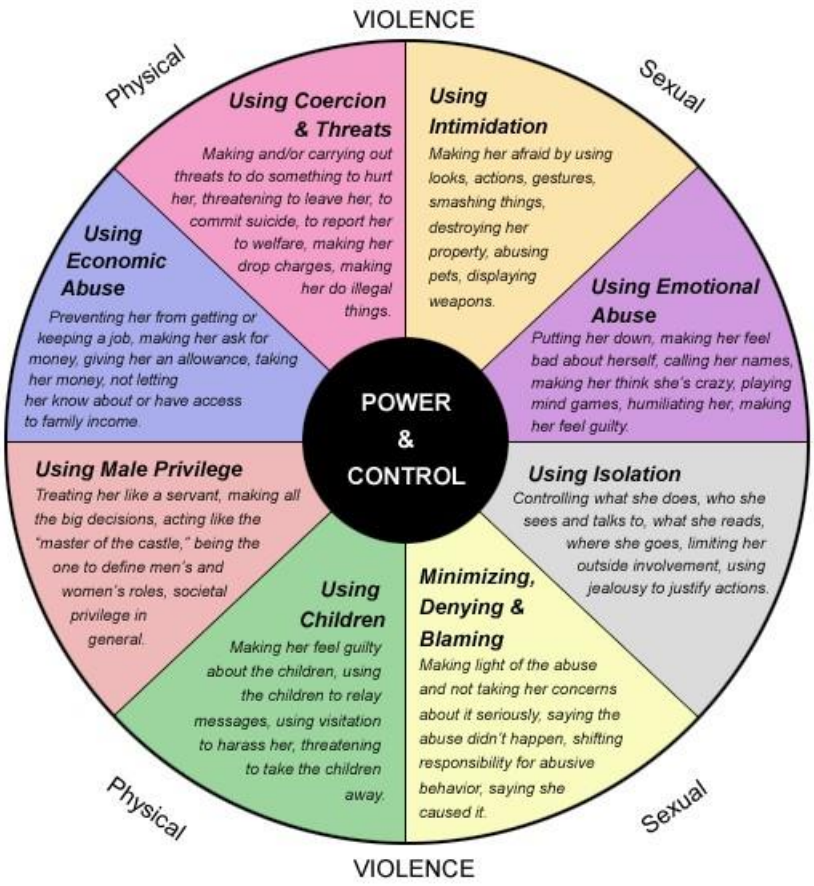
Control Through Children

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

Dynamics of Domestic Violence

Developed by the Domestic Abuse Intervention Project in Duluth, Minnesota, the Power and Control Wheel illustrates the tactics an abuser may use to control a victim. The victim is constantly surrounded by threats and/or actual physical and sexual abuse, as the abuser attempts to exert complete power and control.

Key concepts about Power and Control Dynamics:



Used with permission: Domestic Abuse Intervention Project, Duluth, MN.

- Abusers believe they are entitled to control their victims. They believe that threats and violence are acceptable and will produce the desired results. Therefore, domestic violence is purposeful and instrumental behavior.
- The pattern is directed at restricting independent thought and action so that the victim will become devoted to fulfilling the needs of the abuser.
- The pattern is not impulsive or "out of control" behavior. Tactics that work to control the victim are selectively chosen by the perpetrator. This achievement is unfulfilling, however, because the abuser can never get enough control to make him/her feel comfortable. It is impossible, despite the victim's attempts to comply.
- Domestic violence is not limited to a person who physically hurts a spouse or family member but includes many other instances of using power and control.

Legal Options Available to Victims of Violence

Many domestic violence referrals to supervised visitation are the result of one parent obtaining an Injunction for Protection Against Domestic Violence. Thus, it is important to understand the legal options available to victims of violence.

In the state of Florida there are five different types of injunctions that can protect victims from perpetrators who commit acts of domestic violence, repeat violence, sexual violence, or dating violence, and stalking. It is important to understand the five different types of injunctions.

1. Injunction for Protection Against Domestic violence

Persons who may Petition for a Domestic Violence Injunction

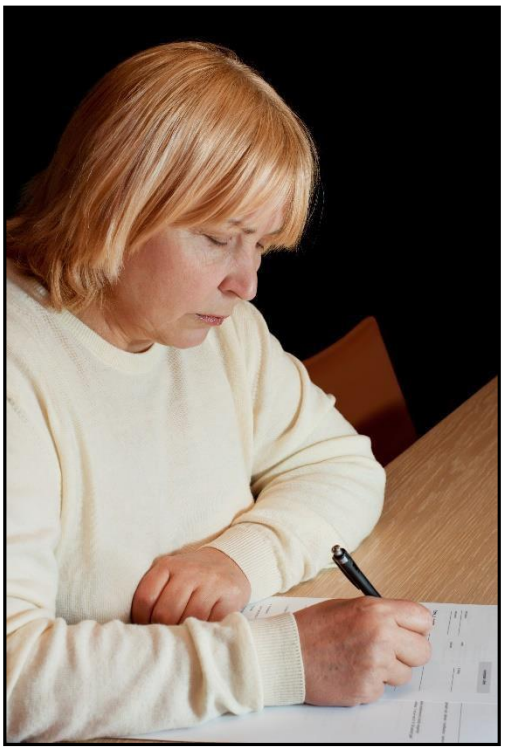
"Any person described in paragraph (e), who is either the victim of domestic violence as defined in s. 741.28 or has reasonable cause to believe he or she is in

imminent danger of becoming the victim of any act of domestic violence, has standing in the circuit court to file a sworn petition for an injunction for protection against domestic violence." 741.30(1) (a), Florida Statutes.

Other Types of Injunctions

Florida Statutes 784.046 contains the repeat violence, dating violence, and sexual violence injunctions.

2. Repeat Violence



"Repeat violence" means two incidents of violence or stalking committed by the respondent, one of which must have been within 6 months of the filing of the petition, which are directed against the petitioner or the petitioner's immediate family member." 784.046(1) (b), Florida Statutes.

"Violence" means any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, or false imprisonment, or any criminal offense resulting in physical injury or death, by a person against any other person. 784.046(1) (a), Florida Statutes.

Persons who may Petition for a Repeat Violence Injunction

"Any person who is the victim of repeat violence or the parent or legal guardian of any minor child who is living at home and who seeks an injunction for protection against repeat violence on behalf of the minor child has standing in the circuit court to file a sworn petition for an injunction for protection against repeat violence." 784.046(2) (a), Florida Statutes.

3. Dating Violence

"Dating violence" means violence between individuals who have or have had a continuing and significant relationship of a romantic or intimate nature. The existence of such a relationship shall be determined based on the consideration of the following factors:

1. A dating relationship must have existed within the past 6 months;
2. The nature of the relationship must have been characterized by the expectation of affection or sexual involvement between the parties; and
3. The frequency and type of interaction between the persons involved in the relationship must have included that the persons have been involved over time and on a continuous basis during the course of the relationship."

The term does not include violence in a casual acquaintanceship or violence between individuals who only have engaged in ordinary fraternization in a business or social context. 786.046(1) (d), Florida Statutes.

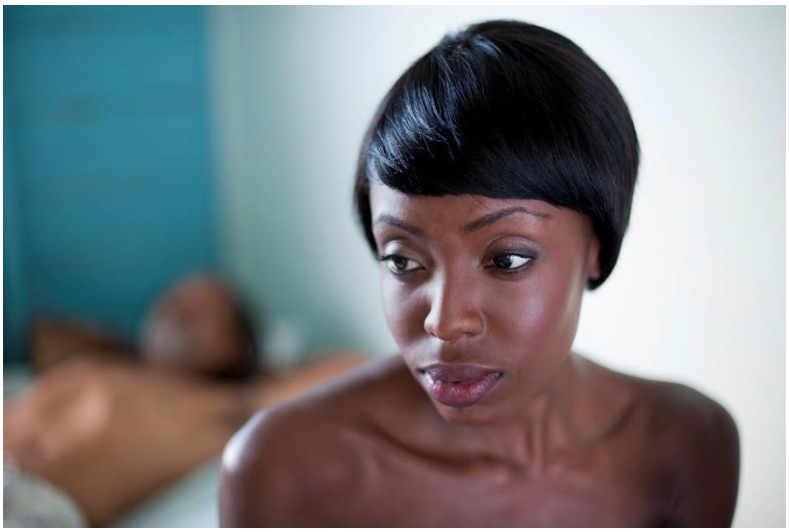
Persons who may petition for an injunction for dating violence:

"Any person who is the victim of dating violence and has reasonable cause to believe he or she is in imminent danger of becoming the victim of another act of dating violence, or any person who has reasonable cause to believe he or she is in imminent danger of becoming the victim of an act of dating violence, or the parent or legal guardian of any minor child who is living at home and who seeks an injunction for protection against dating violence on behalf of that minor child, has standing in the circuit court to file a sworn petition for an injunction for protection against dating violence." 784.046(2) (b), Florida Statutes.

4. Sexual Violence

"Sexual violence" means any one incident of:

1. Sexual battery, as defined in chapter 794;
2. A lewd or lascivious act, as defined in chapter 800, committed upon or in the presence of a person younger than 16 years of age;
3. Luring or enticing a child, as described in chapter 787;
4. Sexual performance by a child, as described in chapter 827; or
5. Any other forcible felony wherein a sexual act is committed or attempted, regardless of whether criminal charges based on the incident were filed, reduced, or dismissed by the state attorney." 784.046(1) (c), Florida Statutes.



Persons who may petition for a sexual violence injunction:

"A person who is the victim of sexual violence or the parent or legal guardian of a minor child who is living at home who is the victim of sexual violence has standing in the circuit court to file a sworn petition for an injunction for protection against sexual violence on his or her own behalf or on behalf of the minor child if:

1. The person has reported the sexual violence to a law enforcement agency and is cooperating in any criminal proceeding against the

respondent, regardless of whether criminal charges based on the sexual violence have been filed, reduced, or dismissed by the state attorney; or

2. The respondent who committed the sexual violence against the victim or minor child was sentenced to a term of imprisonment in state prison for the sexual violence and the respondent's term of imprisonment has expired or is due to expire within 90 days following the date the petition is filed." 784.046(2) (c), Florida Statutes.

5. Stalking

- **"**A person who willfully, maliciously, and repeatedly follows, harasses, or cyberstalks another person commits the offense of stalking, a misdemeanor of the first degree." §784.048(2), Florida Statutes.
- "A person who willfully, maliciously, and repeatedly follows, harasses or cyberstalks another person, and makes a credible threat to that person commits the offense of aggravated stalking, a felony of the third degree." §784.048(3), Florida Statutes.

Persons who may file for a stalking injunction:

- "A person who is the victim of stalking or the parent or legal guardian of a minor child who is living at home who seeks an injunction for protection against stalking on behalf of the minor child has standing in the circuit court to file a sworn petition for an injunction for protection against stalking." §784.0485(1) (a), Florida Statutes.
- "If it appears to the court that stalking exists, the court may grant a temporary injunction ex parte, pending a full hearing, and may grant such relief as the court deems proper, including an injunction restraining the respondent from committing any act of stalking." §784.0485(5) (a), Florida Statutes.

The full Stalking Statute is found in 784.048, Florida Statutes.

Characteristics of Perpetrators

Abusers do not differ from non-abusers in race, religion, or economic status. Abusers come from every profession, every level of education, every income level, every ethnic group, and every geographic location.

For various reasons, abusers can seem more "believable" and sympathetic than their victims. Therefore, it is very important for visit monitors to have an awareness of common abuser characteristics and behaviors in order to greater understand the dynamics of domestic violence.

Abusers deny responsibility. Often times, abusers will not take accountability for their abusive behavior. They might refuse responsibility for their actions by minimizing, denying, or lying about abusive episodes. Abusers may blame their partner for their abusive actions or claim that their actions were justifiable due to the victim's actions.

Batterers may blame alcohol or drug use for their behavior. Abusers may attribute their abusive behaviors to alcohol or other substances. However, research indicates that batterers still abuse even when they are not using substances.

The "Jekyll and Hyde" perpetrator personality. This type of personality refers to the tendency of many batterers to possess good characteristics that might be charming or even loving. Then they also possess a darker abusive side. Batterers may not be abusive all of the time, in all places, or with all individuals. The tendency for abusers to have both good and bad characteristics help hide the reality of the abuse.

Some, but not all, abusers may have been abused as children. While being abused as a child does not predict future violence or involvement in violence, it can increase the risk for future domestic violence. Supervised visitation plays an important role in breaking this cycle of violence. Without preventative measures, children may grow up believing that domestic violence is a normal part of relationships.

Children's Experiences with Domestic Violence

When children live in a home where domestic violence is present, they can be affected in many ways regardless of their age. For reasons they cannot control,

infants, toddlers, and school aged children may be impacted directly and/or indirectly by the perpetrator's violence.

Ways Children May be Impacted

Infants: Ages 0-1

- Born prematurely due to the effects of abuse on the mother
- Can hear or see the abuse
- Awaken due to loud yelling and actions
- In victim parent's arms during abusive episode, children may be stripped from parent's arms by abuser

Toddlers: Ages 2-4

- Can see or hear the abuse.
- Tries to stop the altercation, can become injured during process.
- Questioned by abusive parent about victim parent's activities
- Kidnapped or held hostage by abusive parent

School Age: Ages 5-12

- Can hear or see the abuse
- May try to physically intervene during violent episode
- Runs to the neighbor or calls 911 for help
- Used as a spy by the perpetrating parent against the other parent
- Forced to participate in the attack on the other parent
- Physically, emotionally, or sexually abused by perpetrating parent to control the other parent
- Restricted from contact with others to keep the abuse a secret

Adolescents: Ages 13-18

- Hits parents or siblings
- Tries to stop the abuse
- Becomes abused
- Used as a spy by perpetrating parent
- Used as a confidante by perpetrator or victim

Children's Responses to Domestic Violence

Children will have their own unique experiences with and responses to witnessing domestic violence. It is important to consider the possible emotional, physical, and behavioral responses that children might have in order to better understand a family's situation.

The responses that children have to domestic violence may vary due to multiple factors including:

- *The severity or duration of domestic violence*. Some children might witness the perpetrating parent threaten the victim parent with a weapon. Other children may witness an abusive episode.
- *A child's perception of the violence*. Children may believe that each abusive episode is life-threatening for the victim parent and can cause chronic stress in a child.
- *The age of the child*. At different ages, children may have different responses due to cognitive development and level of understanding.
- *The quality of the child's relationship with parents or one parent.*
- *The child's personal trauma history*. Every person experiences trauma differently and children have varying levels of resiliency, particularly when they remain connected with the non-abusive parent.

The single most critical factor in how children weather exposure to domestic violence is the presence of at least one loving and supportive adult in their life. Thus, children whose mothers are available and supportive will be better able to develop self-regulation abilities within the context of effective mother–child interactions.

Below are examples of the emotional, physical, and behavioral responses of witnessing abuse.

Table 13.2
Responses to Witnessing Abuse

Emotional	*Physical*	*Behavioral*
• Fear • Anxiety • Shame • Depression • Anger • Disturbances in Sleep	• Stomachaches and headaches • Bedwetting • Inability to concentrate	• Acting out and aggression • Withdrawal • Poor school performance • Developmental delays (speech, motor, or cognitive skills) • Self-injurious behavior

Due to the traumatic nature of witnessing domestic violence, children may have specific short or long term responses.

Note

- Your role as a supervised visitation monitor is to understand the possible responses that children may have so that the impact of short-term and long-term responses are minimized.

Short-term responses

- Hyperarousal
- Re-experiencing
- Avoidance
- Withdrawal
- Reactions to reminders

Long-term responses

- Substance abuse
- Suicidal behaviors
- Impulsive acts
- Chronic health problems
- Criminal and violent behavior
- Domestic violence perpetration or victimization in the future

What Neuroscience Says About Domestic Violence

Recent neuroscience research on brain development has led to new information regarding the effects of stress on the developing brains of children. While this research is important to be aware of, it is also important to note that every child is different and may have different experiences and effects on their brain. Monitors should not make generalizations about victim's experiences or

attribute these effects and characteristics to all victims. The stress that is caused by being exposed to domestic violence can affect the development of important brain structures. The brain structures that are most likely to be affected by domestic violence are developing neurons and the hippocampus. Those two brain structures are important because they assist children in forming trusting relationships with others, including their parents and friends.

The "Fight or Flight" Response

Exposure to stress, caused by events such as domestic violence, leads to frequent activation of the "fight or flight" response, even in babies. When this response is activated, individuals must decide whether they want to run away or fight back in a situation. Many children who witness domestic violence are constantly activating their fight or flight response, which creates a great amount of stress and produces negative effects on the brain. The long term effects of stress created by the fight or flight response on children include minor mental illness or even extreme and violent outbursts.

"Neuroscience shows us that exposure to domestic violence harms children's brains at the neuronal level, with lifetime consequences."

These negative effects can last throughout the life course. This is because exposure to violence creates and changes the architecture of the child's brain. While some stress may be positive for a child's developing brain, the stress produced by constant activation of the fight or flight response is very damaging.

How Stress Affects a Child's Brain

Neuroscience research supports what is called "fear conditioning" (See Table) and how it plays a role in a child's later problems with anxiety. Increased cortisol, a stress hormone, can "poison" circuits in the brain, causing permanent damage. Children exposed to high levels of stress, such as witnessing domestic violence, produce elevated amounts of cortisol. Elevated levels of stress hormones can cause confusion in infants because they feel they are unable to satisfy the fight or flight signals due to their lack of mobility. Therefore, infants may start to dissociate or have what is called a "defeat response." This response may also cause long-term damage to the child and the ability to function socially.

It is important for children to have meaningful relationships with their caregiving parents. Babies in particular react well to positive interaction with their parent and experience intense stress (high levels of cortisol) when this positive interaction is unavailable to them. Witnessing domestic violence can damage a trusting relationship between a child and a caregiver. For example, if the caregiving parent is constantly worried about his or her living conditions (when he or she will

be abused next, etc.,) the child may be aware of this tension. That negative energy may impact the level of stress experienced by the child.

Children who witness domestic violence that experience this toxic stress are also at risk for damage to their brain.

Table 13.3
Long-Term Effects of Excess Stress

Effect	*Explanation*	*Outcome*
Increased Cortisol	An increase in stress hormones like cortisol can poison circuits in the child's brain	Depending on which circuits are damaged, the child's ability to form new relationships may be permanently disrupted.
Disassociation	Being in "fight or flight" mode for extended periods of time with no option for either.	The child shuts down in order to avoid the stress.
Fear Conditioning	Child experiences "embedded stress" and remains at a high level of stress for long periods of time	Increases the likelihood of anxiety troubles throughout the child's life.
Mental Health	Children exposed to domestic violence are at a higher risk of developing mental illness. This includes substance abuse, learning disorders, hyper arousal, increased violent tendencies, etc.	Increased startle response, serious sleep disorders, anxiety, hyperactivity, conduct disorder, attention deficit and hyperactivity disorder (ADHD), and PTSD

Highlights from Neuroscience Research

1. Neuroscience research allows social service providers to gain a more complete view of the damage caused by domestic violence perpetrators.
2. Exposure to domestic violence can lead to maladaptive behaviors such as substance abuse, suicide attempts, and depressive disorders.
3. Neuroscience provides evidence that a close attachment with a nurturing parental figure supports healthy brain development and can restore brain health after experiencing domestic violence.

4. This evidence leaves no doubt that when a non-perpetrating parent seeks assistance from the courts to protect a child from exposure to domestic violence, judges' decisions will influence the development of a child's brain and impact the child's mental and physical health, learning capacity, and behavior across the child's lifetime.

Working with Victims in Supervised Visitation

Supervised visitation can be stressful, especially on victims of domestic violence. A majority of violence research has been done with women victims, therefore, most of the available data relate to female victims with male perpetrators. Remember, women face a greater risk of being killed after leaving the abusive relationship, and this risk does not disappear simply because the victim and perpetrator are being supervised. Victims are at risk of being stalked before or after visitation**.**

As a supervised visitation program, it can be very beneficial for staff to learn about trauma-informed care and services. To learn more about trauma-informed care and services, See Chapter 15, Practice Skills for Visit Monitors.

The link below provides a listing of certified domestic violence centers in Florida!

http://www.fcadv.org/centers

Table 13.4 Working with Victims		
What to do	**How it helps**	**Results**
Create a Safety Plan at visits, and refer to certified domestic violence center for an expansive safety plan.	• **Arrange for both parties to arrive and depart at different times** • **If the victim still does not feel safe, arrange for a law enforcement officer to follow her and/or escort her from the building.**	• **Having a safety plan helps to ensure the safety of victims and their children.**
Refer to other services when necessary.	• **If you feel the victim needs or the victim independently requests individual or additional counseling for mental health problems, substance abuse problems, parenting issues, etc., do not hesitate to offer these referrals.** • **When you offer a referral, make sure you follow up with the person you made the referral with. For example, ask questions such as "Did you have a chance to use that referral I gave you? Do you need any additional services?" etc.**	• **Many issues involving the plight of victims cannot be addressed by the supervised visitation program or staff. In these cases, it is appropriate and encouraged to refer victims to other services.**
Stay Focused on Safety	• **Abusers might not necessarily seem like abusers. They may deny abuse. Stay focused on the safety of the children and the vulnerable parent.**	• **There is no standard victim or abuser. Keep this in mind when working in a supervised visitation setting.**
Learn more about trauma-informed care	• **Being trauma informed can allow visitation monitors to create an understanding and supportive environment for victims.**	• **Monitors who are educated about trauma are more sensitive to client's needs.**

Domestic Violence and Mental Illness

Victims experience depression, anxiety, sadness, etc. at higher levels as a result of perpetrator's violence. Some common presenting issues for domestic violence victims are:

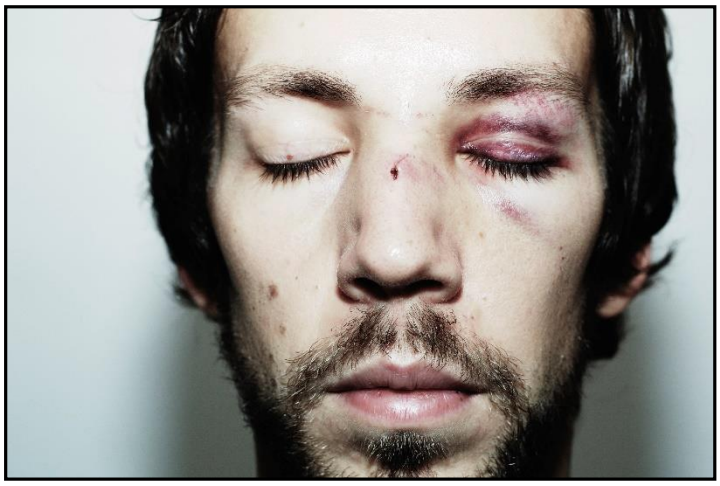
- Anxiety and Sadness: 77%
- Major Depression (in the last 12 months): 51.4%
- Phobias 35.1%
    - The phobias may relate directly or indirectly to the abuse
- Bipolar and Manic Depression 23%
    - This number is significantly higher than the general population rate of 0.7%
- PTSD (Post Traumatic Stress Disorder) 16.2%

These problems can affect a victim long after they leave a relationship. The victim may be afraid, ashamed, or isolated by the relationship and may have developed unhealthy coping mechanisms to deal with these emotions.

Male Victims

Effects of Victimization on Male Victims

As with female victims, male victims experience a range of physical, psychological, social, and emotional effects resulting from victimization.



Physical
- Injuries
- Medical conditions caused by violence

Psychological
- Feelings of anxiety, depression, and fear
- Difficulty sleeping or relaxing due to stress
- Feelings of alienation and self-loathing

Social
- Difficulty interacting in and forming relationships
- Feeling a lack of support in social relationships

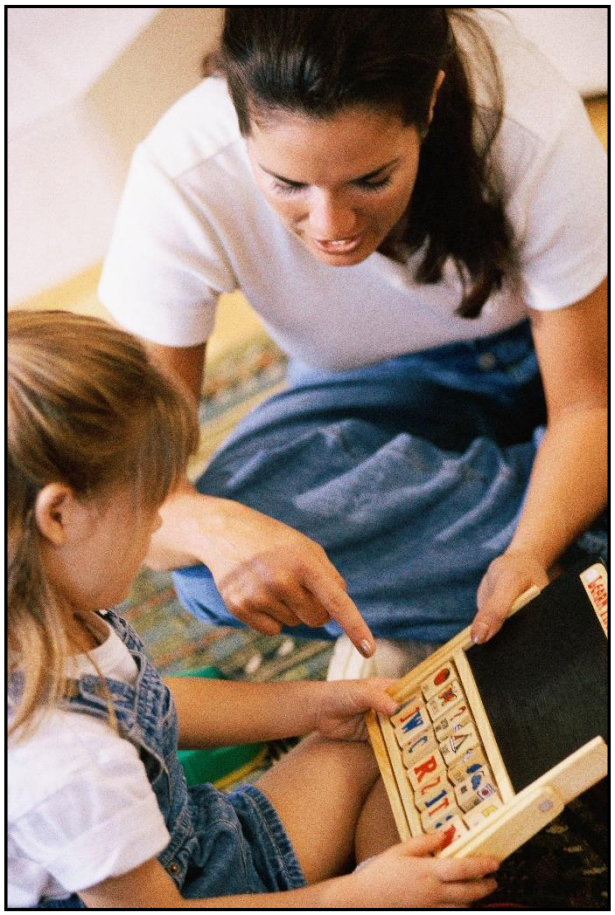
- Separation from social relationships

Emotional

- Feelings of guilt, anger, frustration, and hostility
- Feeling overwhelmed and out of control
- Avoiding experiencing emotions

The Victim as the Visiting Party

Florida statues state that the court shall consider evidence of domestic violence or child abuse as evidence of detriment to the child. (FL. Stat. 61.13) Thus, the court may require perpetrators to attend supervised visitation. Program staff should not presume, however, that only perpetrators will be ordered to supervised visitation. In fact, victims of domestic violence may also be ordered to supervised visitation for several reasons:



1. The perpetrator has convinced the court that he or she has not committed domestic violence.
2. The perpetrator may have convinced the court that it was he or she who was the victim of domestic violence.
3. The perpetrator has convinced the court that he or she was falsely accused of violence and that the children were wrongfully removed.
4. The victim flees to a domestic violence center and the perpetrator accuses the victim of abandoning the children.
5. The perpetrator has more resources and has used financial resources to gain the upper hand in protracted court litigation.
6. The victim has suffered from anxiety and/or depression because of the abuse and appears unstable because of the long-term trauma. The perpetrator, on the other hand, appears calm and in control. This is a tactic that perpetrators commonly use to discredit victims and their mental stability.
7. The victim may have abused substances to cope with violence and the status as a substance abuser discredits his or her claim for parental responsibility of the children.

How Programs Should Respond to Victims as Visitors

There are a variety of ways in which programs can prepare themselves to be responsible to victims as visitors. In addition to having a formal relationship with a certified domestic violence centers, programs should be able to make referrals to community services. Most importantly, when a program determines a victim of domestic violence has been referred to visit as a visitor, specific considerations should be made which include the following:

1. Safety considerations are paramount. The program should ensure that its policies and procedures align with and promote taking all necessary precautions to enhance safety. Program staff may need to alter their arrival and departure policies to minimize stalking opportunities by the custodial parent. The program should ensure that its arrival and departure policies do not endanger the victim. Other considerations such as having the victim wait at a nearby location until the batterer is on site may need to be incorporated.
2. Programs should discuss at intake and periodically with the victim about the risks to the victim, children, and staff that the victim perceives as a threat. This can be an ongoing conversation to ensure program policies can be flexible enough to incorporate safety considerations of the visiting victim.
3. There may be limits that need to be placed on the discussions the victim can have with a child regarding living arrangements so the child does not become a conduit to the batterer's attempts to obtain location information of the victim.
4. Some children may have been alienated from the victim parent by the batterer parent. This means the visiting parent may need additional support during visitation to improve the parent and child communication and relationship.

Essential Local Resources: This chapter provides supervised visitation staff with an overview of the dynamics and safety issues of domestic violence. The most important local resource for victims/survivors is the Local Certified Domestic Violence Center. For a center near you, go to FCADV.org

Working with Children Experiencing Domestic Violence

When children have witness abuse, there are many impacts in their daily lives. In addition, children's experiences with domestic violence may impact the supervised visitation process. Monitors should be aware of children's reactions to domestic violence and what behaviors may be present during visitation as a result of the violence.

Infants: Ages 0-1

- Fearful or anxious during visitation with perpetrating parent
- Will not leave the arms of non-perpetrating parent

Toddlers: Ages 2-4

- Fearful or anxious during visitation with perpetrating parent
- Will not leave non-perpetrating parent
- Experiences developmental set-back like regression in toilet-training

School Age: Ages 5-12

- Expressed loyalty to abusive parent or non-perpetrating parent
- Refused to visit
- Expresses anger toward visiting parent
- Adopts facial expressions that are not congruent with their feelings (e.g. smiling when scared)

Adolescents: Ages 13-18

- Refuses to visit. Embarrassed about using visitation services.
- Withdrawn during visit
- Attends visitation even if they do not want to be there in order to protect siblings and non-perpetrating parent.

Teen Girls

- Angry at victim/perpetrator for making them visit
- Confronts parent about the abuse

Teen Boys

- Angry at victim/perpetrator for making them visit
- Aggressive towards abusive parent

It is important to note that there are variations in children's experiences and that some of these indicators may be present even when children have not witnessed or experienced violence, such as being embarrassed to use visitation services.

A child's experience with witnessing domestic violence can have an impact on visitation and monitors should not ignore those effects but engage in the techniques below to help address them. Refer to the table below to learn about ways that monitors can work with children during a visit to make them feel safe and have positive, healthy interactions with their parent.

Table 13.5 Working with Children	
What to do	*Explanation*
Help foster children's self-esteem	• Self-esteem issues may result from witnessing domestic violence because it can create confusion, doubt, and fear. Children may even blame themselves for the violence that has occurred in their home. • Monitors can work with children to help foster self-esteem during visits in order to address those risks. Doing activities that make a child feel successful and encouraging parents to use positive language with their children can help increase self-esteem and combat negative self-perceptions.
Ensure a structured and predictable environment	• Children may be worried for their safety during a visit with the perpetrating parent. It's important to establish a procedure for visits that allow a child to feel a sense of security. • If a particular visit monitor has always worked with one parent and child, the child may become frightened if there is suddenly a different visit monitor. Work with children to ensure that they are comfortable and feel safe during a visit.
Model appropriate interactions	• Children who witness domestic violence may have distorted ideas about what healthy and positive interactions are in a parent-child relationship. • Monitors can work with families to help them understand what appropriate interactions look and sound like. • A visit monitor can model appropriate interactions by using positive language and engaging in age appropriate conversations with the child.
Understand the unique needs of teens	• Teenagers who have witnessed domestic violence may have developed unhealthy or negative perceptions about relationship. Supervised visitation monitors can work with teenagers and families to have appropriate conversations about healthy relationships and nonviolent ways to address frustration or conflict. • Monitors should understand that visits with teenagers may be drastically different than visits with young children. Therefore, monitors should consider and understand how teenagers are affected differently by domestic violence.

Working with Perpetrators

In addition to working with victims and children experiencing domestic violence, monitors will likely work with perpetrators as both visiting and custodial parents. When working with perpetrators it is important for monitors to consider how certain characteristics may affect supervised visitation and what special considerations must be made for safety and visitation compliance. In addition to the information provided in this chapter, monitors should also review the Practice Skills chapter to understand safety, termination, and intervention during visits.

In domestic violence referrals there is already an established history of violence in the family which increases the level of considerations monitors must take to ensure the safety of visiting children/families, and staff members. Monitors should do these 5 things when working with perpetrating parents.

1. **Have a conversation about program expectations.** Before the first visit begins, monitors should have a conversation with perpetrating parents about the programs expectations of parental conduct inside and outside of the program. This is an opportunity for monitors to discuss what is considered appropriate interactions with children and what topics/conversations are not appropriate for the duration of a visit.
2. **Inform the parent about program restrictions and limitations.** Programs may have different protocol about what is allowed inside the visiting center or what activities are allowed between parents and children. This information should be clearly communicated to perpetrating parents before the first visit.
3. **Discuss consequences for violating program policies and procedures.** Monitors should explain to perpetrating parent's the consequences of violating program policies and procedures. Perpetrating parents can violate program policies by contacting the custodial parent outside of the program or following the child and custodial parent home after the visit has ended.
4. **Explain that a visit/services can be terminated at any time.** If a monitor finds the visit to be harmful to the child or inappropriate the monitor should terminate the visit. Any type of violence toward the custodial parent that violates supervised visitation policies or an injunction will affect the perpetrating parent's ability to visit with their child.

REMINDER:
Monitors can learn more about intervening during a visit, terminating visits, and reporting critical incidents in the practice skills chapter.

5. **Encourage the parent to rebuild the parent-child relationship.** Most importantly, supervised visitation programs offer perpetrating parents the opportunity to rebuild the parent-child relationship. Domestic violence can have several effects on children that can hurt them individually but their relationship with the perpetrating parent as well. Monitors can help encourage parents to build a healthy and positive relationship with their child.

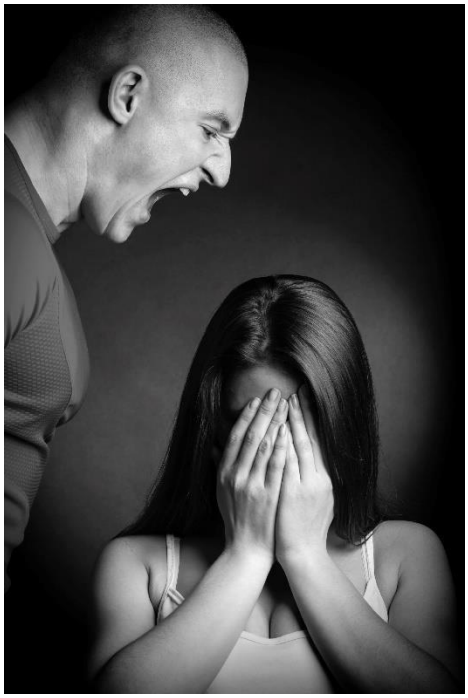
Continue reading for more information about communication with courts about safety and domestic violence issues.

How Batterer Characteristics Affect Supervised Visitation

The common behaviors and characteristics of batterers can have an impact on supervised visitation. Below are examples of how these behaviors may manifest during a visit.

Characteristics

- *Denial of Abuse/Minimization.* Children may ask visiting parents questions about abuse and the parents may deny the abuse, say it was an accident, or minimize their actions. Visiting parent may claim that it was the other parent's fault for the abuse and that he or she caused the abuse to happen.



- *Blaming Partner.* Batterers may try to deflect responsibility for being at supervised visitation and blame the other parent, saying things like, "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. Examples include: 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.* Batterers 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.* Parent driving around the visitation program at the time of the scheduled visits but not coming into program. Parent verbally threatens 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 where the children are attending school. Additionally, visiting parents may ask children to relay messages to the other parent.

- *Stalking (in person or through a third party).* Batterers may follow the parent who is leaving a program and record the license number of the victim's car. Monitors should pay close attention to conversation, because perpetrators may reveal stalking incidents during conversations with children. 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. Batterers may make it difficult for the program by paying in pennies or other small coins.

- *Animal Abuse.* A batterer may inform the 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.

Think about this…

- **These behaviors and characteristics can have a negative impact on supervised visitation for a variety of reasons:**
  - **The child becomes upset by the visiting parent.**
  - **These behaviors prevent the visitation staff from performing their duties properly.**
  - **These behaviors can hinder a healthy interaction between the parent and child.**

- **It is important to think about how these behaviors and characteristics will affect visit monitors, the visiting child(ren), other families, and the program in general.**

- **After exploring the ways that abuser demeanor can affect supervised visitation, think about how visit monitors can address these behaviors in order to promote safety and well-being in the program.**

See Chapter 15, Practice Skills for Visit Monitors to learn more about appropriate interventions.

- *Physical Violence.* Non-custodial parents may use violence against the other parent while the family is using services. In the history of supervised visitation, programs have reported murders or physical assaults that have occurred either on-site or near the program. These violent events can also occur outside of the programs perimeters, whether it be the custodial parent's home or workplace, which is why safety must be prioritized at all times.

- *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.

STOP and Think

After reading this section, you should be able to answer the following question regarding the case scenario from the start of the chapter.

What batterer characteristics does Tristan display?

Risk Identification

Separation Violence

Research has revealed that the time after a victim leaves his or her perpetrator of domestic violence can be the most dangerous time for the victim. This is because the nature of the power and control dynamic of domestic violence. The batterer seeks to control the victim, and when the victim leaves that control is diminished. The batterer may seek to regain that control – creating real safety risks for the victim and children. When a case is referred to supervised visitation with the perpetrator as the visitor, that perpetrator has lost a great deal of control. Therefore, risks may be greater. In order to enhance victim and children safety, programs should consider doing the following:

- Develop security protocols on site. The best practice is to include using onsite security personnel (preferably law enforcement officials). Programs should also consider tools such as locked entrance doors, intercom systems, panic buttons, and weapon detectors that staff have been thoroughly trained to use.
- Conduct thorough screening of every case to determine the risks to each family member.

- Create safety plans that ensure that the victim and perpetrator do not come into sight or audio contact during visits.
- Create flexible and carefully created arrival and departure times to ensure the safety of the victim and children.
- Establish a clear method of communication with the referring court about any safety problems with program participants.
- Be sure to have highly trained staff who understand how to intervene if the perpetrator speaks negatively about the victim or denies, minimizes, or blames the other participants for the violence.
- Ensure that the program has copies of parents' injunctions on hand.

STOP and Think

After reading this section, you should be able to answer the following question regarding the case scenario from the start of the chapter.

What policies and procedures need to be in place in order to protect Victoria from her batterer?

Red Flags

Below is a partial list of parental behaviors at visits that may indicate heightened risk, necessitate suspension, or termination of services.

- Parents using the visitation program to monitor the other parent's location.
  - Waiting in a vehicle for the other parent before or after the visit.
  - Asking the children where the other parent lives.
- Parents verbally or physically threatening the other parent, child, or staff.
- Efforts to bring weapons to programs. (This list is not exhaustive
  - Guns, knives, pepper spray.
- Parents refusing to follow program safety rules or trying to control the actions of the staff.

Identifying Risks to Victims

In every case in which an injunction for protection against domestic violence has been ordered by a court, visitation providers should take additional steps to ensure safety at services. Risk screening is an on-going process, not a one-time event. Before the first visit, the program should obtain the following:

1. All relevant court and law enforcement records. The parties should provide copies of these to the program prior to intake.

2. Thorough intake with both parties and the children. The intake process provides an opportunity to ask about family history, safety concerns, and family needs. These may include victim advocacy services, transportation, housing, counseling, and a range of issues that are directly or indirectly related to safety. In addition, intake provides parents with crucial information about program policies relating to confidentiality and release of program records.

Danger Assessment

When considering the safety of a victim, there are certain behaviors that a social service provider should be aware of that increase the risk of danger. Some of these are described in tools called danger assessments. Certified Domestic Violence Centers in Florida use assessment tools which can be kept confidential based on Florida's victim/advocate privilege and confidentiality laws. Supervised visitation staff cannot guarantee the confidentiality of such records. Advocates at certified domestic violence centers who administer these tools are trained to provide services to victims and conduct safety planning around these specific risk factors. It is recommended that supervised visitation center staff do not administer such tools on their own but rather learn about the high risk indicators for homicide, listed in such tools, in order to increase their knowledge and skills to work with survivors and their children.

High risk indicators include (but are not limited to) the following behaviors:

1. Abuser threatens to kill the victim
2. Abuser attempts to strangle the victim
3. Abuser threatens to harm/kill the children
4. Abuser threatens to kill pets
5. Abuser threatens to kill loved ones
6. Abuser has access to a gun; threatens to use weapon against victim
7. Victim believes the abuser will kill her
8. Abuser threatens to commit suicide
9. Abuser is violent against the victim while she is pregnant
10. Abuser uses illegal drugs or is a problem drinker/alcoholic
11. Abuser is obsessively jealous and tracks the victim's movement
12. Increase in violence over the past year
13. Abuser forces the victim to have sex
14. Abuser maintains control over the victim and children
15. Victim has left or attempted to leave the abuser.

Although a perpetrator may murder at any time, without warning, all of the factors above are problematic and may indicate an increased risk of lethality. The most important information that a supervised visitation provider can share with a client who is a victim of domestic violence is the contact information for the local Certified Domestic Violence Center. Staff at these centers can help screen clients for danger, help clients develop safety plans, help them petition for injunctions for protection against domestic violence, stalking, and dating violence, as well as help them access other legal resources.

The list of Florida Certified Domestic Violence Centers can be found at FCADV.org.

Supervised visitation programs should work in partnership with the court system to protect vulnerable families, especially when there is violence present. Thus, programs must establish a way to communicate with the referring court. In communication with the court, program administrators should be able to report problems such as the following:

- Parental noncompliance with program rules, including no-shows and cancellations related to domestic violence;
- Children's unwillingness to participate in visits due to the violence;
- Parental substance abuse;
- Parental mental illness issues interfering with visits;
- Parental misconduct on-site or any safety concerns; and
- Parental misconduct off-site reported to Visitation staff, including but not limited to parental arrests, additional litigation in family/dependency/criminal court, and violations of probation, violence, stalking and threats.

Program directors should work with the local trial court administrator or chief judge to find appropriate ways to alert the court to problems. All communication about the case should be copied to all parties and their attorneys. Judges have the power to set hearings sua sponte, or on their own, and parties can set hearings and file motions to address the problems reported.

PRACTICE EXAMPLES

Case Scenario 1

Nelson and Grace Forest have recently been referred to your program due to domestic violence. Not too long ago, neighbors witnessed Nelson drag Grace across their driveway during an explosive argument, leaving Grace with a gaping head wound. Grace obtained an Injunction for Protection Against Domestic Violence and left the home to relocate with their 9-year-old son Jackson.

Discussion Questions:

1. Receiving this referral, what kind of information and documents will you need during intake?

2. What questions will you ask the victim parent?

3. How will you determine the risk involved with this referral?

4. What training does your staff need to have in order to protect the victim parent, the child(ren), other visiting families, and staff?

Discussion Questions:

1. How might Grace Forest's behavior affect the way she is treated/perceived by staff at your program?

2. What are the red flags in this visitation scenario?

3. What batterer characteristics does Mr. Forest exhibit in this situation?

4. What services might be helpful to refer to Grace or the case manager?

5. What can your program do to adequately address victim parent's needs and concerns with visitation?

Case Scenario 2

For the past few visits as Grace Forest drops off her son, she has looked distressed and her appearance has become increasingly disheveled. During check-in for each visit, Grace is constantly looking behind her and asking questions about whether or not her husband has arrived at the program. On the other hand, Nelson arrives at the program in a fairly calm manner. Sometimes, Nelson asks Jackson how his mom is doing. Regardless of Jackson's answer, Nelson will look at him and say, "Your mom has mental problems, I'm sure you've noticed. I'm not sure she why she behaves that way, and I've tried to help her."

Case Scenario 3

During a visit, Nelson asks his son several questions about school. Nelson questions Jackson about his homework, grades, and friends. Jackson has attended a new school since the separation. Nelson proceeds to probe Jackson about his new school, how he gets home, and if he's enjoying his teachers. At the end of the visit, Nelson tells Jackson to remind his mom to be mindful of traffic when getting him to school in the morning. However, Jackson quickly responds and tells his father that traffic doesn't matter because they live down the street from the school.

Discussion Questions:

1. Are Mr. Forests questions appropriate?

2. What should a visit monitor do when the perpetrator parent asks questions or makes requests regarding the victim parent?

3. Should the level of risk be reevaluated for this case referral?

4. Would you inform the victim parent about the perpetrator parent's questions?

Quiz Yourself!

1. **TRUE or FALSE. The perpetrator might gain physical custody of the children, thus making the victim parent the visitor at the program.**

2. **Domestic violence is a repetitive pattern of behaviors to maintain _____and_____control over an intimate partner.**

3. **All of the following are common characteristics of batterers, EXCEPT:**
    a. **Denial of abuse/minimization**
    b. **Control/ manipulation**
    c. **Attacks victim's parenting skills**
    d. **Accepts responsibility and takes accountability for abuse.**

4. **TRUE or FALSE. Children who witness domestic violence are not at risk for brain damage.**

5. **When should a visit or case referral be suspended or terminated?**
    a. **When battering parent uses the visitation program to monitor the victim parent's location.**
    b. **When a parent verbally or physically threatens the other parent, child, or staff.**
    c. **When parent refuses to follow program safety rules or tries to control the actions of the staff.**
    d. **All of the above**

Answers: 1. True 2. Power and Control 3. D 4. False 5. D

- **Resources for Advocates- Trauma-Informed Domestic Violence Advocacy.** http://www.nationalcenterdvtraumamh.org/trainingta/resources-for-advocates-trauma-informed-dv-advocacy/ Provides links to webinars and tip sheets that provide a comprehensive view of how to create culturally competent, accessible, and trauma-informed services and organizations.
- **Tips for Creating a Welcoming Environment.** http://www.fcadv.org/sites/default/files/Tipsheet_Welcoming%20Environment_NCDVTMH_Aug2011.pdf. Offers different ways that social service programs can provide a welcoming environment for victims of domestic violence.
- **Tips for Enhancing Emotional Safety.** http://www.fcadv.org/sites/default/files/Tipsheet_Emotional%20Safety_NCDVTMH_Aug2011.pdf. This resource identifies seven tips to promote and increase emotional safety within programs.
- **A Trauma-Informed Approach to Domestic Violence Advocacy.** http://www.fcadv.org/sites/default/files/Tipsheet_TI%20DV%20Advocacy_NCDVTMH_Aug2011.pdf. Discusses the five core components necessary for a trauma-informed approach to domestic violence advocacy and helping survivors strengthen their psychological capacity to work through multiple issues associated with domestic violence.

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CHAPTER 14

STALKING IN SUPERVISED VISITATION

Case Scenario

Mrs. Gonzalez drops off her child, Antonio, to visit with Mr. Gonzalez. The two parents are separated but the divorce is not yet finalized. The court gave Mr. Gonzalez supervised visits because he has severe substance abuse issues and had fallen asleep at a McDonalds drive-through while Antonio was in the car with him. The first three visits were ordinary with no violations. At the fourth visit, Mrs. Gonzalez spoke with program staff and told them that she thought Mr. Gonzalez had followed her home after the last two visits. She hadn't said anything to staff before because she didn't have any proof, but she noted that strange things had been happening around her house since then. She said that her back door was open when she came home from work the other day, and her computer was open on the kitchen counter, but no one was home. She made a report to local law enforcement. She informed program staff that Antonio said that he saw his father at school the other day during recess. Mrs. Gonzalez also believes that she saw Mr. Gonzalez drive past her house several times in the last few weeks.

After completion of this chapter, you will be able to answer the following questions:

What kind of questions should the program staff ask Mrs. Gonzalez?

Identify some of the risks in this situation.

What referrals might you make to Mrs. Gonzalez?

How would you follow up with Mrs. Gonzalez at the next visit?

Introduction

Each year, about 7.5 million people are stalked in the United States. Although stalking has affected many people, the crime is still frequently overlooked, minimized, and misunderstood. The dynamics of stalking can vary from case to case, but perpetrators of stalking are often current or former intimate partners of their victims. Stalking incidents between former intimate partners are dangerous and have a high risk for lethality.

Supervised visitation programs must consider how stalking may become an issue for parents they are working with. For example, there is an intersection between stalking and domestic violence, and it is critical for programs to recognize that domestic violence referrals pose a unique risk for stalking.

The nature of supervised visitation programs provides perpetrators with greater access to their victims. Stalking can occur as victims come and go from the supervised visitation center, during the visitation or exchange of the child(ren), or in between visits. Perpetrators may use a variety of tactics to monitor, gather information, and ultimately intimidate their victims in order to regain control.

What will I learn in this chapter?

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

- Describe the prevalence of stalking in the U.S.
- Define stalking and describe its common dynamics
- Understand Florida law regarding stalking
- Recognize the intersection of stalking and domestic violence
- Understand the impact stalking can have on victims
- Identify common tactics used by stalkers to track and monitor their victims
- Assess the risk for stalking with parents upon intake
- Apply program measures to prevent stalking

Statistics

As mentioned in the introduction, stalking is frequently overlooked and minimalized. Yet, stalking can be very dangerous for victims and their children so it should be taken seriously.

The Office on Violence Against Women at the U.S. Department of Justice released the following statistics:

1. The **majority of stalking victims are stalked by someone they know**:
    - 61% of female victims and 44% of male victims of stalking are stalked **by a current or former intimate partner.**
    - 25% of female victims and 32% of male victims are stalked by an acquaintance.

2. **76% of women killed** by their intimate partners had also been stalked by that same intimate partner.

3. **Two-thirds of stalkers pursue their victims at least once per week**, many daily, using more than one tactic.

4. In **1 out of 5** stalking cases, **weapons are used** to threaten or harm stalking victims.

5. **1 in 7 stalking** victims move to a different home because of their victimization.

6. **More than half** of stalking victims who are employed lose five days of work or more because of the stalking.

Definition and Dynamics

Monitors should understand both the informal and legal definition of stalking because it allows them to develop a working knowledge of the issue. Being able to define stalking will allow monitors to better identify it when it happens at their programs.

Once monitors have a firm understanding about the definitions of stalking, the next step is to learn how the dynamics of stalking (behaviors and tactics used by perpetrators) can change depending on context and the situation. For example, in supervised visitation programs, perpetrators sometimes use more covert styles of stalking, especially in cases where the victim has obtained an injunction against stalking.

The behaviors and tactics used by perpetrators can vary, making it more difficult for people to recognize stalking if they are not competent in the subject. Visitation

programs play an important role in preventing stalking from occurring in their programs.

Non-Legal Definition

The National Institute of Justice defines stalking as, "a course of conduct directed at a specific person that involves repeated (two or more occasions) visual or physical proximity, nonconsensual communication, or verbal, written, or implied threats, or a combination thereof, that would cause a reasonable person fear."

Florida Statute Stalking Definition §784.048

A person who willfully, maliciously, and repeatedly follows, harasses, or cyberstalks another person commits the offense of stalking, a misdemeanor of the first degree. (s. 784.048(2), F.S.)

> *"Harass"* means to engage in a course of conduct directed at a specific person which causes substantial emotional distress to that person and serves no legitimate purpose. (s. 748.048(1)(a), F.S.)
>
> > Cyberstalking or Stalking that causes substantial emotional distress to the victim and serves no legitimate purpose is a 1st degree misdemeanor punishable by up to 1 year in jail and fines up to $1,000.

A person who willfully, maliciously, and repeatedly follows, harasses, or cyberstalks another person and makes a credible threat to that person commits the offense of aggravated stalking, a felony of the third degree. (s. 784.048(3), F.S.)

> *"Credible threat"* means a verbal or nonverbal threat, or a combination of the two, including threats delivered by electronic communication or implied by a pattern of conduct, which places the person who is the target of the threat in reasonable fear for his or her safety or the safety of his or her family members or individuals closely associated with the person, and which is made with the apparent ability to carry out the threat to cause such harm. It is not necessary to prove that the person making the threat had the intent to actually carry out the threat. The present incarceration of the person making the threat is not a bar to prosecution under this section. (s. 748.048(1)(c), F.S.)
>
> > Aggravated stalking is considered a 3rd degree felony and is punishable by up to 15 years in prison and fines up to $10,000.

"Cyberstalk" means to engage in a course of conduct to communicate, or to cause to be communicated, words, images or language by or through the use of electronic mail or electronic communication, directed at a specific person, causing substantial emotional distress to that person and serving no legitimate purpose. (s. 784.048(1)(a-d), F.S.)

> *"Course of conduct"* means a pattern of conduct composed of a series of acts over a period of time, however short, which evidences a continuity of purpose. (s. 748.048(1)(b) F.S.)

Persons who may petition for a stalking injunction

A person who is the victim of stalking or the parent or legal guardian of a minor child who is living at home who seeks an injunction for protection against stalking on behalf of the minor child has standing in the circuit court to file a sworn petition for an injunction for protection against stalking. (s. 784.0485(1)(a), F.S.)

If it appears to the court that stalking exists, the court may grant a temporary injunction ex parte, pending a full hearing, and may grant such relief as the court deems proper, including an injunction restraining the respondent from committing any act of stalking. (s. 784.0485(5)(a), F.S.)

A stalking injunction makes it illegal for perpetrators to commit any act of stalking against their victims.

If the stalking is in violation of an injunction for protection, then the person will be charged with aggravated stalking even if there was no threat made.

Stalking Behaviors

Actions that are involved in stalking may seem harmless to onlookers; however, the person experiencing the stalking can feel very afraid or unsafe.

<u>Below is a list of behaviors that stalkers engage in:</u>

- Leaving or sending the victim unwanted items or presents. Some presents may be seemingly romantic, or bizarre
- Following the victim around or waiting outside of places visited by the victim
- Damaging or threatening to damage the victim's property
- Defaming the victim's character
- Harassing the victim online by posting personal information or spreading rumors about the victim
- Engaging in unwanted communication via letters, telephone, text messages, emails, etc.

The **most important thing to consider about these behaviors is that they are unwanted by the victim**. Even if some stalking actions such as delivering gifts or other items like flowers or candy seem harmless, they are **unwanted gestures and a means of the perpetrator communicating with the victim**. Some stalkers have gone to the victim's house and left unwanted gifts, notes, or even cleaned the house while the victim was away. This sort of behavior is not benign and helpful. It is intentionally done to demonstrate to the victim that the stalker has access to the home. It is done **to make the victim feel unsafe and vulnerable**. It is done to show the victim that the stalker can show up anytime. **It is meant to cause fear. It is meant to threaten. Visitation staff should understand these crucial dynamics of stalking so they do not minimize the concerns of victims and the behaviors of perpetrators.**

Common Tactics

Stalkers may use a variety of tactics to monitor or harass their victims. Stalkers often use a different combination of tactics. The Stalking Resource Center found that 78% of perpetrators used more than one tactic to stalk their victims.

Below is a list of the most common stalking tactics:

- *Physical surveillance*: The stalker might monitor or patrol the various places a victim visits (work, home, gym, school, etc.), or may follow the victim on foot or in a car throughout his or her day.

- *Proxy stalking*: This tactic is quite common and involves the participation of people other than the perpetrator to monitor and follow the victim. This tactic is a very real threat in supervised visitation.

REMINDER:
Perpetrators often use more than one type of tactic in their approach to stalk victims.

• *Technology:* Perpetrators sometimes use the internet, email, or other electronic communications to stalk their victims. They might use social networking sites to threaten their victims or to monitor the public information victims post. Other forms of technology such as GPS and cameras are sometimes used to monitor a victim's location. The perpetrator may put spyware on the victim's computer to track website browser history and internet use.

- *Child Involvement:* Perpetrators also frequently use children as tools, targets, or allies in their stalking activities. Perpetrators may use children to send threats, or may harm or threaten to harm the children to instill fear in their victims. Stalking victims may try to change their routines to protect their children from stalking, but it can be very difficult to do so.

Domestic Violence and Stalking

Similar to domestic violence, partner stalking is a crime of power and control. Intimate partner stalking often overlaps with a history of partner physical and sexual violence. Of those who reported being stalked by a former intimate partner, 74% reported violence or coercive control during the relationship.

In stalking cases that involve a former or current intimate partner, there is a heightened risk for lethality and violence compared to stalking by non-intimate partners for several reasons. First, in former intimate partner cases, the stalkers are more likely to physically approach the victim and interfere or threaten the victim. Second, they are more likely to use weapons in their approach. Third, perpetrator behaviors are more likely to escalate into violent behaviors.

It is important to consider this information when working with domestic violence referrals in supervised visitation. Remember that abusers who feel like they are losing power over their victim will try to engage in behaviors that intimidate or harm the victim in an attempt to regain power. The most dangerous time for a victim of domestic violence during an abusive relationship is when that person decides to leave the abuser. During that time, a victim is at the greatest risk for violent and lethal behaviors.

Stalking is a crime of power and control, similar to domestic violence.

In cases of partner stalking, there is an increased risk for lethality and violence.

It is absolutely necessary that supervised visitation programs assess for stalking in domestic violence referrals on a visit-by-visit basis with victims and children. The possibility of stalking occurring is great in domestic violence referrals and it can have deadly consequences.

Impact of Stalking

Stalking victimization can cause a wide range of fears and significant psychological distress in individuals.

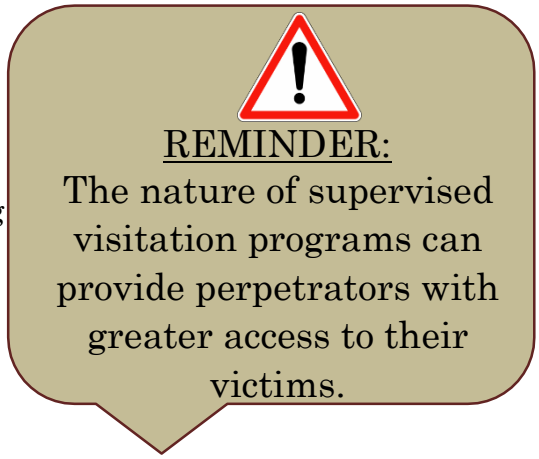
Impact on Victims and Their Children

- The prevalence of anxiety, insomnia, social dysfunction, and severe depression is much higher in stalking victims than in the general population.
- Intimate partner stalking is associated with victims' sleep and health problems.
- Existing health problems may be exacerbated by the stress or distress caused by stalking.
- Increased anxiety and nervousness in both victims and their children is common while stalking is occurring and should prompt program staff to ask about the possibility of stalking.
- Stalking can have serious effects on a victim's career or employment. Many stalking victims lose time from work, have lost their jobs, or are unable to take employment opportunities such as promotions.
- Children of the victim may experience physical or psychological harm.

Stalking can be deeply traumatizing for individuals and their children. To prevent these damaging effects, stalking must be addressed with a sense of urgency.

Supervised Visitation and Stalking

Victims of abuse who are using supervised visitation services may be at a heightened risk for stalking, so program staff need to learn how to recognize stalking and incorporate safety measures to mitigate the risk. In addition, it is important for programs to consider that stalking may occur in any of their referrals. Perpetrators may even ask for the help of other visiting families in their stalking efforts. Therefore, programs should assess and screen every parent involved in visitation services for stalking.



Recognizing Stalking

In some situations, victims may be aware that they are being stalked, and in others they are not aware. Program staff and monitors can help protect those involved in visitation services by knowing how to recognize stalking behaviors that victims may not notice. Below are examples that should raise red flags to program monitors about the possibility of stalking.

Perpetrating parents might:

- Try to give their child a new cellphone during a visit.
  - *Potential for stalking*: A stalker may try to give someone close to their victim a cellphone in order to monitor or track them. Many cellphones come with GPS that can be seen by another phone.

- Consistently arrive early to the program or wait in the car to leave until their child is picked up.
  - *Potential for stalking*: The parent may be trying interact with the other parent or may be trying to follow the parent and child home.

- Say things during a visit like "I saw that you and your mom moved", or "What did you end up getting from the store the other day" that would indicate that they have been monitoring the parent and child's activities and location.
  - *Potential for stalking*: Perpetrating parents may also try to elicit information from children by asking questions about the other parent during visits in order to stalk them outside of the program.

Victim parents might:

- Act very nervous during arrival when dropping their child off
- Say that they saw the other parent driving behind them after leaving the last visit
- Say that the other parent asked their child during the last visit about some of their current whereabouts and activities
- Inform the program staff that a family member or friend of the perpetrator, or even another visiting parent, has been showing up in many of the same places that the victim has been

Prevention Strategies

It may be difficult to prevent perpetrators from stalking their victims, but safety measures must be in place to try and decrease the likelihood of it occurring. Supervised visitation programs do provide an opportunity for stalkers to interact and follow their victims, but this "opportunity" for stalking can be mitigated with safety precautions.

Stalking must be addressed with a sense of urgency due to its damaging effects and risk for violence.

Supervised visitation programs should do the following to mitigate the risk of stalking in their programs:

1. **Ask during intake whether the vulnerable parent has any concerns about feeling safe at the program.**

This information may be helpful, even though it is not a formal screening. It may lead to information about what specific behavior has occurred in the past. It may open a conversation with the parent to determine what might be helpful to make the visits safer. It may lead to information about specific behavior that increases risk to the parent. Be open to working with the client in ways that apply to the parents' particular situation.

Remember to provide the parent with information about accessing the local certified domestic violence center, but do not coerce the client about contacting the center.

2. **Limit interactions between family members of the principals** involved in the programs; doing this might help prevent proxy stalking.
    - Program staff should ask all parents on a regular basis if they have been approached by the other parent or if the other parent is trying to monitor their behavior.
3. **Create a NO technology rule** that prohibits cellphones and other devices from entering the program center. This is important to eliminate outside contact and the taking of photographs.
4. **Establish exchange and pick up times** and enforce those times consistently.
    - A stalker may refuse to follow these rules and if that happens, a program may determine whether or not to terminate visitation services.

When monitors and program staff remain diligent and focused, they can help mitigate the likelihood of stalking occurring.

Addressing Stalking

If visit monitors have been notified of or have identified stalking behaviors in the families they work with, it is important they refer victims to local resources that are available to help, including law enforcement.

Certified domestic violence centers can assist stalking victims through the court process of filing for an injunction for protection. They can also develop a safety plan with victims and assess and manage the risks present in the stalking situation. To learn more about Florida's certified domestic violence centers, please visit www.fcadv.org

While stalking incidents may occur outside of the program, it is still relevant for program staff to assess for stalking in any capacity upon intake and check-in during each visit. Program staff should also document all reported cases of stalking.

<u>REMINDER:</u>
When monitors and program staff remain diligent and focused, they can help mitigate the likelihood of stalking occurring.

It must be made clear to all parents involved in supervised visitation services, that are exhibiting stalking behaviors, that stalking is not tolerated under any circumstances.

If an injunction for protection against stalking fails to prevent and eliminate stalking behaviors, the visitation program may need to terminate services with the perpetrator/stalker.

The Gonzalez Family Revisited

The case scenario provided at the beginning of the chapter detailed Mrs. Gonzalez's concerns and experiences of stalking committed against her by Mr. Gonzalez. The questions presented with the case scenario are revisited below:

1. **What kind of questions should the program staff ask Mrs. Gonzalez? Ask:**
   - Is there a history of violence in your relationship with Mr. Gonzalez?
   - Do you have an injunction or order of protection against domestic violence or stalking?
   - Has Mr. Gonzalez ever engaged in stalking behaviors prior to your separation? Have you had any problems with him following you or keeping track of your movements?
   - Does Mr. Gonzalez have access to the home you're currently living in?
   - Is your son's school aware of your recent separation and utilization of visitation services?
   - Does your son's school have a copy of any injunction or order of protection?

2. **Identify some of the risks in this situation.**
   - Someone has come into Mrs. Gonzalez's home while she was away and taken out her computer.
   - Her computer may have compromised with spyware, and Mr. Gonzales has been tracking her browsing history to monitor her actions.
   - The parents are recently separated, and it is unknown if there is a history of domestic violence.

3. **What would you say to Mr. Gonzalez?**

   - Program staff could talk to Mr. Gonzalez and revisit the supervised visitation programs policies on stalking.
   - You could say that program staff has noticed his car in the parking lot while Mrs. Gonzalez picked up Antonio, and that he needs to follow program policies (arriving and leaving at different times) in order to continue services.
   - Staff should speak to Ms. Gonzalez and ask how they can support her. They should document Mr. Gonzalez's actions, and be careful not to "blame" Mrs.

Gonzalez. Blaming her could increase her risk level. Focus on Mr. Gonzalez's dangerous behavior.

- If staff suspect that Mr. Gonzalez is stalking Mrs. Gonzalez, they should support her, ask how they can help, and refer Mrs. Gonzalez to a certified domestic violence center for help.
- Stalking must not be allowed at supervised visits, and staff themselves should contact law enforcement if they suspect that Mr. Gonzalez is using the visitation program to stalk Mrs. Gonzalez.
- Note that in Florida, Mrs. Gonzalez needs only two incidents of stalking to take legal action (including cyberstalking), but that her decision to take action in filing for an injunction must be left to Mrs. Gonzalez.

4. **How would you follow up with Mrs. Gonzalez at the next visit?**
   - Check in with her to see if local resources were able to help her file for an order of protection. Document your contact. However, remember that adults must have independence to make their own decisions. Staff should never force, coerce, or judge a victim's decision to seek or refrain from seeking an order for protection or injunction against stalking.
   - Ask her if there have been any recent stalking activities since you last spoke with her.
   - Discuss with her if there are any additional actions that the supervised visitation program can help with.

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CHAPTER 15

PRACTICE SKILLS FOR VISIT MONITORS

Case Scenario

Bradley is court-ordered to use the local supervised visitation program to see his 11-year-old daughter, Loretta, but the visits have been awkward. Bradley shows up to a visit with a small necklace that he gives to Loretta, who seems pleased. Christie, the visitation monitor assigned to the visit, thinks it's sweet to see a dad giving a gift to his daughter, so she doesn't intervene or even think to record the gift in her observation notes. The visit seems to be at a stand-still, as Bradley and Loretta peer at each other through awkward silence. Christie writes down in her notes that Loretta must be shy, but says nothing to encourage engagement. All of a sudden, Loretta's mother Sonya walks into the visitation room without permission at a time she knows she should not be there. Loretta runs to her, saying, "Mommy, look at my new necklace Daddy gave me!" Sonya's face reddens and she turns to Bradley, screaming, "How could you give my baby your new girlfriend's necklace? How dare you?!" Bradley and Sonya begin yelling insults at each other, and just as the conflict is escalating, Christie turns and leaves the room to get help, leaving Loretta in a dangerous situation. The security guard helps to calm the adults down and they depart separately. Later, Christie's supervisor asks to see her notes from the visit and is disappointed to see a lack of description of the gift-giving or the pattern of unhealthy communication in the family.

After completing this chapter, you will be able to answer the following questions:

- What would have been helpful observations for Christie to record?
- What skills could have been modeled by Christie for Bradley?
- What skills could have been utilized by Christie to facilitate healthy communication?
- How could Christie have supported Bradley and Loretta's confidence to motivate them to set goals?
- What are some positive goals for Bradley and Loretta to work toward during visitation?
- What should Christie have done to prevent the conflict or resolve the conflict as it arose?
- What critical incidents occurred? How should Christie report these critical incidents?
- What could Christie do better to prevent and respond to critical incidents in the future?

Introduction

Monitoring supervised visits is not a simple task. It requires a vast skill set and various facilitation abilities, from gauging clients' emotional needs accurately to recording sessions properly. Supervised visitation involves engaging clients in a way that fosters healthy communication, supportive parent-child interaction, and parental self-growth. Crises and conflicts can occur, and it is up to the visit monitor to intervene appropriately and find solutions. Juggling these roles can seem like a daunting task, but with the appropriate skills, visit monitors have the opportunity to help families engage in healthy relationships and meet their goals.

This chapter will allow you to learn new skills, as well as review previously learned facilitation techniques, to become a more skilled visit monitor. Learning new skills can help give you the confidence to model healthy communication, maintain control and safety in visits, prevent problems before they occur, and resolve any conflict that arises.

What will I learn in this chapter?

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

- Record observations made during visits effectively
- Practice parent coaching and modeling to facilitate learning and application of new parenting skills
- Help families build confidence through visitation
- Model skills such as engagement, healthy communication, and goal-setting
- Resolve conflicts in a healthy manner
- Intervene in and de-escalate crises
- Understand the basics of using trauma-informed approaches

This chapter will be divided into two sections:

The Role of the Monitor

Practice Skills

Part 1

The Role of the Monitor

Monitors are trusted to supervise visits between parents and children and ensure the health, safety, and welfare of children. It is recognized that monitors play an important role in the welfare of children and this chapter will help in understanding the skills, requirements, and the role of visitation monitors.

In many supervised visitation programs, the contact between the parent and the child is structured so that program personnel may encourage parent-child relationships by providing age-appropriate activities, helping parents develop or enhance parenting skills when necessary, modeling appropriate interactions with the child and discouraging inappropriate parental conduct. Although supervised visitation program staff facilitate and support the parent and the child relationship, facilitation and support should not be construed to mean therapeutic intervention rising to the level of a therapist-client relationships.

Monitor Responsibilities

The responsibilities of visitation monitors extend beyond contact between the visitor and the child(ren) in accordance with the program's mission, to facilitating and supporting that contact as necessary. In all cases, the visitation monitor shall:

- Ensure that contact between parties proceeds pursuant to the visitation agreement and court order;
- Relay relevant information relating to the child's welfare between the custodian and

REMINDER:

These are general guidelines for monitors. Your individual program may have more specific duties and responsibilities for visitation monitors.

visitor at the commencement and conclusion of supervised contact (e.g. special needs, medication, diet);
- Intervene, if necessary and appropriate, to ensure the welfare of the child and/or vulnerable parent;
- Facilitate, if necessary and appropriate, child/parent interaction during the supervised contact;
- Terminate the visit if the child's safety or that of other parties' or staff cannot be maintained;
- Provide constructive feedback, correction, or redirection respectfully to the parent(s);
- Document the visits consistent with program policies.

Code of Conduct

In addition to the above responsibilities, all program personnel must abide by a Code of Conduct set forth by the Recommendations of the Supervised Visitation Standards Committee to include the statements below.

All participants in the services of the program are entitled to respectful, well-trained staff and volunteers. The supervised visitation/monitored exchange program staff/volunteer agrees to maintain high standards of conduct in carrying out his or her duties and obligations. Staff agree also to:

- Adhere to the program's policies and procedures in the monitoring of all families diligently;
- Resist influences that interfere with impartial monitoring;
- Report honestly and impartially regarding what occurs during the course of service;
- Respect the privacy of the child and the family and hold confidential all information obtained in the course of service as a staff member or volunteer with the visitation/monitored exchange program, as required by law and program standards;
- Decline to monitor cases in which he or she may have a conflict of interest as described in the standards;
- Attend pre-service training and in-service trainings as required by position description and length of employment or service with the program;
- Decline to practice, condone, facilitate, or participate in any form of discrimination on the basis of race, color, sex, sexual orientation, age,

STOP and Think

- **How are children, families, and staff protected by the Code of Conduct?**
- **How can you, as a monitor, ensure that you meet the standards of the Code of Conduct?**

religion, national origin, marital status, political belief, mental or physical disability, or any other preference or personal characteristic, condition, or status;

- Decline any referrals of non-program, private-pay cases in which private parties or their attorneys have asked for supervised visitation or monitored exchange services; and
- Keep all information regarding persons who participate in supervised visitation services confidential as required by program policies.

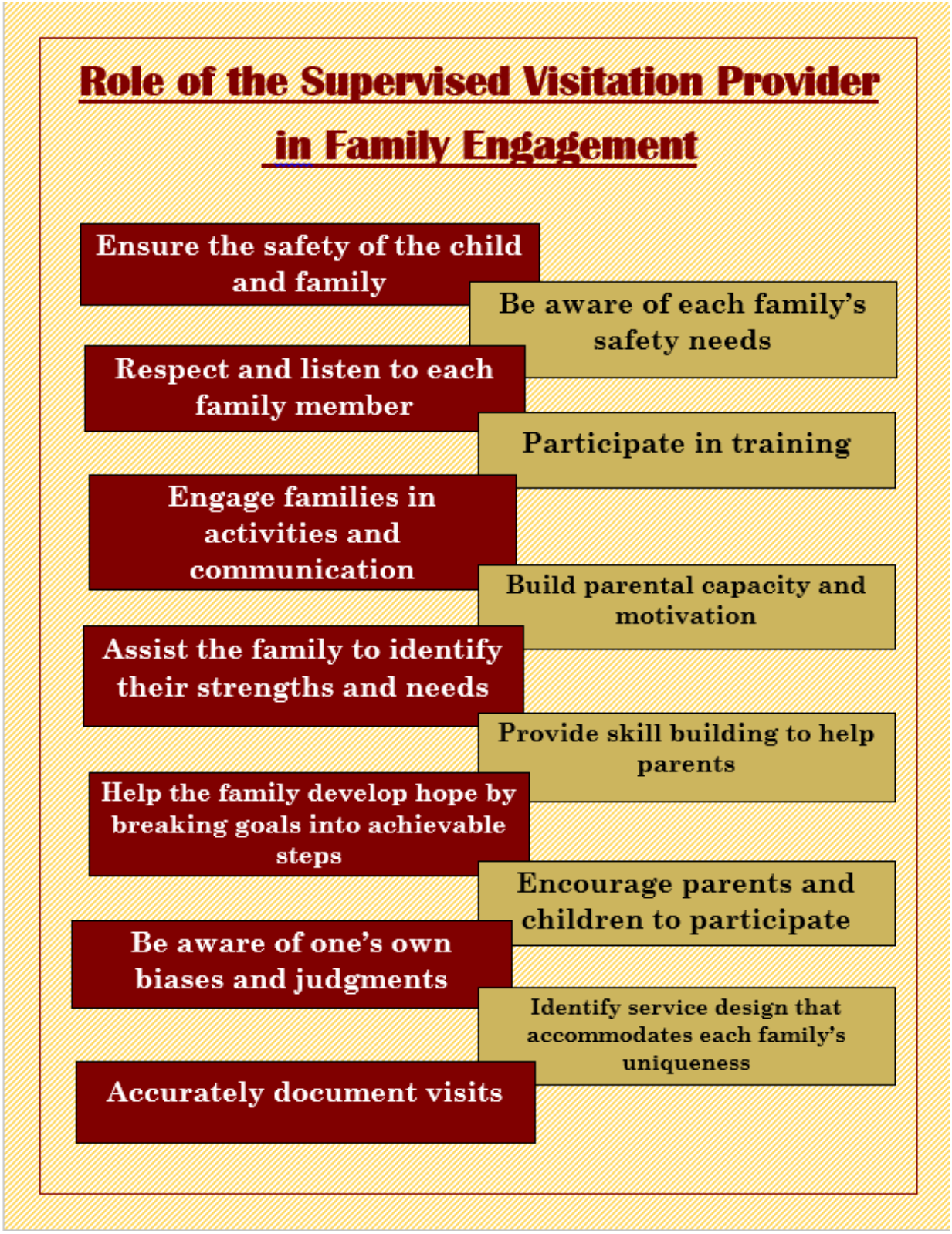
I will not disclose, or participate in the disclosure of, confidential information relating to a case, child, or family to any person who is not a party to the cause, except in observation reports and as required by law or court order, both during and after my involvement with the program. I will abide by all protections of confidentiality provided to victims of domestic violence. I understand that a violation of confidentiality may result in disciplinary action up to and including termination. I further understand that I could be subject to legal action.

Monitor Signature:_____Date: _____

Failure to comply with the Code of Conduct may result in disciplinary action, termination, or legal action. The individual hereby acknowledges that he/she does not have a right to serve in any capacity at the program, but instead that he/she serves at the program director's discretion.

Monitor Signature:_____Date: _____

See the "Role of the Supervised Visitation Provider" Handout



Observing and Recording

In your role as a visitation monitor, observing and recording visits is a vital skill to develop. Monitors must be proficient in conducting visits, observing properly, and recording pertinent information. **Observation** is the process of watching an individual or family interact. **Recording** is the process of documenting the observations or behavior in an objective manner.

Observations

It's important to avoid putting your judgment or perceptions into your notes. Only objective observations, such as visible actions and words spoken, are helpful in the recording of visits.

Objective observations are behaviors or verbalizations that were seen or heard, such as "Mr. Gandy yelled at his son Marc when he started crying" or "Mrs. Johnson held her three-year-old son on her lap and read him a book".

Subjective observations are labels or judgments such as "Mrs. Young was anxious during the visit" or "Joseph was being aggressive toward the monitor". These statements don't convey helpful information. What would be more helpful to note would be, "Mrs. Young was pacing back in forth during the visit and verbally expressed feeling anxious about her work assignment due tomorrow." Or "Joseph threatened the monitor, saying, 'If you tell me what to do one more time, I may have to do something' and raised his fist at her."

What to Observe

As a supervised visitation monitor, you must observe visitations for many different families. While families may change, you as a monitor will make the same active observations in every visit. The best way to actively observe is to take note of who, what, when, where, and how the events are occurring in front of you. As you observe a family, it is important to note the following observations:

NOTE

Pull out a piece of paper and stop to look at the world around you. Record your observations by asking yourself:

- Who is involved?
- What concrete actions and behaviors are occurring?
- What words or sounds do I hear?
- Is there anything concerning happening that I should note?
- Could an individual get a clear picture of the events occurring around me by just looking at my notes?
- The easiest way to conceptualize documentation is by thinking: WHO, WHAT, WHEN, WHERE, AND HOW. Monitors should be mindful to not think about "why" as this predicates judgment and opinion.

- What is the parent/child doing?
- What is the interaction?
- What does the parent/child say?
- What questions are asked by the parent/child?
- How does the child react to the parent?
    - Smiles?
    - Cries?
    - Cold shoulder?
    - Laughs?
    - Ignores?
- Is there a relationship between the parent and child?
- Does the parent use corporal punishment?

Objective Observations

When observing families, take note of factual events rather than subjective feelings.

Ex. "The child cried and refused to sit next to his mother."

RATHER THAN

"The child was upset with his mother."

This language allows the reader to see what happened during the visit rather than what the monitor interpreted.

See the "Helpful Behaviors to Observe & Record in Children" Handout

Helpful Behaviors to Observe & Record in Children

It is particularly important to record the behaviors and interactions of children to help track developmental progress, as well as help identify any potential indicators of neglect or abuse.

When observing children, make sure to note the following:

1. **Use of Language**
   - Does the child use full sentences? Does he/she initiate conversation or express feelings in words? Is he/she choosing to use appropriate words when interacting with others?
2. **Physical Movement**
   - Is the child active and moving around the room? Is the child high or low-energy? Does the child seem to be healthy and able to use his body appropriately? Is the child able to balance, walk, crawl, jump, throw, etc.?
3. **Mood & Temperament**
   - Is the child smiling, laughing, making eye contact, or displaying any signs of wanting to interact? Is the child refusing to interact? Is the child positive, flexible, and open to new experiences?
4. **Parent-Child Interactions**
   - Are the parent and child interacting? How so? Are they talking, playing, reading, making eye contact, etc.? Do any of the interactions seem inappropriate?
5. **Activities and Play**
   - Is the child engaged in the activity at hand? Is he/she able to share, take turns, clean up, etc.? Is the child disruptive? Does the child initiate play and interaction?
6. **Times of Quiet and Transition**
   - Is the child able to be quiet? Is he/she able to make smooth transitions? Does the child follow instructions easily?
7. **Skills**
   - Does the child display a variety of developmentally-appropriate skills, such as talking, reading, writing, expressing emotions, sharing, playing with others, etc.? What is the child good at? What skills does the child need more time developing?
8. **Self-Esteem**
   - Does the child seem pleased with his/her own accomplishments? How does the child talk about him or herself?
9. **Health & Well-Being**
   - Does the child complain of feeling sick? Is the child absent due to illness? Does he/she have allergies? Does the child have energy for interaction and activities?

Recording

Keeping records enables programs to identify a client's need for services, track services delivered, and document critical incidents that occur, among various other benefits. Courts and child welfare agencies that refer visits to programs often want an accurate record of visits.

There are other reasons to keep good records. Imagine if a client switches visitation programs, or the monitor assigned to the family is sick for the day. Recording client history and past visits enables service providers to have the information necessary to maintain continuity and stability. Or perhaps a visit needs to be terminated due to a critical incident, such as a client bringing a weapon into the program. Documentation can help programs accurately record what occurred. It is important for monitors to maintain a factual record of every visit that contains, at a minimum, the items in the following checklist.

Checklist of the Minimum Requirements for Recording a Visit	
	Client identifier or case number
	Who brought the child to the visit
	Who supervised the visit
	Any additional authorized observers
	Date, time, and duration of visit
	Who participated in the visit
	A detailed description of any **Critical Incidents** that occurred. See section on "Critical Incidents" for further instructions on documenting critical incidents.
	An account of termination, cancellation, or temporary suspension of visitation by the program, including the reasons for the termination or suspension of contact.
	Any failure to comply with program's procedures
	Cancellations, tardiness, or no-shows by the client and the reasons given by the client for cancelling, being late to, or missing the visit.
	Incidents or suspicion of abuse or neglect as required by law, including documentation of any calls made to 1-800-96-ABUSE.
	Visitation Notes of the parent-child interaction, either **Summary** or **Observation Notes** as described in the next section.
	Contact Notes, which are summary accounts of all other contacts by the program staff in person, in writing, by telephone, or electronically with any party, the children, the court, attorneys, or other paraprofessionals or professionals involved in the case. These Contact Notes must be kept in the case file. All entries should be dated and signed by the person writing the Contact Note.

Visitation Notes

In addition to keeping basic records of information regarding parent-child contact as described above, all supervised visitation programs should have polices regarding any other kinds of documentation and recording they may keep about the contact, such as summary or detailed observation notes on the interaction between the parent and child.

Recording Visits

There is variation across 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 of this variety, the content here may or may not apply to any specific program but is useful for monitors to be familiar with the issues involved in observation and recording of visits.

The summary note must be factual, objective, and absent of any professional recommendations. Unlike the detailed observation note, the summary note shall not contain a comprehensive list of all observations. Instead, this report is meant to provide a brief synopsis of the parent- child contact.

Observation Notes are detailed observations that offer a comprehensive account of events that took place between the visitor and child during visits, signed by the staff member/volunteer who completed the notes. Observation notes must also be factual, objective, and absent of any professional recommendation. In addition, observation notes may also include various observations and direct statements from the child, parent, or other authorized observers. When developing policies governing observation notes, programs should take into account the potential for the notes to be reviewed by courts, parents and/or his/her attorney, and other outside agencies. All notes should be constructed in a way that is sensitive to the cultural identification of the family, the safety needs of vulnerable parents and/or children, and provisions of Florida law addressing the collection of information about the case and family. Due to the potential for observation notes to be interpreted incorrectly and be used to harass the program or client, programs should consider keeping only summary notes, without lengthy details of activities, except in cases of Critical Incidents.

Writing Contemporaneously

When observing visits, monitors are encouraged to take notes during the interaction. This concurrent, or contemporaneous recording, is beneficial for a number of reasons including:

- Memories fail
- Observations tend to be more accurate
- Clear notes are necessary for each case
- Concurrent notes reduce confusion and increase reliability
- Observers feel more confident in their capability to capture observations when they are contemporaneously being recorded

In a busy visitation center, monitors may not always be able to write case notes immediately after a visit occurs. Writing and taking notes while the visit occurs can aid monitors to remember what occurred accurately during the visit.

STOP and Think

After reading this section, you should be able to answer the following question regarding the case scenario from the start of the chapter.

What would have been helpful observations for Christie to record?

Recording Children's Behavior

Recording children's actions can be especially important, as children often express more in actions than in words. By recording your observations, you can document children's behavior and the quality of parent-child interactions, leading to more accurate goal-setting for your clients. Observations of children can, over time, lead to the discovery of a multitude of important findings regarding the child's well-being, including:

A Note on Cultural Sensitivity:

It is important to be sensitive to cultural values, such as differences in eye contact or displays of affection. Every family is different.

More information is available in Chapter 7, Working with Culturally Diverse Families.

- Developmental gains or setbacks
- Modes of coping
- Individualized learning preferences
- Behavioral patterns that may indicate the presence of abuse or neglect
- Special needs, such as a developmental or learning disability or attention-deficit disorder
- Medical concerns

It is imperative to the quality and safety of supervised visitation programs that visit monitors keep precise records of. Records not only help programs facilitate services that are effective for clients, but can also be compiled and used to determine best practices, or to help display the need for continued funding of supervised visitation.

Cultural Differences

As staff fill out forms and describe the parent-child interaction, or recount interactions in narrative format, it is likely that the information is based on one's own cultural norms. It is important for monitors to recognize the cultural differences of the families understand how those differ from the dominant culture. Monitors must be sensitive to differences in other people's ideas of respect, affection, and parent-child interaction. While there is training available to address the needs of other cultures who use supervised visitation, programs must ensure that they are promoting an understanding and familiarity of other families' practices, rather than simply adding a superficial, heightened respect for minority cultures. One way to do this is to explore at intake how family members interact with each other. Here's an example: "Mr. Bhatia, we want to be sensitive to families' needs and traditions. Are there any practices that your family has that you'd like us to know about? Are there any special ways you observe your religion? Are there any holidays coming up that you will be celebrating, so that we can help you celebrate with your child?

There is no truly objective perspective as a monitor due to personal experience and culture. Understanding the truly difficult task of observation will provide monitors with the ability to be mindful and to always work towards observing visits fairly, being mindful of the paramount role of safety.

Monitors must be mindful of how they are observing and recording visits. When observing and recording visits, monitors must only document the facts and of the visit (behaviors, verbalizations). In this sense, monitors should avoid documenting subjective matter such as emotions, perception, or cultural norms. This means that visit notes should be written in quantifiable terms—that which can be seen, heard, smelled, counted, or measured. There are many words that are open to personal interpretation and should be avoided (manipulative, uncooperative, normal,). Instead of using these types of words, monitors should record observed behaviors and verbal communication that will allow case managers, judges, and other monitors to draw their own conclusions.

Verbal Communication of Visit Notes

Visitation monitors communicate with case managers and judges through written communication and visitation notes. In some cases, monitors may be required to discuss a client case with a third party involved with the case through verbal communication over the phone or in person. Monitors may have been well trained in in writing objective, fact-driven visit notes, but sometimes, when communicating verbally, those same monitors may stray from the objective events. Noting this tendency, monitors should be mindful of their verbal exchanges, as well as attempt to only give information that is found in the case notes or file. Avoid chit-chat in phone calls. Stick to the basics of the case. Don't add opinions or extraneous details.

Intervening in Visits

Each visitation program has policies and procedures describing when and how a monitor should intervene during a visit. It is encouraged for monitors to have a clear understanding of the requirements of their own program for visit interventions. In many cases, monitors may be unsure of how to intervene or even if they should intervene. Considering this, monitors should feel comfortable with using assertiveness to communicate clear instructions.

What to Say?

"Mr. Minor, I would like to speak to you away from the children for a moment."

(Move to a different area)

"I can tell you have anger toward your ex-wife, but it is not appropriate to involve the children in this manner. I will have to terminate the visit if you continue to make derogatory comments."

Some situations that call for a monitor to intervene include:

- The visiting parent questions the children in detail about the activities of the custodial parent.
- The visiting parent tells the children to convey a message to the custodial parent.
- The visiting parent makes derogatory comments about the custodial parent, step-parent, foster parent, or judge.
- The visiting parent falsely tells the children that he or she will be back soon—unless reunification really is imminent.
- The visiting parent asks the children which parent they want to live with.
- The visiting parent promises trips, gifts, or privileges on the condition that the child does something ("I will bring you to Disney World if you tell me where your new school is…").
- The visiting parent harms or threatens to harm the child emotionally or physically during a visit.
- The visiting parent harms or threatens to harm other visitation participants, custodial parent dropping off children, or staff.
- The visiting parent has significant impairments due to mental illness, physical illness, or substance abuse that prevent them from engaging appropriately with the child (e.g., parent is intoxicated during the visit).

When intervening in visits, monitors should employ assertive communication skills. This requires monitors to communicate what is desired in an open, courteous, and

firm manner. Assertive communication can be very effectively defusing anger, even in hostile situations.

Critical Incidents

A **critical incident** is an occurrence involving any circumstance that threatens the safety of, or results in the injury of, any participant or staff/volunteer, and/or that requires the intervention of a third party such as child protection services, fire rescue, or police.

Critical incidents can result from an escalated conflict or a variety of other situations, including:

- A child has a seizure during a visit.
- A car is shot at in the parking lot during a visit.
- A parent raises a fist to staff.
- A parent physically abuses a child during a visit.
- A parent stalks the other parent or case manager in the parking lot.
- A parent brings a weapon to the agency.
- A parent uses drugs in the agency bathroom.
- A parent arrives intoxicated.
- A child falls and is bleeding
- A parent takes the child and tries to leave the agency with him/her.

Depending on the incident, staff should intervene by:

-Suspending the visit.

-Notifying emergency personnel.

-Involving other professionals.

Reporting of Critical Incidents & Termination of Visits

In cases of critical incidents, always respond first, document second. Following a critical incident, visits will likely be suspended or terminated.

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

While **Visitation Notes** may feature a summary of events, a **Critical Incident Report** should be a specific, detailed account of the incident that includes what happened, who was involved, and what actions were taken by the program staff.

More specifically, a critical incident report should include at a minimum:

1. A list of staff or security personnel who witnessed the incident,

2. A description of the rule violation reported as a narrative (describing the event as it occurred), and

3. A list of parties/attorneys to whom the report was sent.

Sample Critical Incident Report

Case Number or identifying information _____

Style of Case_____

Custodial parent _____

Non-custodial parent _____

Children _____

_____

List all parties involved in incident _____

_____

List all witnesses to incident_____

_____

Time and date of incident

_____

DESCRIPTION OF INCIDENT

_____
_____
_____
_____
_____
_____
_____

Name of person completing this form_____Date _____

DESCRIBE STEPS TAKEN BY STAFF AND/OR VOLUNTEERS

_____
_____
_____
_____

Were Police Contacted? YES NO

Name of Responding Officer:_____Date: _____

Attach any police report to this sheet.

Other Actions Taken (with details)

Other parent/party informed_____When?_____
Executive Director Informed?_____When? _____

Court informed? YES NO

CBC or DCF informed? YES NO

Guardian Ad Litem informed? YES NO

~~Details~~ _____

_____
Additional Comments: _____

Report Reviewed By:

Signature:_____Date: _____

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:

1. A description of the incident or incidents necessitating termination, and

2. A list of sources to whom copies of the report will be sent, including the parties involved, their lawyers, social services caseworkers, and guardians ad litem assigned to the case. Mental health professionals the court has ordered to receive such information should also receive copies of the reports.

The best practice would be for programs to include a Notice of Suspension of Future Visits in Termination Reports, which 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.

Remember to debrief staff following a critical incident by offering referrals to counseling, making suggestions on how to avoid similar incidents in the future, and seeking increased training for staff.

STOP and Think

After reading this section, you should be able to answer the following questions regarding the case scenario from the start of the chapter.

What critical incidents occurred? How should Christie report these critical incidents? What could Christie do better to prevent and respond to critical incidents in the future?

A Trauma-Informed Approach

Understanding the effects of trauma on individuals, groups, and communities is a key factor in delivering effective services. As a supervised visitation monitor, it is estimated that 61% of men and 51% of women will experience at least one lifetime traumatic event. You will work with many children and families who have suffered some sort of trauma. Supervised visitation professionals who interact with clients who have experienced trauma should be understanding and sensitive to those experiences. Visitation providers should be knowledgeable about the individual's history to provide appropriate empathic responses.

What is Trauma?

The term "trauma" refers to experiences that cause intense physical and psychological stress reactions. It can refer to a single event, multiple events, or a set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being. Below are several types of traumatic events, although it is not an all-inclusive list, as trauma differs for every individual.

- Experiencing or witnessing interpersonal violence (domestic violence, child abuse)
- Physical, sexual, or institutional abuse or neglect
- War, terrorism, or natural disasters
- Stigmatization due to gender, race, poverty, sexual orientation, or incarceration

Trauma overwhelms one's ability to cope and deal with everyday stressors and activities. Individuals who have experienced a trauma will fall within a continuum from feeling overwhelmed to overcoming the trauma. As a supervised visitation monitor, many times when you first begin working with a family, they will be on the overwhelmed side of the continuum. Hopefully, towards the end of your time with the family, they will have moved to the overcoming side of the trauma continuum, indicating the processing of the trauma and the development of adaptive coping skills.

Trauma informed care was described in Chapter 5, Connecting Theory to Practice.

More Information

Several organizations have developed resources to help agencies become more trauma-informed. Consider accessing any of the following to develop a more comprehensive understanding of how your organization can become trauma- informed.

The National Council for Behavioral Health offers a number of trainings and resources to help organizations implement the most recent best practices. There website is www.thenationalcouncil.org.

Thrive Initiative is the Maine based organization for leading organizations to become trauma-informed. The Trauma-Informed Agency Assessment can be accessed here. The website is thriveinitiative.org.

Trauma Informed Care Project is available at traumainformedcareproject.org.

See Implementing Changes Handout

Implementing Changes to Become a Trauma-Informed Organization

The following steps are suggested to organization leaders to develop more trauma-informed practices within their organization.

1. Form a trauma-informed change team
   a. Identify persons in the organization that desire to become trauma-informed and wish to implement change in the organization. At least one member should be in a role to implement system wide change (supervisor or director level).
   b. Keep the team limited to no more than 10 people, have as many departments represented as possible.
2. Distribute the Trauma-Informed Agency Assessment (see below). All staff or strategic positions can take this assessment. Consider using an online survey tool for easy dissemination.
3. Review the results of the Trauma-Informed Agency Assessment and flag any areas that are consistently rated low.
4. Prioritize the need by using the Prioritization matrix. Chart each domain in the two by two matrix by changeability (capacity as in resources and readiness) and importance (how much will this impact/affect the issue or the agency).
   a. The domains that score highest on importance and changeability should take first priority.
5. Develop a plan to address the needs of your own organization.
6. Disseminate the new plan and training to implement the desired changes. The change team becomes the facilitators of change that takes place within the organization.
7. Develop ways to adequately train all staff on the basic of trauma-informed care. Consider hiring a consultant to lead the training or have staff attend a training webinar.
8. The change team should continually evaluate the needs of the organization and formulate ways to improve the organization culture.

This is a continual process and requires continued evaluation and dissemination of new ideas for the organization. The Trauma-Informed Agency Assessment should be redistributed at regular intervals.

The Trauma-Informed Agency Assessment can be accessed at
http://www.traumainformedcareproject.org/resources.php

For additional help in becoming a Trauma-Informed Agency please visit:
Thriveinitative.org Thenationalcouncil.org Traumainformedcareproject.org

Part 2

Skills for Monitors

In all interactions with families, monitors must use skills to build a healthy relationship during the supervised visitation process. There are a variety of practice abilities that monitors need when working with families, including healthy communication techniques, supportive modeling and parent coaching behaviors, effective conflict resolution, capabilities to build parent confidence, ability to construct goals for supervised visitation, and skills for building parent motivation. This section of the chapter will explore each of these elements.

Communication Skills

Monitors must use supportive verbal and non-verbal communication techniques to engage families in supervised visitation, but they can also use these visits as opportunities to model healthy communication for parents to use when supervision is no longer needed. Consider the many benefits of healthy communication:

It can help you and your clients to

1) Better understand other's perspectives and situations

2) Resolve conflicts

3) Build respect and trust

4) Create an environment that supports new ideas and problem solving

Tips for Communication as a Supervised Visitation Provider

- **Encouraging attitude:** engage the participants in communication through encouragement. Examples might be telling the custodial parent, "You are the expert on your child and I am here to support you both during visitation. Tell me a little about your child."

- **Paraphrasing:** repeat back to the client a summary of what he or she is saying to assure the client that you understand what is being conveyed: "OK…What I hear you saying is_____. Is that correct?"
- **Open and closed questions:** use questions that require short answers, as well as questions that allow more in-depth responses. For example, "I'm very interested. Tell me more about what games you play at home."
- **Be genuine, warm, professional, and respectful:** 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.
- **Be assertive**: direct participants to respond appropriately to others in a firm and respectful manner.
- **Give directions:** state specific outcomes and get feedback so it is clear that the recipient understands the message.
- **Practice non-verbal skills:** this includes behaviors such as head nods and eye contact. Non-verbal communication can also be as ineffective as poor verbal communication. Visit monitors need to be aware of how their everyday posture, gestures, and body-space may affect communication.
- **Use assertive confrontation only when appropriate,** such as when a child is put at risk during a visit.

Conversations to Avoid

• Avoid burdening the parent with your own problems: such as, "I am so tired today. My child was sick last night and my car broke down…"

• Avoid displays of impatience: such as, frustrating sighs, clenched jaws, and irritation.

• Avoid political discussions, such as "Who are you voting for?"

• Avoid arguing.

Communication Blockers to Avoid:

• Don't use surprise exclamations: such as, "That's awful! I never heard such a thing!"

• Don't criticize: such as, "You are just not acting like you care at all today."

• Don't ask "Why" questions.

• Don't patronize: "You poor thing, I know just how you feel."

• Don't preach: "You should always…"

- Don't make false promises: "I'm sure you'll get your children back in the next month."
- Don't threaten or coerce a parent: "If you don't go in that room and see your child right now, I am going right to the judge, and he won't be happy."

There are a few strategies that can help you become a better communicator and that you can teach and model to parents to encourage supportive communication in the family and home.

Strategy #1: Active Listening

Successful listening involves understanding how the speaker feels about what the speaker wants to communicate, not just the words being said. Active listening involves re-stating or paraphrasing what you hear to confirm that you have heard and understood.

How to Listen Actively:

1) **Remove as many barriers to listening as possible.** Listening barriers can be psychological, like emotions, or they can be physical, such as noise or visual distractions, such as the TV, computers, or telephones. Barriers also can include distractions, trigger words, vocabulary differences, and limited attention spans.

- One common barrier to listening is called the shift response, or the tendency of listeners to turn the topic of conversation to themselves without showing interest in the speaker's topic of conversation. If you ever think of what you are going to say next while someone is talking to you, you have engaged in this communication barrier. Be careful not to get distracted in conversation.

2) **Put your full focus on the speaker.** Face the speaker, sit up straight or lean forward slightly to show your attentiveness, and maintain eye contact.

3) **Avoid interrupting, or redirecting the conversation** to your own concerns. Truly focus in the moment on what the speaker is saying.

4) **Show your interest.** Respond appropriately, verbally and nonverbally. Use encouraging "mhmm" or "okay" responses, nod, raise eyebrows and use prompts, such as, "What did you do then?" Think of what would help encourage you in conversation and then apply that to the speaker.

5) **Focus solely on what the speaker is saying**. It can be hard to focus, but try your best not to think of what you will say next. It will help the conversation flow more naturally.

6) **Minimize internal distractions.** Try to let go of your distracting thoughts and continuously re-focus your attention to the speaker.

Table 15.1
Common Methods to Show Active Listening

Method	Description	Example
Restating	Paraphrase the speaker's point to make sure you understand.	"So I hear you saying…"
Summarizing	Bring together separate pieces of a story or problem and check that you are connecting them correctly.	"So it sounds to me as if…"
Minimal encouragers	Use brief, positive prompts to keep the conversation going and to show you are listening.	"Oh?", "I understand.", or "Mm-hmm"
Reflecting	Reflect the speaker's words in terms of feelings.	"This seems really important to you."
Probing	Ask questions to get deeper insight and get involved in the conversation.	"What do you think would happen if you…?"
Validation	Acknowledge the speaker's problems, issues, and feelings. Listen openly and with empathy.	"I appreciate your willingness to discuss…"
Using "I" Statements	"I" statements help you to focus on the problem, not the person involved in a negative situation. They help let the speaker know what you feel and why.	"I know you have a lot to say, but I need to…"

Redirecting	If the speaker shows signs of being overly aggressive, agitated, or angry, this is the time to shift the discussion to another topic.	"Let's continue this talk later."

Strategy #2: Nonverbal Communication

Nonverbal communication involves nonverbal cues that signal the way a person feels about a conversation or person. Everyone uses nonverbal communication. Look at the two pictures below and decide which person looks ready to have a pleasant, open discussion.

Without saying a word, both people are communicating how they feel. The woman on the left is crossing her arms and looking to the side, which may display a barrier to communication. The woman on the left is making direct eye contact, leaning forward, and smiling, showing a readiness to communicate. Nonverbal communication can be unintentional. You may not even realize the message that your body is sending. However, you can teach yourself to be mindful about how your body language is being read by others. For example, frowning, looking away or down, or having your arms crossed may convey that you are feeling negative emotions, such as anger, sadness or frustration. On the other hand, smiling, leaning forward, nodding, and encouraging hand signals show that you are in a positive mood and ready to communicate.

Nonverbal communication is important because it can relay information, such as emotions or biases, which can change the context and meaning of a conversation. Nonverbal methods of communication can include the following:

- Body language
- Facial expressions
- Body movement
- Gestures
- Eye contact
- Posture
- Tone of voice
- Muscle tension
- Breathing

Tips for Nonverbal Communication:

1) Use nonverbal signals that match your words to strengthen their meaning.

2) Use body language to convey positive feelings, even when you are not actually experiencing them.

3) Standing tall with shoulders back, smiling, and maintaining eye contact can help you feel more confident in a conversation and put the other person at ease.

Nonverbal Communication Exercise

*Draw a line to match the nonverbal communication to its meaning.**

Individual looks upset and worried by his nonverbal communication. He or she could maybe even be overwhelmed.

Individual seems joyful and is displaying love and affection, as well as an openness to communication, through his or her body language and facial expression.

Individual seems angry and is showing a desire to stop communication through his or her hand motions and facial expression.

Individual looks sad, possibly traumatized from a negative experience. His or her body language communicates worthlessness and loneliness.

Remember, while nonverbal communication can help you perceive others' emotions more effectively, body language and facial expressions vary between individuals and are not a conclusive way to determine an individual's emotions.

Teaching Children Communication at Visits

Communication skills are vital for adults and children. Studies show that effective communicators are happier, achieve more in school settings, and are more successful overall. You can begin to develop supportive communication methods in children during visits, but teaching parents how to encourage healthy communication in their children will help them fully develop these methods.

Teaching children good communication skills starts immediately and lasts throughout childhood and adolescence. At different stages of childhood, different skills should be developed. The ultimate goal is to raise an individual who converses courteously, listens to what others say, and is able to clearly express his or her own thoughts, ideas, and opinions. It is important to note that this goal may not be transferable to all parents and monitors should be aware of the cultural norms for healthy communication in each family.

Basic Communication Practices

There are a number of things you should do to help facilitate communication in children. The practices mentioned below can be used with all developmental stages.

- **Actively listen to the child.** When you show the child how to listen, this demonstrates that paying attention when someone else is speaking is important and courteous.
- **Get on the child's level.** Getting on the child's level will facilitate good eye contact. Eye contact is important because it is a non-verbal way to communicate with someone that helps to show your interest in what is being shared.
- **Display signs of verbal and nonverbal listening.** When the child is speaking, not only can you acknowledge verbally what they are saying such as saying "yes," and "mm-hmm," but you can also nod your head and react to what they're saying with facial expressions.
- **Verify that the child listens to you.** When talking to your child, ask them to repeat what you said in his or her own words or ask what the child thinks

about what you are speaking about. This way you know if the child is listening to you actively, and you can then say, "Thank you for paying attention" to show that you care.

- **Use "I" statements to communicate how you think and feel.** Start your sentences with "I" instead of "you" to relate what you are thinking. This will teach children how to speak in a direct way to others about their thoughts and reactions.
- **Ask probing questions to encourage the child to engage in open communication.** By asking probing questions, such as, "You look upset. Is it because of the thunderstorm and you can't go outside?" the child will learn to communicate more often and new conversation topics can be covered.
- **Teach the child not to interrupt when someone else is speaking.** Tell the child that allowing others to speak fully and express opinions without being disrupted is courteous. If the child interrupts you, calmly and politely tell him or her not to and explain how this can be a distraction to the person who had first been speaking. Also, don't interrupt the child either so that you can model this behavior for him or her.

Table 15.2
Child Communication Facilitation Techniques, By Age

Age of Child	Communication Developmental Milestones	Techniques to Teach Children Communication
Babies and Toddlers- *Birth to Age Three*	• Sounds (crying, cooing, squealing) • Facial expressions (eye contact, smiling, grimacing) • Gestures (moving legs in excitement or distress) • Fragmental word development • Repetition of words • Simple sentence development • Understanding of two-step commands	-Use running commentary for gestures. For example, the infant is pointing to the fridge. "Do you want a drink? Do you want milk? I'll get you some milk. Here is your drink of milk." -Repeat basic sounds or words, encouraging the child to repeat after you and learn new words.
Preschool Age- *Three to Five Years of Age*	• Development of more complex sentences	-Ask the child questions to include him/her in decision-making.

School Age – *Six to Twelve Years of Age*	• The use of "No" and "Why" • Decision-making • Imitation of words • Description of experiences • Growth of vocabulary • Grammar and punctuation • Understanding of three part instructions • Giving school presentations • Independent reading of chapter books • Writing of stories and letters • Use of phone to communicate	-Communicate with dolls or action figures to co-create a story. -Read together. -Ask specific, open-ended questions, such as "What feedback did your teacher give you on your assignment?" to avoid short, vague answers. -Make sure to avoid talking down to children of this age, as they want their growth and maturity to be acknowledged.
Teenagers- *Thirteen to Eighteen Years of Age*	• Rhythm and tone of speech • Body language • Development of communication style • Use of social media to communicate	-Challenge the teen to avoid the use of fillers like "um" and "like" for a few minutes to increase confidence. -Ask teens to consider how sarcasm can be hurtful to other people.

See Handout on Child Communication

Top 10 Strategies to Facilitate Child Communication

Below are 10 strategies you can use to facilitate the development of positive communication skills in children.

1. Get on the child's level.
2. Actively listen to your child.
3. Display signs of verbal and nonverbal listening.
4. Ask questions to encourage the child to have open communication.
5. Teach the child not to interrupt while someone else is speaking.
6. Verify that the child listens to you.
7. Use "I" phrases related to how you think and feel.
8. Help the child develop a wide vocabulary.
9. Teach the child the importance of body language and facial expressions.
10. Practice assertive communication techniques with the child.

Parent-Child Engagement

Parent-child engagement is a strengths-based, foundational practice that promotes partnership between service providers and parents in making decisions and setting and achieving goals. It emphasizes open communication, honesty, empathy, and culturally relevant services. It respects family dynamics and personal experiences. It promotes safety, permanency, and the well-being of children and their parent. It aids the family in achieving stronger parent-child bonds and sometimes can lead to reunification.

What are the Key Elements and Components of Parent-Child Engagement?

- It builds on existing resources and kinship connections.
- It emphasizes positive, two-way communication.
- It emphasizes responsiveness and flexibility to accommodate parents' work issues, culture, and unique needs.
- If focuses on gathering and using existing knowledge about families over time.
- It is strengths-based.
- It is inclusive of parents during goal-setting and problem solving.
- It is respectful of parents' cultural backgrounds and practices.

Why reunify?

Child protection professionals reunify children with their parent or parents because of a belief in permanency, or the intent of families to stay together. The underlying assumption of child welfare practice is that children benefit from being raised by their natural parents, when these families are nurturing, interdependent, and have the legal right to be together.

NOTE:

The goal for reunification in dependency cases is to reunify the child with one or both parents, but not to reunify the nuclear family. Reunification focuses on ensuring children have access to one or both of their parents who can provide safety and support.

Permanency is based on important values, including:

- the importance of family.
- the inherent value of biological families.
- the relevance of attachment between parent and child.

Permanency is the foundation of the Adoption Assistance and Child Welfare Act of 1980. This legislation includes two important caveats:

- every child has the right to live in a safe, nurturing, permanent home
- the parent(s) must make "reasonable efforts" to restore a stable, nurturing home before they can be reunified with their child

Necessary Steps for Permanency

To legally reunify a child with his or her parent(s), many steps are involved to help the family achieve legal status. These include:

- Case manager assessment of parent progress
- Case manager recommendation to court
  - Develops written service agreement for reunification support
  - Prepares parents, child, and resource provider
- Reunification with development of a visitation schedule
- Provision of post-reunification support and services
- Permanency
- Closing the case

Encouraging Parent-Child Communication & Interaction

To foster strong parent-child bonds in the families you work with, encouraging supportive communication and interaction is essential. Parent-child bonding can help create a positive relationship in which there is trust, comfort, and understanding. Engaging in activities during visitation provides parents and their children with opportunities for communication and fun. Here are some simple, inexpensive activities that can be done at visitation to engage parents and children in positive communication:

- **Read a book together.** You can have the parent ask the child engaging questions about the story, such as, "Who is the main character?" (for younger children) or "What would you do if you were in that situation?" (for older children).
- **Play a board game**. You can provide board games or puzzles to parents to play with their children to promote a fun bonding session.
- **Engage in playful copycat.** You can have the child choose an activity, such as clapping hands, jumping, facial expressions, and instruct the parent to playfully copy what the child is doing, imitating their volume and speed. Eye contact, smiles, and laughs can help to promote healthy attachment.
- **Tell stories.** You can encourage parents and children to talk about their day or tell stories from their past by asking engaging questions, such as, "What was the best part of your day?", "Where would you like to travel to?", and "What was the best meal you've ever had?"
    - You can also engage families in **round-robin style storytelling** by giving them a topic and having them take turns adding a sentence to the story
- **Play charades.** Engage more energetic families, especially those with more than one child, with a game of charades. Have the parent and child(ren) write down movies, books, or characters they think the other family members would know. Then, have family members take turns blindly choosing a slip of paper and act out the movie, book, or character without talking. Parents can help younger children write or act as needed.

Engaging parents and children in bonding activities that promote positive conversation and interaction helps to build trust and excitement for visits. It also sets the stage for growth and bonding in future visits.

STOP and Think

After reading this section, you should be able to answer the following question regarding the case scenario from the start of the chapter.

What skills could Christie have utilized to facilitate healthy communication?

Parent Modeling and Coaching

When supervised visitation is successful, it builds parental capacity and motivation. It's an excellent opportunity to help increase the bond between a child and parent, while reinforcing positive aspects of their relationship. Through parent coaching and modeling, visitation monitors can help parents learn how to better communicate with their children and get the most out of visitation. This will directly benefit children, who need supportive and loving parents.

Behavioral Parent Training

The environment of supervised visitation is an ideal place to employ certain principles of Behavioral Parent Training (BPT), also commonly referred to as Parent Management Training (PMT). ***BPT has been recognized as a best practice for reducing maladaptive child behaviors and increasing parenting skills.*** It focuses on teaching parents how to give positive reinforcement, such as praise and rewards, which is often the most effective way to foster positive child behavioral patterns. Techniques of this training include modeling, reinforcement, and correction. These are discussed below.

DID YOU KNOW?

Behavioral Parent Training has been shown to:

- Limit child disruptive behavior
  - Including aggression, hyperactivity, temper tantrums, and difficulty following directions
  - Increase positive child behavior and interactions
  - Foster strong parent-child bonds

Modeling is the act of giving a parent an example of positive behavior. If a parent is saying or doing something inappropriate during a visit, it's important for a supervised visitation monitor to maintain composure and calmly redirect. This involves a monitor doing the following:

• Focusing on the visiting parent; standing up straight and maintaining eye contact with the visiting parent (unless such behavior is not culturally appropriate).

• Maintaining an appropriate voice volume and relatable tone for both the parent and the child.

• Refrain from pointing, frowning, sighing, or showing anxiousness or fidgeting.

Reinforcement is praising a parent for a positive behavior.

Example: A supervised visitation monitor could say "I'm sure Jimmy appreciated your positive comment about his math test!"

Correction is instructing a parent on how to perform a positive behavior.

Example: A supervised visitation monitor could tell a parent who does not react to a child's good news: "Look! Jimmy got a big test back today, I'm sure he'd like to hear how proud you are."

Trauma-Informed Skills

Monitors can use visitation as an opportunity for parents to practice trauma-informed parenting skills. These skills include setting appropriate limits and boundaries, managing children's triggers and reactions, and reinforcing safety messages.

Modeling during Supervised Visits

Modeling behavior for parents and children helps strengthen relationships and encourage positive parenting strategies. Suggestions for supervised visitation monitors during sessions include:

• **Give parents suggestions** on how to interact with their children when they need help. This can help strengthen bonds between family members.

• **Intervene** if a parent becomes too violent, angry, or aggressive when interacting with a child. The monitor can do this by modeling positive parenting behaviors.

• **Remind parents** that they are their child's first teacher, and that they can have fun teaching their children.

Parent modeling and coaching can be used throughout supervised visitation to enhance the relationship between parents and children and make

supervised visitation more pleasant in the future. Parent coaching can be directed at the parent to encourage engagement and interactions with the child, or parent modeling can be directed towards children to model appropriate responses and behaviors. See the chart below for examples of positive coaching and modeling techniques that you can utilize during supervised visitation.

Table 15.3
Examples of Positive Parent Modeling & Coaching in Supervised Visitation

Situation	What You Can Say To The Parent	What You Can Say To The Child
Parent expresses that they are tired, upset, or frustrated.	• "Well, I'm glad that you were able to come today so you can visit Mark." • "I know you're tired/frustrated but I just wanted to tell you how much you're improving your behavior/promptness during visitation."	• "Want to read a book to your mom?" • "I know you were looking forward to telling your mom about your school dance. Would you like to share about it with her now?"
Parent becomes frustrated with child or doesn't know what to say.	• "Last week, Jimmy wanted to play Monopoly. Does that sound like something you want to do today?" • "We have some new books this week. Would you like to read one to your daughter?"	• "Erin, I know you didn't do "nothing" at school today. Let's try talking about what you did in science class." • "I'm sure your mom would like to hear about how you learned to play soccer in school."
Parent and children aren't sure what to do or play.	• "What kind of things did you do when you were eight? Do you think Farrah would like to do those things?" • "I know Johnny mentioned he wanted to read one of the new books today, how about you read to him?"	• "Shayla, you are such a big girl. Why don't you ask your dad to play Legos with you?" • "Kyla, is there another game you would like to play? We have so many things you can do with your mom!"

Parent is visiting with multiple children who may have different ages or interests.	• What kinds of games to Jeremy and Johnny like to play together?" • "Can you think of any activities that would be fun for a three-year-old and a nine-year-old?"	• What do you two like to do when you are together? • Tell me about a time you had fun with your sister.
Child is acting out or not responding to the parent.	<u>During the visit:</u> • "Mom, remember what we said about sharing?" • "Uh oh, Dad, looks like Marquis is getting a bit upset. Why don't you try those new skills we talked about?" <u>After the visit:</u> • "We have discussed Shayla's outbursts before. I think it would be helpful if you could cut in when she starts to have a tantrum and ask her to calm down for you."	• "Kevin, I can see you're frustrated, but we do not yell during visits with your mom. Is there something we can do to help you calm down?" • "Dani, this time is special, for you and your dad to play and talk. Would you like to answer your dad so you can have a good time?"
Parent is opposed to certain parenting behavior that the monitor is trying to model or encourage.	• "Well, we're here to work on your case plan. Let's work on making visits successful and follow the program rules so that you and your son can have a good visit." • "This may not be how you were raised or what your parents did, but we want you to succeed at your case plan today. There are so many positive interactions that can happen at visits. This will make your relationship better in the long run."	N/A

Don't forget the WHY. Explain WHY you make the suggestions to parents. It may be obvious to you, but the WHY is important to parents who have limited skill sets.

Parent modeling and coaching can be used in all areas of visitation and the parent-child relationship, but can be essential when parents are utilizing negative parenting practices such as:

Behavioral parent training can help you teach families to interact in more supportive ways and promote stronger parent-child bonds. BPT can be used to encourage a variety of positive family attributes. Some of the most relevant areas in which BPT can be used include:

- Healthy communication
- The use of motivation, confidence-building and goal-setting
- Parent-child engagement

The next sections will discuss conflict resolution, confidence building, and goal setting, and motivation for parents for use in their own families. These skills can enable parents to build strong bonds with their children and better meet their children's developmental and emotional needs during supervised visitation and beyond.

If a child misbehaves, and a parent moves to slap a child, how should a monitor react? A monitor could respond in the following ways:

• Tell the parent directly that it is not okay to hit the child while at supervised visitation, which is a violence-free area.

• Model another way to discipline the child, such as talking to him/her about why the behavior displayed was unsafe, disrespectful, not okay, etc.

• Ask a parent to step out of the room for a moment, and discuss the issue with him/her directly.

Depending on the severity of a parent's actions, it may be necessary to remove a child immediately for safety reasons. But in some situations, one of these options will be appropriate.

STOP and Think

After reading this section, you should be able to answer the following question regarding the case scenario from the start of the chapter.

What skills could Christie have modeled for Bradley?

Conflict Resolution

Conflict resolution is a crucial skill to effective communication, as conflicts are bound to occur at visitation. Resolving conflicts can be difficult, but this skill provides a chance for you to problem solve and react to conflict in a positive manner.

How conflicts are handled determines the outcome of the conflict. If handled well, issues can provide opportunities for personal growth, as well as a chance to strengthen the provider-client relationship. There are specific strategies that you can use to prevent conflict and address it in an effective manner.

Tips to Prevent Conflict

Some ways supervised visitation providers can work to prevent conflict effectively include:

1) Recognize when clients are becoming stressed or conflict is arising. Start to become aware of your clients' baseline demeanor, so you can recall when they are becoming stressed. Also look out for physical responses that all people experience during stress, such as tightening of muscles, clenching of hands, shallow breathing, or forgetting to breathe.

2) Assess clients' concerns or discomfort. Inquire about any problems or concerns that the client may be having at this initial stage, and provide support and encouragement where needed to resolve any distress.

3) Encourage clients to take a moment to calm down whenever needed. By providing support for this option, clients can feel comfortable taking a break to count to ten and can then make a rational decision on whether to stop the conversation or continue.

4) Encourage use of relaxation and appropriate coping mechanisms. Ask clients what soothes them, such as taking a few deep breaths, clenching and relaxing muscles, recalling a soothing image, or listening to relaxing music. This can be used during times of conflict or stress to calm down.

Addressing Conflict

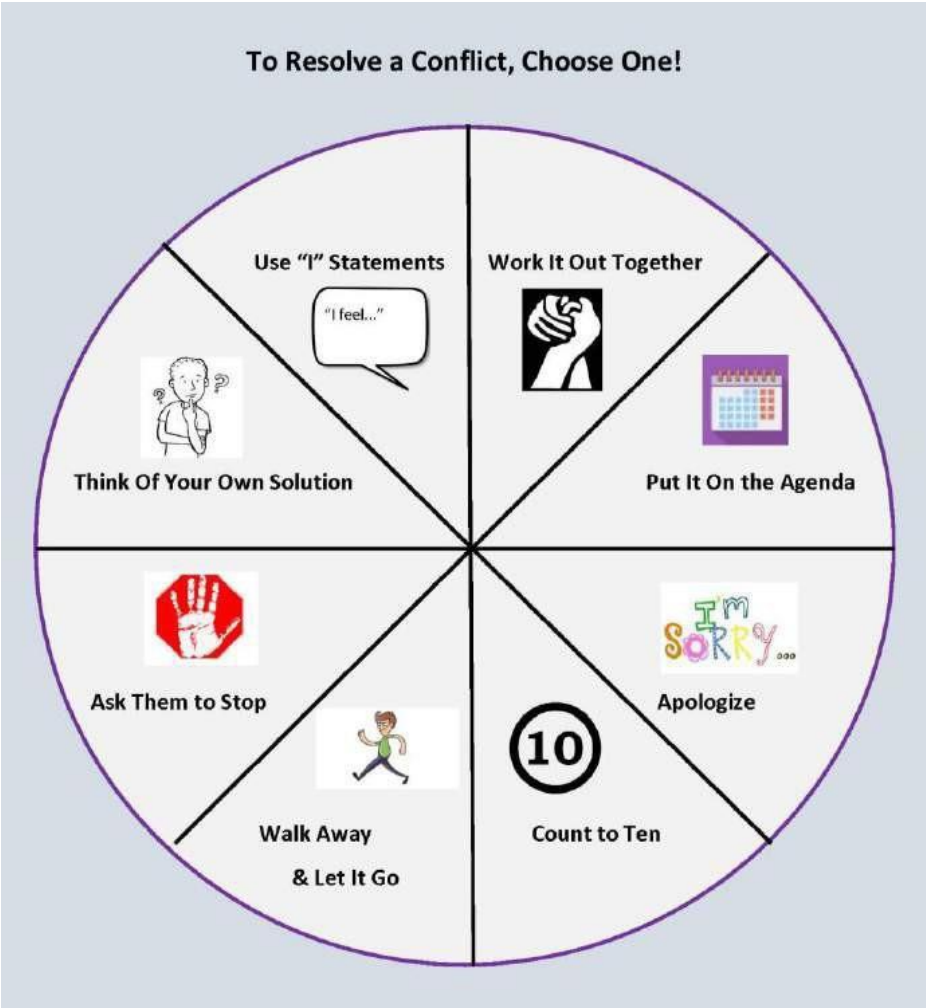
Sometimes, conflict will still occur. Conflicts often escalate quickly and can become dangerous within minutes, so it is important to intervene immediately to defuse the situation. Depending on the situation, supervised visitation providers can defuse the conflict by:

- Utilizing assertiveness skills
- Acknowledging individual feelings
- Providing helpful information
- Redirecting to another topic or activity
- Utilizing security staff and agency protocols

Table 15.4
Continuum of Conflict

	Characteristics of Stage	What You Can Do
Discomfort Stage	-Awareness of client becoming uncomfortable, annoyed, hesitant, or stressed.	-Assess client's concerns and provide support.
Incident Stage	-Presence of a sharp exchange leaving one or both individuals upset or irritated.	-Defuse the situation through assertiveness, acknowledging feelings or redirecting. -Be sure to utilize security staff and agency protocols.
Misunderstanding Stage	-Motives of each side and facts of the situation are often confused.	-Listen to each side's concerns and attempt to discern what the topic of concern is. -Use active listening to show your support.
Tension Stage	-A high level of tension arises from a mixture of attitudes, feelings, misunderstandings, and outcomes of the incident.	-Attempt to get each side to view the other's perspective or at minimum respect the other individual.
Critical Incident/Crisis Stage	-Behavior is affected, normal functioning becomes difficult, and extreme actions are often considered.	-Utilize security staff and make sure to keep children and other clients safe and away from the critical incident.

See Conflict Resolution Wheel.



STOP and Think

After reading this section, you should be able to answer the following question regarding the case scenario from the start of the chapter.

What should Christie have done to prevent the conflict or resolve the conflict as it arose?

Confidence-Building

Helping families gain confidence, set goals, and learn to self-motivate can be monumental in having success with supervised visitation. These tools can help parents set and achieve goals through self-confidence, motivation, and hard work that can benefit their families long-term.

Confidence refers to the way people think about themselves and the value that they believe they have. Having confidence allows an individual to believe in the power of his or her own abilities and strengths. This is an essential first step in setting and achieving goals.

Building Confidence in Parents

To foster confidence in parents, help them identify their strengths and abilities by using the following tips:

- **Compliment parents on what they are doing right** during visits with supportive words, such as, "I have noticed you are doing a great job at being on time the past few visits. I am happy to see you prioritizing your child"
- **Help parents identify their strengths** by having them make a list of their positive attributes or circle words they identify with from an existing list.
- **Encourage positive self-talk** by providing parents with affirmations they can use at home to practice positive self-talk and foster confidence.
- **Educate parents on their physical needs** for plenty sleep, water, and healthy foods to feel their best.
- **Help parents set small goals they can achieve realistically** to help them see their abilities.
- **Motivate parents to become more involved in positive activities** they enjoy that can also act as healthy coping methods to stress, such as running, poetry, painting, keeping a journal, or sports.

Helping Parents Support Children's Confidence

Confidence is an important factor in determining a person's happiness, self-esteem, and success in life. Confidence changes over time, but childhood is the most important period in the development of a person's confidence as it helps children learn, play with other children, interact with adults, improve and grow. Supervised visitation is an environment where parents can support their children's confidence. Monitors can help parents create a supportive environment to foster confidence by implementing the following skills:

- **Remind parents that they often have the biggest effect on their child's self-esteem.**
- **Give parents and children tasks that they can easily achieve together**, such as coloring, working through a puzzle, or reading a book.
- **Have parents help their child come up with at least three good things about him/herself**, and then post the list somewhere visible. Parents and children can work together to add to it occasionally throughout the visitation process.
- **Inform parents of the importance of a safe and loving environment.** Visitation should be a place where children feel safe and loved. Monitors should encourage parents to leave any conflict or issues out of the visit. Children who are exposed to their parents' conflict are more likely to develop low self-esteem. Monitors can encourage parents to focus on their child and the visit at hand.

Ultimately, parents need to understand that children must first feel that others have confidence in them to build their own confidence. Parents can be the first to express that to them, as well as a constant reminder of this confidence. As parents continue to work with their child on building confidence, they can gain a better understanding of their child's interests and passions. With that knowledge, parents can then support their children to become more involved in rewarding activities. Through a parent's love, support, and instructive direction, children will build confidence as individuals through the visitation process.

STOP and Think

After reading this section, you should be able to answer the following question regarding the case scenario from the start of the chapter.

How could Christie have built up Bradley and Loretta's confidence to help motivate them to set goals?

Goal-Setting

Exposing your clients to goal-setting can support parent desires to set goals to improve their parenting skills. This can make their visitations and relationships with their children more successful. By learning goal setting themselves, your clients can teach their children to set goals, as well. This supports attainable goals, self-discipline, and a feeling of accomplishment.

Setting goals is a great way to motivate parents to accomplish steps toward a healthier family. Many studies have shown that simply writing down a goal makes it more likely that a person will accomplish it. Helping parents organize their vision into a goal that will give parents a greater chance of attaining it. You can help parents create organized goals by making sure it follows the SMART acronym:

- **S- specific** (Be detailed about what it is that needs to be accomplished. No generalizations)
- **M- measurable** (There should be no doubt about whether the goal is reached.
- **A- actionable** (When writing goals, use action words such as 'practice', 'quit', 'finish', instead of 'be', 'am', 'have.')
- **R- realistic** (A goal should stretch a person just outside of their comfort zone, but it should not be unreachable. For example, it might be unrealistic to say, "Be president of the Parent-Teacher Association (PTA)" if a parent works during the day and is unable to make it to meetings, but a more realistic goal could be to "Contribute to the PTA by baking cookies for their fundraising bake sale on September 12th".)

- **T- time-bound** (Every goal needs a date to be completed by, otherwise it is just a dream. By setting a time limit, a person is motivated to accomplish the goal before the time is up.)

Using this acronym to structure goals helps to ensure that they will be met. Helping to set smaller, more realistic goals can help foster confidence and motivation to meet future goals from getting to feel success over a smaller goal.

Goals should also be stated positively, rather than negatively. For example, instead of saying "Don't get frustrated with my child when they don't listen to me," a parent could say "Find three successful ways of communicating with children" or "Practice patience with my child when they are not focused on me by calmly redirecting their attention."

How Do We Apply These Goal-Setting Skills to Parenting?

There are many specific skills necessary to parent successfully. These might include flexibility, consistency and stability, nurturing, accepting responsibility for one's actions, and dealing with stress.

So how can goals be created to focus on these parenting skills in a way that will be most beneficial? ***By breaking down general goals, they can be rephrased to be more specific and realistic.*** See Table 15.5 for examples.

Table 15.5
Setting a SMART Goal

General Goal	Specific, SMART Goal
Find vocational training	Find a training program for my beautician certification by March 1st.
Be reliable regarding spending time with my child	Be reliable by showing up on time to the next 4 visitation appointments.
Be patient every time my child throws a tantrum	Acknowledge my child's feelings the next time she has a temper tantrum Explain calmly why she cannot have the toy/candy/etc.
Be loving toward my child	Hug my child 3 times throughout the next session. Tell my child that I love him 3 times during the next session.
Keep my temper in check when someone asks about my family/work	Count to ten to calm myself before speaking, the next time someone asks me about work. Research two coping skills this weekend so that I can apply them during my supervised visits.

STOP and Think

After reading this section, you should be able to answer the following question regarding the case scenario from the start of the chapter.

What are some positive goals for Bradley and Loretta to work toward during visitation?

Our Goal-Setting Handout.

Setting a SMART Goal

Think about your life and what you'd like to see in your future. What is something you'd like to see change in your life? Think about one goal you have for yourself. Use this worksheet as a guide to setting your goal, working towards your goal, and finally, achieving your goal.

Remember a **SMART** goal means a goal is:

SPECIFIC—detailed, no generalization
MEASURABLE—able to see goal is completed
ACTIONABLE—focused on specific actions
REALISTIC—reachable, within abilities
TIMEBOUND—with a completion date

1. What is one goal you'd like to set for yourself?
   Remember SMART! Specific—Measurable—Actionable—Realistic—Timebound

_____

_____

2. How long will it take you to achieve your goal? _____

3. What are three things you can work on this month to help you achieve your goal?

(a) _____

(b) _____

(c) _____

4. What are three things you can work on this week to work to help you achieve your goal?

(a) _____

(b) _____

(c) _____

5. What is one thing you can do today to start working on your goal?

_____

6. What are some resources in your life and community that can help you achieve your goal?
(Think about social service providers, social supports, and other community resources.)

_____

_____

7. How will your life change when you have achieved your goal?

_____

_____

Motivation

Building parents' confidence and helping them set specific, measurable goals are two great skills, but without motivation, those goals may remain unmet.

Motivating Parents

Motivation involves encouragement, recognition of achievements, and giving individuals the tools and environment they need to achieve their goals. It emphasizes clients' strengths and promotes the achievement of goals.

To motivate your clients to reach their goals, remember these tips:

1. Every person is motivated about something. Identify what motivates your clients, whether it is the outdoors, their work, or another passion. If you can connect this motivation to the goal at hand, parents will feel more motivated to attain the goal.

2. A supportive environment is needed to achieve difficult goals. Be sure to encourage your client and recognize his or her accomplishments to encourage a positive support system.

3. Clear direction is essential to reaching a goal. Check in with your client regularly to ensure understanding of their next step at all times.

4. What motivates one client may not be motivating for another. Every individual is motivated in different ways. Try different methods of motivating, such as connecting the client to resources or providing encouraging words to find what works for the client.

Teaching Parents to Motivate Children

All clients need motivation to achieve their goals, but children in particular require frequent motivation to make changes and grow. Motivating children involves instilling positive values, making visual reminders of goals, and giving constant attention and support towards achievement of specific goals. Visitation monitors must work with parents to motivate children. With the involvement of visitation monitors in modeling positive motivation strategies for parents, children will feel

confident and motivated. Monitors can model how to motivate children during visits by following these tips:

- **Work with their natural abilities.** Monitors should encourage parents to identify their child's strengths and to use those strengths to motivate them to do a task makes them feel special and important.
- **Use supportive language**. Monitors can use supportive language when engaging parents and children. This modeled behavior will help parents in using language in a supportive way, as well. When informing clients about a task, monitors should make it sound achievable to give them confidence in accomplishing it.
- **Communicate your expectations.** When working with parents, be clear and explain the task thoroughly. Answer any questions the parent may have to increase understanding. As monitors model clear expectations, parents will be able to communicate with their children more clearly, as well.
- **Model hard work and positive values.** Monitors should encourage parents to share positive values with their children. Children model adults. By discussing a time when the parent has fulfilled a responsibility, children will see a model of hard work ethic.
- **Always explain why**. It is important that the child understand why the responsibility is important.
- **Offer rewards.** Monitors can provide parents with small objects, such as stickers, or special privileges, such as extra time. These rewards can help parents motivate children.

- **Give frequent positive feedback**. As monitors provide enthusiasm and positive feedback, parents can model such language and engage with their children. Some encouragement lines monitors can suggest to parents: "You can be really proud of yourself!" or "Look what you did!" A big smile or thumbs up can be very important to a child, as well.

Monitors should use visitation as a time to model motivation strategies and help parents motivate their children. With these skills, monitors will help build parent-child engagement and lead the way to positive visitations.

PRACTICE EXAMPLES

Case Scenario 1

Aaron attends visits regularly with his son Luke. The visitation monitor Rose noticed at previous visits that although Luke is a sweet, playful child, he often becomes nervous, hyper, and overstimulated when visiting with his father. At previous visits, Aaron has reacted to his son's high energy level with frustration and by shutting off from interaction. This has further aggravated the situation by causing Luke to feel ignored. Aaron has expressed concern over continuing visits with his son.

Discussion Questions:

1. How could Rose work with Aaron on his behaviors during visits?

2. How could Rose utilize parent-child engagement?

3. How can Rose facilitate healthy communication during visits?

Case Scenario 2

Rolanda has been referred to supervised visitation for visits with her son, Tyrek. Tyrek was recently removed from the home for allegations of neglect. The visitation monitor, Bill, wants to work with Rolanda to teach her skills to care for her son. When Rolanda enters the program, she is wearing clothing with visible stains. Bill asks about Rolanda's goals for the future, and she responds meekly, saying, "I can't do anything. I'm no good. I can't even take care of my son."

Discussion Questions:

1. What can Bill do to build Rolanda's self-confidence?

2. How can Bill employ motivation to inspire change in Rolanda's self-perception?

3. What small goals could Bills set with Rolanda for future visits?

4. How can Bill address the importance of self-care with Rolanda?

Test Your Knowledge!

Take this quiz to see what you have learned from the training.

1. **True or False: When recording a visit, you want to record only subjective observations that label or show judgement toward the client's actions.**

2. **_____is the act of giving/showing a parent an example of positive behavior.**
   a) Reinforcement b) Modeling c) Goal Setting

3. **Healthy communication involves the use of nonverbal communication, which involves all of the following EXCEPT:** a) Body language b) Restating the speaker's point c) Facial expressions d)Posture

4. **When helping clients create goals, they should be SMART or:**
   S-_M-_____A-_____R-_____T-_____.

5. **The opportunity for parent coaching and modeling can happen:**
   a) whenever the supervised visitation monitor and parent interact.
   b) only during intake.
   c) during visitation with child, parent, and supervised visitation monitor.

6. **The Parent-Child Engagement approach emphasizes the _____of service providers and families.**
   a) disengagement
   b) collaboration
   c) separation
   d) division

7. **True or False: The Continuum of Conflict involves discomfort, incident, misunderstanding, tension, and critical incident stages.**

Answers: 1. False 2. Modeling 3. B 4. Specific, Measureable, Actionable, Realistic, & Time-Bound 5. A 6. B 7. True

- **Guidelines for Accurate and Objective Recording- Behavioral Descriptions.** *http://libvolume3.xyz/electronics/btech/semester4/fundamentalsofhdl/behavioraldescriptions/behavioraldescriptionsnotes1.pdf.* A simple outline of how to record accurate and objective observations of behaviors in any setting.

- **Teaching Parents New Skills to Support Their Young Children's Development.** *https://www.med.unc.edu/earandhearing/pediatric-services/castle/csi/copy_of_kaiser_16_1.pdf.* An article by Kaiser & Hancock that outlines the benefits of parent education about family-centered interventions, particularly modeling positive reinforcement, interaction, and discipline. It provides the most important teaching goals for parents, factors that can increase or decrease the benefits of parent education in some families, specific strategies, and sample observation forms.

- **Guidelines for Parent/Child Communication.** *http://childdevelopmentinfo.com/how-to-be-a-parent/communication/.* This article by the Child Development Institute can be provided to parents to explain the basic principles of good parent-child communication that promotes bonding, specific words of encouragement and praise parents can use with children, and actions that can show them support as well.

- **Building Confidence Tip Card** *http://www.unstuck.com/tip-cards/strength/.* A downloadable PDF tip card on how to build confidence through existing strengths. Use this with clients to engage and motivate!

- **Conflict Resolution Skills.** *https://www.edcc.edu/counseling/documents/Conflict.pdf.* This guide covers the fundamentals of conflict resolution, healthy and unhealthy ways of managing and resolving conflict, four key conflict resolution skills and tips for managing and resolving conflict.

- **25 Science-Backed Ways to Change Your Life by Taking Better Care of Yourself.** *http://greatist.com/happiness/ways-to-practice-self-care.* This article provides specific ideas that have been backed by research to improve self-care. This can help visitation professionals and parents take better care of themselves.

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CHAPTER 16

ENHANCING PROFESSIONALISM: ETHICS IN ACTION

Case Scenario

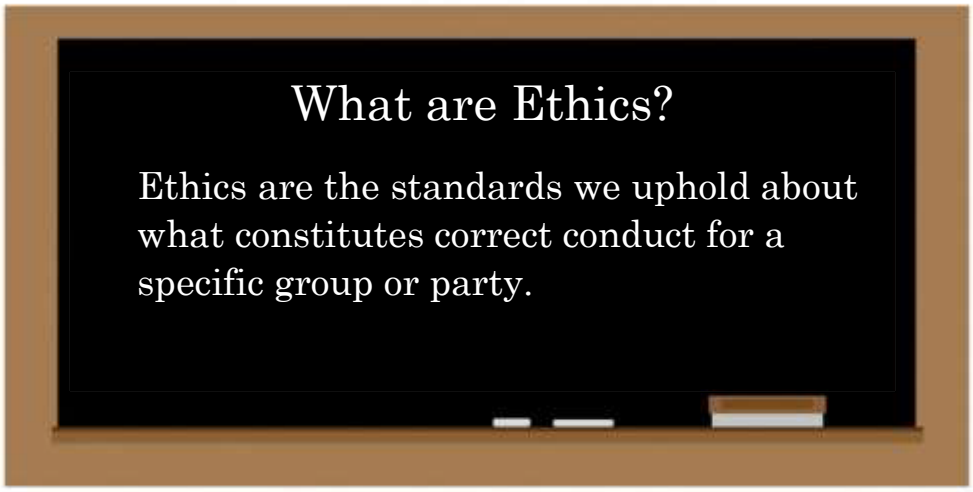
Jenny is court ordered supervised visitation with her father. Typically, when Jenny comes to visitation sessions she is visibly upset to be there and frequently cries during the visits. One day, Jenny tells the visit monitor that she hates her father and is frightened by him because he physically abused her mother and does not want to have any more visitation sessions with him. Jenny refuses to walk into the visit room. Jenny's father, Jim, is demanding that he has a court order to see his daughter and that Carmen needs to force Jenny to meet with him. Carmen does not want to violate the court order, but she also wants Jenny to feel safe.

After completion of this chapter, you will be able to answer the following questions:

- What are the ethical responsibilities of the visit monitor in this scenario?
- Is it more important for Jenny to feel safe or to adhere to the court order?
- Is it ethical for a visit monitor to force a child to see their parent?
- What action would you take in this situation?

Introduction

Supervised visitation monitors will be faced with ethical dilemmas and professional decision-making while working with children and families. In order to provide the best service, it is important for monitors to think critically about some of the major issues that may be faced in this field. Issues such as blending boundaries and diversity awareness may play a role in the client-professional relationship. Monitors should become aware of their own values as well as the standards set forth by the employing agency in order to process through troubling situations. This chapter will provide examples of different ethical dilemmas to help monitors think about appropriate ways to respond.



What will I learn in this chapter?

Upon completion of this chapter, participants will be able to:

- Recognize ethical practice principles for supervised visitation
- Understand the difference between professional and personal standards
- Recognize ethical dilemmas and conflicts
- Learn how to make an ethical decision
- Understand common ethical issues that may arise
- Utilize the steps for ethical decision-making in examples
- Be aware of resources to refer to for ethical guidance

Ethical Practice Principles

As a monitor, it is important to understand the ethical values that shape all practices, skills, and interactions with clients in supervised visitation. There are five ethical principles that monitors should use to guide their everyday work. These principles promote client welfare as well as a strong relationship with the families served. Often ethical values are embedded within professional codes of ethics; The Clearinghouse on Supervised Visitation has defined these five principles to motivate supervised visitation staff in ethical behavior and to assist with solving ethical dilemmas.

- **Safety** – Monitors' primary goal is safety; to protect and serve families and children. In supervised visitation, safety must be placed above all other considerations, including self-interest. Monitors can draw on their knowledge, skills, and policies to promote safety in all family interactions. Monitors are encouraged to understand all aspects of safety at their center and in each individual case.
- **Competence** – Monitors must develop and enhance their professional expertise to work within the appropriate competency expectations for supervised visitation. Monitors should continually strive to increase their professional knowledge and skills and to apply them in their everyday work.
- **Integrity** – Monitors should behave in a trustworthy manner. Monitors must act honestly and responsibly, in addition to promoting ethical practices on the part of the visitation center. Monitors are continually aware of the mission, values, and ethical principles and standards in addition to working in a manner that is consistent with them.
- **Respect** – Monitors should respect the inherent dignity and worth of the person. Through service, monitors must recognize the value of all human beings involved in visitation.
- **Community** – Monitors must be aware that other stakeholders may hold interests that are important and can impact the supervised visitation process such as the court, the child welfare system, the legal system, as well as the agency's policies, standards, and laws.

Note

Ethical dilemmas arise when ethical principles come into conflict. In many ethical decision-making situations, one or more principle is compromised for a "best" course of action.

In addition to the above ethical principles, Florida law provides some parameters regarding how supervised visitation services should be provided. The Clearinghouse on Supervised Visitation also provides a code of conduct for exchange monitors which will serve as a guide to comply with when addressing ethical considerations in practice.

Code of Conduct

The monitor must:

1. Diligently use best practices in the monitoring of all families;
2. Resist influences and pressures that interfere with impartial monitoring;
3. Report honestly and impartially in the Exchange Reports what occurs during exchanges;
4. Respect the privacy of the child and the family and hold confidential all information obtained in the course of service as a staff member or volunteer, as required by law and Program standards;
5. Decline to monitor cases in which he or she may have a conflict of interest;
6. Attend pre-service training, and in-service trainings when the monitor has been with the Program long enough for that to be required;
7. Not practice, condone, facilitate, or participate in any form of discrimination on the basis of race, color, sex, sexual orientation, age, religion, national origin, marital status, political belief, mental or physical handicap, or any other preference or personal characteristic, condition, or status; and
8. Comply with all Program policies

Why do we need Ethics?

- **Reason #1: To serve as a framework for decision making when faced with dilemmas**
- **Reason #2: To define what are acceptable and unacceptable behaviors for visit monitors**
- **Reason #3: To promote high practice standards for the profession**

STOP and Think

- Is it possible to monitor visits and remain neutral with respect to their clients' values?
- What ways do monitors' values affect the visitation process?
- Discuss life experiences you have had that you think will enable you to effectively work with others.
- Discuss limitations in your life experiences that might hinder your understanding of certain clients.

Determining Ethics

The conversation surrounding ethics requires making a distinction between ethics, values, and law and policies.

Ethics are prepositional statements and standards that are used by members of a group to determine the right course of action in any given situation. Ethics rely on rational and logical criteria to aid in making a decision by outlining the priorities of the group or organization.

Values describe ideas that we prize. Values are held close and can determine the worth of the individual holding that value. There is often an emotional component associated with values. Values develop from personal experience and background.

Law and agency policies dictate a particular course of action. There may be legal obligations that require monitors to act in a way that is in conflict with an ethical standard or personal values.

Resolving Professional Dilemmas

Read the following statements and identify whether the visit monitor acted upon ethical principles, values, and/or law.

1. Suzy has visiting children who were removed from the home due to their mother's heroin use. While accompanying one of the children to the bathroom, the child said, "Mommy has a needle in her purse today." Suzy responded by calling the mother into her office and confronting her about the needle. The mother admitted it was true and pulled the needle out of her purse. Suzy responded by calling the case manager over. What did Suzy act upon?

2. John was raised by his parents to promote equality for everyone. Because of his upbringing, he now treats all visiting parents and children equally, regardless of family structure. What did John act upon?

3. Leona's visiting parent discloses that she is pregnant and is considering her options. Despite her personal beliefs, she chooses to focus on the client's right to make her own decision. What did Leona act upon?

4. Oscar learns that a visiting child is being abused at home, and immediately calls the abuse registry to make a report. What did Oscar act upon?

1. Ethical principle & law 2. Ethical principles & values 3. Ethical principles 4. Law

Personal Values and Biases

Everyone has a unique background and experience that help shape the way they see the world. Monitors all have unique perspectives and in conjunction with previous experiences and history, monitors develop personal values. Personal values are largely associated with individual decision behavior, and while this is appropriate in one's own life, personal values and biases should not play a role in professional decision-making in supervised visitation.

- Working in an ethical manner can be difficult when personal values, biases, and professional ethics become hard to distinguish.
- To make appropriate decisions in compliance with professional ethics, monitors should work to understand their own personal values and morals. Monitors must work to understand their own background and experience and more specifically, how that background and experience affects the way they see the world.
- When monitors can identify their own personal values, it becomes easier to see how and when one's values overlap or conflict with professional ethical standards.

While personal values play a major role in an individual's life, the distinction must be made between personal values and professional ethics (should it be distinguished…i.e. personal values and professional ethics?). Personal values involve feelings and do not provide the objectivity that is necessary for decision-making in practice. By entering the supervised visitation realm, monitors have agreed to comply with the standards that are set forth for the profession. It is important for monitors to recognize and manage personal values but only in a manner that allows professional ethics to guide everyday practice. Conflicts involving personal values, although difficult and uncomfortable, should not be considered ethical dilemmas.

To understand personal values versus professional ethics, Table 16.1 displays questions that may arise from a conflicting situation. It is also important to note how monitors can deal with those questions while keeping the distinction between person and professional standards.

Table 16.1

Professional and Personal Standards

Professional	Personal
Ethics What relevant standards and expectations are outlined for supervised visitation? How do ethical principles conflict in this case? • If ethical principles conflict, use an ethical decision-making process to resolve.	**Values** What relevant personal values do I possess that apply in this case and where did they originate? What principles are outlined for supervised visitation and do any of them apply in this case? • If there is conflict between personal and professional values, how can I manage my personal values so that I can allow my professional ethics to guide me? • Seek supervision, use self-reflection and a values clarification process.
Laws and Policies Are there any legal obligations in this case? How do my agency's policies direct me? Are there any conflicts between the outlined ethical principles and my legal obligations/policies? • Legal obligations usually supersede professional ethics. • Agency policies should not prevent the ethical practice of supervised visitation. Seek supervision in both bases.	**Morals** How does my behavior affect my relationship with others in this situation? What would I like to do and/or what would I want done to me in a situation like this? • Distinguish between personal and professional behavior and obligations.

See the Developing Guidelines for Resolving Ethical Dilemmas Handout.

Developing Guidelines for Resolving Ethical Dilemmas

There are a variety of guides to assist monitors in resolving ethical dilemmas. Monitors must consult the visitation monitor Code of Conduct, the minimum standards set forth by the Clearinghouse, the recommendations for best practices, and the law when seeking guidance in ethical decision making. Nonetheless, situations may still arise in programs when additional principles are needed. The following principles are listed in descending levels of priority to assist monitors with compromising ethical principles to reach decisions.

- **Principle of The Protection of Life**: The safety of the program's clients, staff, and volunteers should be secured at all times.
- **Principle of Equality and Inequality**: Dependent upon a parent's situation, a parent who has abused his or her child is subjected to non-equal treatment as opposed to a parent who receives equal treatment.
- **Principle of Autonomy and Freedom:** Programs should provide an environment in which supervised visits can occur on neutral grounds in which no parent and/or child feels uncomfortable. If a parent does not follow program rules or poses a threat, program staff will interfere and limit the parent's autonomy.
- **Principle of Least Harm:** When a monitor is presented with a conflict during a visit, he or she is required to choose the option that causes the least amount of harm.
- **Principle of Privacy and Confidentiality:** Confidentiality must be kept in order to respect a client's privacy and ensure safety.
- **Principle of Truthfulness and Full Disclosure:** During visits, the program staff should always give detailed information about rules, services, reporting requirements, etc.

Ethical Dilemmas

Ethical dilemmas are often thought of as any situation that may make one feel uncomfortable. In reality, a situation must meet the following three conditions to be considered an ethical dilemma.

1. **A decision about which course of action must be made.**
2. **There must be different courses of action from which to choose.**
3. **Some ethical principle is compromised no matter what course of action is taken.**

Ethical Decision-Making

Sometimes an ethical dilemma arises because of a difference between what a client feels should be provided, what the court has ordered, what the visitation staff feels 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. Codes of ethics do not exist as a list of answers to all of the dilemmas which may arise during visitation; however they do offer general guidelines with which to help the decision making process. Researchers who examine ethical decision-making recommend a variety of criteria to assist human service workers in resolving these situations. The steps below will provide you with a model for thorough decision making when confronted with an ethical dilemma.

Steps for Making Ethical Decisions

1. **Identifying the problem or dilemma.** Once you have recognized that you are facing an ethical dilemma it is important to consider the situation from multiple perspectives. Ethical dilemmas are complex and doing this can help you to clarify the different aspects of the problem.
2. **Identify the potential issues involved.** Now that you have gathered all relevant information about the dilemma, prioritize what information is critical and what can be discarded. Basic moral principles such as autonomy,

justice, beneficence, and nonmaleficence may aid you in evaluating the different aspects. You will also want to consider the rights, responsibilities, and welfare of all those who are involved.

3. **Review the relevant codes of ethics.** Decide whether ethical principles from the Exchange Monitor Code of Conduct should be applied to the dilemma. Consider how your own values and ethics and are affecting your decision making.
4. **Know the applicable laws and regulations.** It is imperative that you ensure adherence to state and federal laws which may be applied to the situation. Dilemmas which may concern breaching confidentiality, reporting child or elder abuse, harm pertaining to self or others, parental rights, and record keeping are especially important to be aware of. You will also want to be familiar with any policies for visit monitors pertaining to the situation.
5. **Obtain Consultation.** Being mindful of the policies regarding confidentiality, consult with your supervisor and colleagues. Present your assessment of the situation and your ideas for how to proceed. Afterwards, ask the person for feedback: are there factors you are not considering? Have you evaluated all ethical and legal issues involved in the dilemma? Consultation is important because it can help you consider alternative perspectives, demonstrate your adherence to agency standards, and help you find support for a course of action.
6. **Consider possible and probable courses of action.** Brainstorm all possible courses of action. Be sure to list a wide variety, you may discover some options which seem unorthodox, but may be useful. Remember that taking no action is a possible alternative as well.
7. **Enumerate the consequences of various decisions.** For each possible course of action, ponder what the implications may be for all those involved. What consequences exist for each option?

8. **Decide on what appears to be the best course of action.** Carefully consider all of the information which you have obtained. The more obvious the dilemma, the more clearly the course of action may be. After choosing a course of action, try not to second guess yourself. At the time of a decision you made the best choice you could with the information available to you. Reflecting back on the decision you made will help you to learn from the experience and use that knowledge for future decision making.

Applying the Steps for Ethical Decision-Making

Ethical decision-making can be difficult. Read the following scenario and apply the steps listed above to practice ethical decision-making in a common supervised visitation situation.

Case Scenario

Cassidy has been attending supervised visitation with her father for two months. At one session while Cassidy and the visit monitor, Charlotte, are waiting for her father to arrive, Cassidy reveals details of her father's past sexual abuse. The monitor immediately reports this to the Child Abuse Hotline and is told that the accusations are being investigated. While the investigation is being conducted, the court has ordered that supervised visits continue between Cassidy and her father. The monitor is very concerned for the welfare of Cassidy and wants to terminate all visitation sessions between Cassidy and her father until the investigation is concluded, but does not want to violate the court order and risk losing her job.

Making an Ethical Decision

This monitor is being confronted with an ethical dilemma and should go through the steps for ethical decision-making.

1. First, Charlotte looks at the issue from all perspectives involved. How this will affect Cassidy, the Court order, Cassidy's father, and the staff.
2. The monitor then identifies the potential issues involved. Continuing sessions may be harmful to Cassidy's mental health. If the allegations are incorrect, then Cassidy's father will have unjustly missed out on

visitation sessions while the investigation is conducted. If the monitor does not hold the visitation sessions, then she will not be in compliance with the court order.

3. Once considering who may be affected, the monitor realizes that there are special precautions that can be taken in sexual abuse cases.
4. The monitor then shares this dilemma with her supervisor.
5. The monitor examines all laws which apply to this situation and concludes that by reporting the details which Cassidy shared with her, she has complied with laws which mandate her to disclose to the Child Abuse Hotline any reports of abuse.
6. Using the guidance shared by her supervisor, the monitor examines all possible courses of action. The monitor could continue supervising the sessions between Cassidy and her father, ask the court to cancel the sessions, or she could refer the case to a different visit monitor.
7. With these possible courses of action in mind, the monitor considers what consequences may be involved with each course. If Charlotte continues visit sessions as mandated by the court, this may cause stress for Cassidy. If Charlotte chooses to cancel session she may be reprimanded or lose her job.
8. With all of the information which Charlotte has obtained she is in the best position to choose a well informed and ethical course of action.

STOP and Think

- **What ethical practice principles were conflicted in this case?**
- **What ethical practice principles would be in conflict in either course of action chosen?**

Common Issues Faced

With the above ethical practice principles outlined, there are common ethical issues that may arise. It is important for monitors to consider these common issues and know how to address them as they occur. These issues range from financial to client-worker relationships and there are guidelines to dealing with each of them.

- **Client's right to know** – There are many times when monitors may feel that certain information does not necessarily need to be shared with clients. In supervised visitation, clients have the right to know all information pertaining to them using visitation services.
    - What are the services provided?
    - What is the cost of those services (extra charges for tardiness, absence, extra time)?
    - What are the limitations?
    - What are the qualifications of the professionals?
    - How long will services last?
    - What behavior is expected?
    - What are the limitations of confidentiality?
    - What can lead to termination?

Note

To keep the monitor-client relationship sound, remember the importance of BOUNDARIES.

The use of boundaries can assist with keeping relationships strictly professional and should be discussed by supervisors.

- **Duty to warn** – Supervised visitation monitors have a professional responsibility to warn when a harmful threat is made. High levels of invective are common in supervised visitation and staff should be mindful of what constitutes a threat. It is important to have consultation available and to have support from management and other staff in these situations.
- **Dual relationships** – Whenever there is interaction with a client in more than one manner, monitors risk complicating the client-worker relationship. With dual relationships there are several implications for supervised visitation.
    - Dangers of misunderstandings ("I thought we were friends.")
    - Lack of objectivity
    - Unfulfilled expectations

It is best practice for monitors to hold a single client-monitor relationship with clients and if there are any

conflicts of interest from dual relationships, it would be best to refer the client to a different monitor or center.

- **Financial issues** – Money issues should be clearly written in policies and relayed to clients as part of their right to know. Who, what, when, where, how, and why, are all important factors when determining policies for money issues. In general, it is best to uphold the following policies:
  - **Do not** borrow or lend money to clients.
  - **Do not** barter with clients as it leads to resentment.
  - **Do not** accept gifts under any circumstances.
- **Business records** – It is imperative for monitors to keep all paperwork current. Observing and recording is a crucial part of keeping up with all paperwork. Monitors should receive training to ensure the best practices of record keeping. DO NOT alter records in any case, specifically when litigation occurs.
- **Self-disclosure** – Revealing information about yourself, your family, or lifestyle all contribute to self-disclosure to clients. Often self-disclosure can be seen to humanize the monitor or to help with being well-liked, but it is important to keep personal information separate from interactions with clients. Revealing too much information can lead to misunderstandings with clients about the relationship and may contribute to dual relationships.
- **Impartiality** – Cases are brought to supervised visitation with the confidence that programs will be impartial. Impartiality holds the standards of providing no favor to either party. This includes impartiality regarding race, class, personal interests, and monetary/fiscal interest. It is important for monitors to be hard on issues and to stay focused on parents' mutual interest, their children.

REMEMBER

Impartiality is not indifference. Impartiality takes into account inequality of risks and recognizes power differences.

Monitors should NEVER ignore violence!

It is also important for monitors to be culturally competent and should refer to Chapter 7 to gain more insight on cultural differences and their impact on supervised visitation.

Examples in Action

As the basics of ethical principles and standards have been outlined, monitors should confront other issues that may arise. There are many different ethical dilemmas and some may require compromising different ethical principles outlined for supervised visitation. Monitors should become familiar with different scenarios that could occur in their own agencies, consider relevant questions, and understand how "best" decisions are made.

Scenario 1: Patrick is a recent college graduate working in a supervised visitation agency. He is enthusiastic about helping parents rebuild their relationship with their children. Patrick has begun receiving calls and messages from clients outside of work. He also has offered to lend money to parents in order to purchase gifts and snacks for their kids. During a staff meeting last week, he offered to take on a caseload that is much larger than recommended.

Questions to Consider

- How might Patrick's style of working help or hinder clients?
- Are any ethical principles violated with Patrick's style of working?
- What recommendations would you make to Patrick for him to continue to put forth his best effort without compromising any ethical principles?

Discussion

While many monitors like Patrick have good intentions, some of his practices can be detrimental to both the client, other clients and monitors, as well as the agency. Offering to be available to clients outside of their scheduled time or even outside of work hours can create an overly dependent relationship. When Patrick offers money to clients, it prevents clients' empowerment to develop solutions and ideas for their visits with their children. Another ethical concern in this case involves the exceeding caseload. Monitors must be cautious of caseloads and how higher caseloads may affect their work with families. Visit monitors should observe their caseloads and understand the necessary time commitment for each family. Rather than attempting to provide service to the most families, monitors should aim to provide adequate and quality service to each family on their caseload.

Scenario 2: Sarah is the monitor working with Olivia, her foster mother, Diane, and biological mother, Joanne. Olivia was removed from her mother's care three years ago because Joanne was abusing heroine with her boyfriend and was neglecting Olivia. Since losing Olivia, Joanne has been to rehab and has been clean for a year and a half. Joanne has had limited supervised visits with Olivia and has agreed to an open adoption with Diane. Last week, while waiting for a visit, Joanne admitted to using heroine the previous weekend with her ex-boyfriend. Joanne said to Sarah. "I've been clean for a year and a half, and now this

happens right before the adoption goes through." Joanne begs Sarah not to tell the judge of this isolated setback and promises it won't happen again.

Questions to Consider

- What potential problems would arise if Sarah does or does not report the drug use?
- What ethical principles are in conflict in this scenario?
- Are there any legal/policy obligations that Sarah is bound to comply with?

Discussion
Immediately, Sarah is bound to the policies of the agency as well as any legal restrictions. This may be difficult for Sarah because she might feel close to the client and feel as if she is betraying the client's trust. Safety is the overarching ethical principle and it is crucial for Sarah to uphold the safety of the child and foster mother in making this decision. It also appears that Joanne may not know what the reporting requirements are for Sarah and may not fully understand boundaries between monitors and clients. When working on a case long-term, it may be helpful for monitors to revisit and address the roles, responsibilities, and obligations of the monitor from time to time. Sarah is required to report this drug use as part of misconduct in this case.

Scenario 3: Terry is a passionate supervised visitation monitor who openly states her belief in the preservation of the family unit and much of Terry's passion stems from her strong religious background. Yesterday, Terry received a new case with visiting parent Paul and his daughter Marie. During the first visit, Marie was distant with Paul and did not interact well. Terry suggested that the three of them join in prayer together. Paul informed Terry that they are not a spiritual family and that it might be best to let him try to engage his daughter alone. Terry was shocked and informed Paul that his lack of spirituality led him to this situation in the first place.

Questions to Consider

- What concerns do you have for Terry's behavior?
- How might Terry be better able to distinguish her personal values from work?

- How might Terry's behavior affect the ethical principles outlined for supervised visitation?
- How might Terry's actions affect Paul and Marie's experience in supervised visitation?

Discussion
While religion may hold high importance in a monitor's life, it is important for monitors to be cautious about introducing religious themes into visitation. Clients will come from many different backgrounds and in many cases their values and views will differ from the monitor. Monitors must work to keep personal values separate from professional ethics. Engaging in cultural competency trainings will assist in understanding one's own biases and how to engage in a professional relationship.

Scenario 4: Madison is assigned her first case by her supervisor and is to work primarily on this case until more referrals come in. Madison goes to meet with Jamie, the visiting parent, for intake and immediately realizes that they know each other from high school. Madison meets with Jamie and immediately begins asking her "what happened to you? You used to be a good person. Come on, you can tell me." Jamie asks to step outside for a moment to get some fresh air. Jamie then leaves the center and does not return.

Questions to Consider

- How should a monitor address the issue of having a previous relationship with a client?
- How did Madison's actions affect the client?
- What ethical principles were compromised and how?

Discussion
It is inappropriate to have a dual relationship with clients. When approached with this situation, monitors must be concerned with how the client is impacted. In the situation outlined above, the client probably felt overwhelmed and even embarrassed to be seen in her situation. The client could have also worried about her confidentiality and privacy through the supervised visitation process. It would have been best for Madison to use more trauma-informed language to address Jamie and to seek supervisor assistance to reassign the client. Dual relationships should be avoided in any situation.

Reporting Unethical Behavior

As an ethical visitation monitor, it is your responsibility to not only exercise ethical practice, but to also report unethical behavior when you observe it. If you believe that you have witnessed a breach of ethics by someone within your agency you should feel comfortable in discussing the situation with your supervisor. The goal of supervised visitation is to ensure that the best practices are employed for clients and an effective way of doing this is holding peers accountable to the ethical standards set forth.

NASW Code of Ethics. *http://www.socialworkers.org/pubs/code/default.asp*. This resource will direct you to the Code of Ethics of the National Association of Social Workers.

American Counseling Association Code of Ethics. *http://www.counseling.org/resources/aca-code-of-ethics.pdf*. This resource will direct you to the Code of Ethics for the American Counseling Association.

American Psychological Association. *http://www.apa.org/ethics/code/principles.pdf*. This resource will direct you to the Code of Ethics of the American Psychological Association.

American Association of Marriage and Family Therapists Code of Ethics. *https://aamft.org/iMIS15/AAMFT/Content/Legal_Ethics/Code_of_Ethics.aspx*. This resource will direct you to the Code of Ethics for the American Association of Marriage and Family Therapists.

SVN Code of Ethics. *http://www.svnetwork.net/code-of-ethics.asp*. This resource will direct you to the Code of Ethics for the Supervised Visitation Network.

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