Impacts of Parental Substance Abuse on Children

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

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

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

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

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

Table 7.2 describes various parental behaviors and characteristics with the associated impacts on staff and children at supervised visitation programs.
Table 7.2
The Impact of Parental Behaviors and Characteristics on Staff and Children

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

Identifying Parental Intoxication

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

Some programs use breathalyzers or other tools to assess whether a parent has been using drugs/alcohol before visits or have security staff make this assessment. Others require a drug test be administered in a specified period preceding a scheduled visit. In these programs, visits are cancelled if the test is positive.
While it may be beyond a visit monitor’s expertise and skill to confirm whether a parent is intoxicated, a visit monitor can determine by the parent’s presenting behavior whether the visit or exchange should proceed. For example, if the parent is extremely agitated and behaving in a hostile manner to staff, a decision needs to be made about the risk in allowing a visit to proceed – whether or not the parent’s behavior is due to drug use or something else.

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

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

Symptoms that Mimic Intoxication

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

- **Over-the-counter medicines (OTCs)**
  Examples: Antihistamines make users drowsy; both decongestants and OTC diet formulations can make users agitated and/or dazed.

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

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

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

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

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

Discussion Questions:

1. Do you think the incident was handled appropriately?

2. What are the policies about informing children of cancelled visits at your supervised visitation program?

3. If the staff could not determine the source of the alcohol smell, and the father complied with all other program rules, could the visit have continued?

Techniques for Dealing with Substance Abuse in Visitation Programs

Interacting with Parents:

- If the worker has observed parental behavior that indicates substance abuse may be a problem (for example, the parent arrives at the program intoxicated), recognize that risks for unpredictable behavior or violence exist and that a crisis could develop. Program-specific policies and procedures must be followed in these situations. General tips for dealing with parents are:

- Use assertive communication skills: 1) avoid lecturing; 2) use “I” statements, not “You” statements; 3) keep verbal communication simple and direct – e.g. “I need you to wait here” as opposed to “You must stay here;”
• Separate the parent from others coming for intake;

• Focus only on disruptive behavior at the moment – not on what the parent has or has not done in the past;

• Assess for medical need – If the parent passes out, has difficulty breathing, exhibits signs of withdrawal (seizures, vomiting), or appears to be an immediate threat to himself or others, call for medical or law enforcement help;

• End the visit – “I’m sorry Mr. Jacobs, the visit won’t be held today. We will reschedule for next week;”

• Document the termination after the parent has left the premises; and,

• Provide reports pursuant to program policy.

**Interacting with Children**

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

• Recognize children's resiliencies;

• Help parents during visits recognize children's skills and resiliencies;

• Encourage problem-solving skills;

• Assist them in attaching to other positive adult role models;

• When and where appropriate, remind children they did not cause parent's addiction, that they cannot cure it or control it but can learn to cope with it;

• Let them know they are cared about at your program.

• Encourage them to ask for assistance during visits if they need to do so;

• Try to provide consistency during visits;

• Stress to the older child that addiction is a disease and their parent may do things that are mean or stupid when they drink or use drugs; and,

• Use the 7C's of addiction developed by the National Association of Children of Alcoholics.

**7C’s of Addiction**

I didn’t CAUSE It
I can’t CURE it
I can’t CONTROL it
I can CARE for myself
By COMMUNICATING my feelings, making healthy CHOICES
And by CELEBRATING myself.
Substance Abuse Treatment

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

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

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

Substance Abuse Recovery

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

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

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

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

Case Example & Discussion Questions

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

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

Discussion Questions:

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

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

3. What techniques might visitation monitors use to facilitate the visits?
The Interface Between Substance Abuse & Domestic Violence

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

Both of these conditions are characterized by the following:

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

Effects on Perpetrators and Victims

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

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

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

Case Example & Discussion Questions

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

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

Discussion Questions:

1. How does this case illustrate the interface between domestic violence and substance abuse?
2. Why might Lourdes get high before picking her children up?
3. If she is high, with whom should the staff allow the children to leave?
1. What is one of the primary causes for the increase in child maltreatment reports?
2. Describe the potential health consequences of hallucinogens, cocaine, and methamphetamine.
3. Discuss the stages of substance use from casual use to addiction, and describe the risk to children presented in each stage.
4. Discuss the behavioral, medical, educational and emotional impact of parental substance abuse on children.
5. Describe common behaviors of substance-abusing parents during supervised visitation and the impact of these behaviors on program staff and children.
6. Discuss how to use screening tools as part of an intake when substance abuse is of concern.
7. Describe techniques to employ to facilitate visits between substance-abusing parents and their children.
8. Discuss the interface between domestic violence and substance abuse.
CHAPTER 8

THE IMPACT OF PARENTAL MENTAL ILLNESS ON SUPERVISED VISITATION

Introduction

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

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

Overview

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

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

Objectives

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

1. Define major terms associated with mental health issues;
2. Recognize major categories of mental illness and their respective symptoms and treatment;
3. Recognize the five major types of psychotropic medication used to treat mental illness;
4. Identify risks that may be present during visits;

5. Identify strategies to facilitate a visit between a parent with mental illness and a child;

6. Recognize the impact of parental mental illness at different developmental stages of a child’s life; and

7. Recognize the mental health sequelae of domestic violence that may be observed during supervised visitation.

Snapshots

- Some studies have reported that as many as 70% of parents with mental illness have lost custody of their children.

- Research indicates that children who have a parent with a mental illness are at a significantly greater risk for multiple psychosocial problems.

- Bipolar disorders are the most common type of psychotic disorders women suffer during the perinatal period.

- About 1% of the population in the U.S. are diagnosed with schizophrenia; 1-2% with bipolar disorders.

- Major depression is diagnosed among 10-25% of women in their lifetime and among 5-12% of men.

Mental Health Terminology

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

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

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

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

**Bipolar disorder** (Manic-depressive illness) is a mental illness in which a person has pronounced periods of
being very “up,” and periods of being very “down.” When “up,” the individual feels very excited, high and energetic; when “down,” he or she may feel very depressed, with little or no energy. These periods affect how the individual is thinking and acting. Sometimes an individual with a bipolar disorder can become psychotic.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Illness</th>
<th>Symptoms</th>
<th>Onset</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>Disturbances in thought and perception</td>
<td>Late 20s</td>
<td>Medication</td>
</tr>
<tr>
<td></td>
<td>Delusions</td>
<td></td>
<td>In-patient treatment</td>
</tr>
<tr>
<td></td>
<td>Hallucinations</td>
<td></td>
<td>Social supports</td>
</tr>
<tr>
<td></td>
<td>Social withdrawal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bipolar disorders</td>
<td>Wide mood swings</td>
<td>Over 35</td>
<td>Medications</td>
</tr>
<tr>
<td></td>
<td>During manic phase, rapid flight of ideas, and reckless behavior</td>
<td></td>
<td>In-patient treatment</td>
</tr>
<tr>
<td>Illness</td>
<td>Symptoms</td>
<td>Onset</td>
<td>Treatment</td>
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<td>--------------------</td>
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<tr>
<td>Major depressive disorder</td>
<td>Persistent depressed mood, sleep disorders, appetite and weight changes, feelings of worthlessness, doom</td>
<td>Late 20s</td>
<td>Medication</td>
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<tr>
<td></td>
<td>Difficulty concentrating, thoughts of death or suicide, low energy</td>
<td></td>
<td>Therapy</td>
</tr>
<tr>
<td></td>
<td>Common sometimes in women following childbirth</td>
<td></td>
<td>In-patient treatment</td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td>Features of schizophrenia and mood disorder</td>
<td>Late 20s</td>
<td>Medication</td>
</tr>
<tr>
<td></td>
<td>Women diagnosed more often than men</td>
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<tr>
<td></td>
<td>Delusions</td>
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<td></td>
<td>Inappropriate affect</td>
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<td></td>
<td>Lack of interest in normal activities</td>
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<td></td>
<td>Sleep disturbances</td>
<td></td>
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<td></td>
<td>Racing thoughts</td>
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<td></td>
<td>Impaired judgement</td>
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<td></td>
<td>Decreased ability to care for self or others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personality disorders</td>
<td>Difficulty with relationships</td>
<td>Late adolescence</td>
<td>Therapy</td>
</tr>
<tr>
<td></td>
<td>Lack of empathy</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Problems with social skills, moods, emotional states</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personality traits: inflexible, maladaptive or inappropriate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>Extreme sense of fear and worry</td>
<td>All age groups</td>
<td>Medication</td>
</tr>
<tr>
<td></td>
<td>Psychosomatic complaints</td>
<td></td>
<td>Therapy</td>
</tr>
<tr>
<td></td>
<td>Sustained sense of fear/apprehension</td>
<td></td>
<td>Desensitization</td>
</tr>
<tr>
<td></td>
<td>Difficult in carrying out daily activities</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty concentrating</td>
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</tbody>
</table>
## Impact of Mental Illness on Parenting

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

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

<table>
<thead>
<tr>
<th>Developmental Stage</th>
<th>Child may</th>
<th>Parent may</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infant</strong></td>
<td>Be neglected</td>
<td>Be unable to focus on child’s needs;</td>
</tr>
<tr>
<td></td>
<td>Experience tension and anxiety</td>
<td>Be unaware of infant’s crying; infant may</td>
</tr>
<tr>
<td></td>
<td>Have accidents</td>
<td>Become focus of delusions in severe cases;</td>
</tr>
<tr>
<td></td>
<td>Show lack of response</td>
<td>Be unable to bond with the child;</td>
</tr>
<tr>
<td></td>
<td>Experience separation anxiety</td>
<td>Be distracted in caring for the child.</td>
</tr>
<tr>
<td></td>
<td>Fail to thrive</td>
<td></td>
</tr>
<tr>
<td><strong>Toddler</strong></td>
<td>Experience neglect (emotional, physical)</td>
<td>Devote inadequate time to caregiving</td>
</tr>
<tr>
<td></td>
<td>Experience tension</td>
<td>Misread cues from toddler</td>
</tr>
<tr>
<td></td>
<td>Have accidents due to lack of supervision</td>
<td>Lack consistency</td>
</tr>
<tr>
<td></td>
<td>Experience either over-stimulation or deficits in stimulation</td>
<td>Ignore health needs</td>
</tr>
<tr>
<td></td>
<td>Be physically abused</td>
<td>Experience stress in parenting toddler</td>
</tr>
<tr>
<td><strong>Middle Childhood</strong></td>
<td>Feel shame &amp; self-doubt</td>
<td>Provide inadequate structure</td>
</tr>
<tr>
<td>(6-12 yrs of age)</td>
<td>Begin to be aware of social stigmas around mental illness</td>
<td>Model inappropriate behavior</td>
</tr>
<tr>
<td></td>
<td>Have difficulty with trust</td>
<td>Exact too little or too much control</td>
</tr>
<tr>
<td></td>
<td>Be prone to accidents</td>
<td></td>
</tr>
</tbody>
</table>
Table 8.2 (cont’d)
Impact of Mentally Ill Parent on Children

<table>
<thead>
<tr>
<th>Middle Childhood (6-12 yrs of age)</th>
<th>Child may</th>
<th>Parent may</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience anxiety due to chaos at home</td>
<td>Be unavailable</td>
<td></td>
</tr>
<tr>
<td>Experience emotional neglect</td>
<td>Be emotionally unstable so that child does not know what to expect from day to day</td>
<td></td>
</tr>
<tr>
<td>Feel isolated, under socialized</td>
<td>Be unaware of issues of child who is entering puberty</td>
<td></td>
</tr>
<tr>
<td>Experience educational risks</td>
<td>Have a disorganized life style</td>
<td></td>
</tr>
<tr>
<td>Compensate for caregivers who may be under-involved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have unclear boundaries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience unpredictability in daily life</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adolescence</th>
<th>Child may</th>
<th>Parent may</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience loss or disorganization</td>
<td>Previous characteristics listed above plus:</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>Not like change; be inflexible in meeting adolescent’s needs</td>
<td></td>
</tr>
<tr>
<td>Problems in socialization</td>
<td>Have disorganized life style</td>
<td></td>
</tr>
<tr>
<td>More sensitive to social stigma</td>
<td>Intolerant of adolescent’s moods</td>
<td></td>
</tr>
<tr>
<td>Anger toward parent</td>
<td>Disengage from parenting due to stress</td>
<td></td>
</tr>
<tr>
<td>Difficulty concentrating</td>
<td>Inconsistent with discipline</td>
<td></td>
</tr>
<tr>
<td>Problems in peer relationships, school performance</td>
<td>Difficulty setting boundaries</td>
<td></td>
</tr>
<tr>
<td>Greater risk for substance abuse, sexual behavior</td>
<td>Allow adolescent to take over care of younger siblings</td>
<td></td>
</tr>
</tbody>
</table>

**Psychotropic Medications**

Psychotropic medications are used to control the symptoms of mental illness. These medications do not “cure” mental illness; they only provide relief from some of the major symptoms. While psychotropic medications have improved since their first use in the 1960’s, it is still a trial and error process for patients to learn what dosage works best and what type of drug provides the most relief. Compliance with medications is complicated in some instances because of their side effects, their expense, and the patient’s lack of understanding that the drugs often have to be taken for some period of time before symptoms are reduced.
There are five classes of psychotropic medications which visitation monitors should become familiar with: antipsychotic medications, anti-depressants, mood-stabilizing drugs, anti-anxiety medications, and psycho-stimulants. Visit monitors may encounter parents who are taking these medications to control the symptoms of their particular condition. If the parent is complying with the prescribed use of the medication, the visit monitor may observe certain side effects of these drugs which can impact the parent’s ability to interact with his or her children during visits. Sometimes it is not the medication that causes the parent difficulty but the mental illness itself (or even a combination of both the symptoms of the mental illness and the medication). It is not the role of the visit monitor in most situations to assess the parent’s compliance with their medication. Rather, it is the monitor’s role to be informed about the types of psychotropic medications and their role in controlling symptoms, as well as to be able to recognize common side effects which may impact visits. For example, some patients may experience jerking or tics from their medications; others may become so sedated that they are unable to attend to a child during a visit.

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

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

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

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

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

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

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

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

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

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

Examples of benzodiazepenes include *Xanax, Librium, Valium, Ativan,* and *Dalmane.* Beta-blockers include
Tenormin, Lopressor, and Inderal. Side effects of anti-anxiety medications may include sedation, dizziness, confusion, and headache.

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

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**Case Examples**

**& Discussion Questions**

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

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

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

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

**Discussion Questions:**

1. How might each parent's behavior or symptoms impact visits?
2. How might a visit monitor facilitate visits in each of these cases?
Identifying Risks During Visits

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

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

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

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

Table 8.3
Assessing Parents at Intake & Visits

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Check if present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disheveled</td>
<td>□</td>
</tr>
<tr>
<td>Motor status</td>
<td>□</td>
</tr>
<tr>
<td>Tremors</td>
<td>□</td>
</tr>
<tr>
<td>Odd gestures</td>
<td>□</td>
</tr>
<tr>
<td>Very slowed</td>
<td>□</td>
</tr>
<tr>
<td>Bizarre dress or inappropriate dress</td>
<td>□</td>
</tr>
<tr>
<td>Exaggerated make-up or hairstyle</td>
<td>□</td>
</tr>
<tr>
<td>Other observations about appearance</td>
<td>□</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavior</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Posture</td>
<td></td>
</tr>
<tr>
<td>Slumped</td>
<td>□</td>
</tr>
<tr>
<td>Tense</td>
<td>□</td>
</tr>
</tbody>
</table>
Table 8.3 (cont’d)
Assessing Parents at Intake Visits

<table>
<thead>
<tr>
<th>Facial Expressions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fearful</td>
<td></td>
</tr>
<tr>
<td>Angry</td>
<td></td>
</tr>
<tr>
<td>Bizarre</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Movement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Can’t sit still</td>
<td></td>
</tr>
<tr>
<td>Restless</td>
<td></td>
</tr>
<tr>
<td>Lethargic</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Voice/speech</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Very loud</td>
<td></td>
</tr>
<tr>
<td>Demanding</td>
<td></td>
</tr>
<tr>
<td>Jumps from one topic to another</td>
<td></td>
</tr>
<tr>
<td>Threatening</td>
<td></td>
</tr>
<tr>
<td>Very little verbal response</td>
<td></td>
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</tbody>
</table>

**Feeling or Mood**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fearful</td>
<td></td>
</tr>
<tr>
<td>Depressed</td>
<td></td>
</tr>
<tr>
<td>Elated</td>
<td></td>
</tr>
<tr>
<td>Excited</td>
<td></td>
</tr>
<tr>
<td>Agitated</td>
<td></td>
</tr>
<tr>
<td>Angry</td>
<td></td>
</tr>
<tr>
<td>Tearful</td>
<td></td>
</tr>
</tbody>
</table>

**Perception**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Seems to have auditory hallucinations</td>
<td></td>
</tr>
<tr>
<td>Seems to have visual hallucinations</td>
<td></td>
</tr>
</tbody>
</table>

**Thinking**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation</td>
<td></td>
</tr>
<tr>
<td>Confused over where he or she is</td>
<td></td>
</tr>
<tr>
<td>Doesn’t know who he or she is</td>
<td></td>
</tr>
<tr>
<td>Seems confused about date or time of day</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Memory</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Can’t recall personal information</td>
<td></td>
</tr>
<tr>
<td>Can’t recall recent visits</td>
<td></td>
</tr>
<tr>
<td>Can’t recall past events</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Thoughts</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Expresses suicidal thoughts</td>
<td></td>
</tr>
<tr>
<td>Expresses homicidal thoughts</td>
<td></td>
</tr>
<tr>
<td>Has delusions (fixed, false thoughts about something – such as the CIA is following her or him).</td>
<td></td>
</tr>
<tr>
<td>Expresses belief that he/she is controlled by external forces (aliens, CIA)</td>
<td></td>
</tr>
</tbody>
</table>
Case Example & Discussion Questions

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

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

Discussion Questions:

1. What, if any, risks are present in allowing Mr. Callaway to visit his children?
2. What categories in the checklist above might a visit monitor use in determining risks?

Facilitation Strategies

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

- Review background information and areas of concern prior to observing a visit. Do this each time a visit is scheduled. A parent’s assessment may vary depending on the episodic nature of the illness, compliance with medication, other treatment interventions, etc.

- Use the checklist in Table 8.3 to help organize observations. Note the items checked and determine if they are severe enough to warrant either canceling the visit, rescheduling it, or some other option. These decisions should be made by the program director.

- Try to reduce any excess noise or other stimulation (TVs, radios, loud toys) in the room where the visit will take place.

- If the program’s resources allow it, assign one visit monitor to each family with a history of mental illness instead of using group visits. Try to place that family in a room apart from others.

- Use “I” statements – not “you” when requesting that the parent do something.

- Do not challenge delusional thinking – for example, if the parent says the FBI is chasing him, don’t
challenge the statement or contradict it. At the point at which the parent expresses delusional thoughts, those thoughts are fixed and real – a visit monitor cannot persuade the parent to think otherwise.

- Likewise, do not deny hallucinations – either visual or auditory. If the parent asks if you hear what he or she hears, you can say you don’t (if you don’t) but don’t say that the parent is “just hearing something that isn’t there.”

- Acknowledge the feeling the parent is having regarding either delusions or hallucinations – “I know it must be difficult to think or worry that the FBI is following you.”

- Ask the parent if he or she needs to take a break during the visit. If so, have him or her go to a quiet area, and see if time away allows the parent an opportunity to recover adequately or control emotions well enough for the visit to continue.

- If the parent is planning to visit for a long period of time (e.g., several hours), the program director or visit monitor might want to ask the parent to help identify behaviors which may indicate a relapse – such as wearing unusual clothes, not sleeping, having disturbed thinking. Some parents might be able to do this, and might also agree that visits will be rescheduled if the behavior occurs.

- Have the child express any feelings of shame, guilt, or embarrassment prior to a visit or afterwards.

- Inform the child about the adverse impact of a parent’s medication if the parent appears sedated or unable to communicate effectively.

- Arrange with the child a signal to use if the parent’s behavior or emotions become too overwhelming. Have the child take a break or terminate the visit.

- Inform on-site security if the parent’s mental health status is so unstable or unpredictable that the safety of the parent, child, staff or anyone else on site is at risk. In Florida, law enforcement officers can take custody of mentally ill individuals who present risk to themselves or others and can transport them to a mental health facility for examination under the provisions of the Baker Act.

**Mental Illness and Domestic Violence**

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

2. Discuss the major categories of mental illness.

3. Describe the impact of parental mental illness on children.

4. List some of the names of commonly prescribed psychotropic medications and their side effects.

5. Discuss strategies to employ when facilitating a visit between a parent with mental illness and his/her child.

6. Identify potential risks that may affect a visit between a parent with mental health symptoms and his/her child.
Parents who have chronic illnesses or developmental disabilities present unique challenges in supervised visitation. Both conditions create parenting stressors that result not just from the parent’s health status but also from related factors such as financial status, access to social services, and access to medical/therapeutic care. The outcomes for parents and children can include financial problems, social isolation, frustration, separation, depression, embarrassment, shame, or resentment.

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

Overview

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

Objectives

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

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

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

4. Use effective strategies to facilitate visits between a child and a parent with a chronic illness;

5. Employ effective strategies to facilitate visits between a child and a parent with a developmental disability;

6. Understand how the Americans with Disabilities Act applies to supervised visitation programs;

7. Employ universal precautions for responding to the possibility of exposure to infectious agents; and

8. Identify risk factors which may present the potential for harm during visits.

Snapshots

- Children who have a parent who is HIV-infected tend to be from families who also experience poverty, lack of access to necessary social services, discrimination, or family disruption.

- Parents with a developmental disability are more likely to have children with developmental disabilities.

- Parenting with a developmental disability is becoming more common; this may be due to deinstitutionalization.

- Developmentally disabled parents who come to the attention of child protective services share many of the characteristics of non-developmentally-disabled parents who also have child protective service involvement: inadequate incomes, unemployment, poor vocational skills, and disadvantaged childhoods.

Parents with a Chronic Illness

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

- Distress;

- Fear of losing the parent to chronic illness;

- Resentment;

- Anger;

- Embarrassment;

- Disappointment;

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

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

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

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

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

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

Discussion Questions:

1. How might a visit monitor might prepare Louise’s children for their visit with their mother?

2. What suggestions might the program director or visit monitor use to address the reaction of other families to Louise’s HIV status?

3. What are the ethical considerations inherent in this case example?

Strategies for Facilitating Visits in Cases Involving Parents with Chronic Illnesses

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

- Understanding the progression of a parent’s particular illness. Has the illness recently been diagnosed? Is it in an advanced stage? Is it terminal? Is the illness contagious? If so, under what circumstances (e.g., airborne, bodily fluids)?

- Employing universal precautions if the illness presents any risk of transmission to others in the program (See box on universal precautions following this section).

- Obtaining appropriate training and education on common chronic illnesses and avoiding misinformation or myths about certain conditions. For example, believing that touching someone with AIDS will cause you to become infected or that cancer is contagious are both erroneous.
● Being sensitive to the physical needs of parents during visits, such as tiring easily, not being able to physically play with a child, being in pain or appearing sedated because of pain medication.

● Accommodating the needs of parents during visits in compliance with ADA requirements. For example, making sure the facility is accessible to handicapped, that someone is available to sign for the hearing impaired.

● Responding to the child’s reaction to the parent’s health status in a sensitive manner. Children whose parents are receiving radiation or chemotherapy may notice marks from the radiation, loss of their parent’s hair, or catheters placed in chests for drug infusions. Children may notice that their parent is very tired, has to take medications, or is unable to interact with them. These changes can be very frightening for children. Reassurance given by either the visit monitor or the parent can help alleviate the concern. A statement such as “Your mother is sick, and the doctor is doing what she can to make her better” may help the child cope with the emotions of seeing a sick parent.

● Referring the child or caregivers to resources or support groups for children who have parents with chronic illnesses.

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

Universal Precautions

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

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

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

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

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**Case Example & Discussion Questions**

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

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

**Discussion Questions:**

1. What emotions might Mr. Green be experiencing at visits?
2. What emotions might the children be experiencing at visits?
3. How might a visit monitor facilitate the visits in the Green case?
Characteristics of Developmental Disabilities

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

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

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

Exercise

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

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

Challenges Facing Parents with Developmental Disabilities

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

Socialization Experiences

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

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

Learning Style Differences (applies to those with cognitive disabilities)
• Learning deficits such as processing and/or memory problems;
• Limited functional academics, such as reading and writing;
• Limited ability to use problem-solving in complex or unfamiliar situations;
• Difficulty keeping track of time; and/or
• Difficulty applying knowledge from one situation to another.

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

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

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

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

Discussion Questions:

1. How does this case example illustrate the characteristics discussed in the previous section about developmental disabled individuals and their children?

2. How might the visit monitor in this case prepare the mother or the child for the visit?

3. How could the staff better deal with the mother when she comes for a visit, knowing she has been told the visit has been cancelled?

Challenges to Consider

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

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

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

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

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

QUIZ

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

Introduction

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

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

Overview

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

Objectives

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

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

- The American Bar Association encourages courts to provide or identify, and make use of, locations in which supervised visitation and visitation exchanges can safely occur.

- Statistics kept by the Florida Office of the State Courts Administrator reflect the following for 2004:
  - Over 13,000 Petitions for Dependency were filed;
  - Over 90,000 Petitions for Dissolution were filed; and
  - Over 63,000 Petitions for Injunctions for Protection were filed.

Program Obligation to the Court

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

Communicating with the Court

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

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

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

Non-Case Specific Communication

Non-case specific information includes kinds of cases accepted, hours of operation, changes in services, reports of staff changes, program resource growth or shortages, waiting lists, and incidents such as floods,
Fire, or other events not related to litigation. Communication from the program to the court regarding such information is generally accomplished through the trial court administrator or the chief judge. Even though it is usually the role of the director to discuss these issues, this information is not confidential, and visitation monitors are not legally prohibited from discussing it.

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

**Case Specific Communication**

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

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

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

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

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

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**Exercise**

**Appropriate and Inappropriate Communication with the Court**

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

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

Case specific _____  
Non-case Specific _____

Appropriate Communication _____  
Inappropriate Communication _____

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

Case specific _____  
Non-case Specific _____

Appropriate Communication _____  
Inappropriate Communication _____

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

Case specific _____  
Non-case Specific _____

Appropriate Communication _____  
Inappropriate Communication _____
Exercise (cont’d)

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

Case specific _____ Appropriate Communication _____
Non-case Specific _____ Inappropriate Communication _____

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

Case specific _____ Appropriate Communication _____
Non-case Specific _____ Inappropriate Communication _____

Case Example & Discussion Questions

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

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

Discussion Questions:

1. How might a family ordered to supervised visitation feel if they knew they were the topic of such a conversation?

2. How might a lawyer for one of the parents react, especially if he felt that his client had been treated unfairly in one of the court’s decisions?

3. If Judge Smith decides to recuse himself from the case, how might a case delay affect the family?

4. What impact could such a situation have on the reputation of the program, especially if it is repeated by other staff or volunteers?
Reports to the Court

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

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

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

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

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

Critical incidents include the following:

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

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

- Staff intervenes in a visit to teach a parent how to play a board game with a child;
- Parent scolds child for ignoring staff instructions; and
- Parent is angry with staff or expresses frustration at program rules.
If a visit monitor witnesses a critical incident, he or she should complete a detailed account of the incident after it has been resolved. This report would be provided to the program director, who is responsible for providing it to the court and to the parties. The account should include the following elements:

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

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

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

Cautions on Use of Reports

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

Such a cautionary note is necessary for the following reasons:

Expertise: The majority of supervised visitation monitors in Florida are not licensed mental health professionals, and are unqualified to make recommendations as to placement of the child, or to decide whether or not the underlying allegations in the case are true.
**Limited View of the Case:** Even if the supervised visitation staff members collect extensive background information regarding the parties, they are not Guardians ad Litem, who interview the parties and child and spend time getting to know them in a natural setting.

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

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

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

**Uses of Reports to the Court**

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

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<th><strong>Table 10.1</strong></th>
<th><strong>Appropriate and Inappropriate Uses of Observation, Summary and Critical Incident Reports</strong></th>
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| **Inappropriate** | To prove that the parent’s rule-abiding behavior at visits means that the allegations in the case against him/her are untrue.  
To show that the child(ren) is not afraid of the noncustodial parent during visits, and therefore, no abuse occurred.  
To demonstrate that unsupervised visits would pose no danger to any party.  
To show how the child would act without monitors present. |
| **Appropriate** | To factually document an incident which occurs at a supervised visit that may have endangered a monitor or participants.  
To demonstrate how a monitor redirects a parent’s behavior to assist with building parenting skills.  
To verify that a parent complied with a court order to use a visitation program.  
To analyze the incident and create program policies to avoid a re-occurrence of the critical incident. |