CLEARINGHOUSE ON SUPERVISED VISITATION

SPRING 2024 E-PRESS

CONTENTS

Karen Oehme, Director
koehme@fsu.edu
850-644-1715

Questions from Directors

“Hearsay”

We had a director contact us in January and report that an attorney objected to the admission of supervised visitation records because they contained "hearsay." The judge allowed the statements made by the party and the child reported in the observation notes to be excluded. Our director Karen Oehme sent out an email sent out an email if anyone else in FL has seen supervised visitation records excluded therein.

House Bill 385 “Purple Light Bill”

HB 385 passed the House on 1/18/24 and was sent to the Senate. The corresponding Senate Bill 580 is now on the Senate floor, awaiting final passage, after passing through all its committees. The two bills are identical, so there do not appear to be obstacles to final passage.

If the bill passes, as the Clearinghouse expects it to do, Karen has been invited to participate in a judicial training panel. The panel will be sponsored by the Office of the State Court Administrators to highlight for judges the limitations of the bill, safety considerations in domestic violence cases, and the training provided to supervised visitation programs to protect the families ordered to those programs.

We will discuss both issues at the next monthly webinar/phone conference.

Upcoming Phone Conferences

March 20, 2024 @ 12PM/11CT

April 17, 2024 @ 12PM/11CT

May 22, 2024 @ 12PM/11CT

Research Corner

Prenatal and Childhood Smoke Exposure Associations with Cognition, Language, and Attention-Deficit/Hyperactivity Disorder (2023)

Abstract

Objective: To assess the relationships of prenatal and childhood smoke exposure with specific neurodevelopmental and behavioral problems during early childhood.

Study design: A subsample (n = 386) of mother-child dyads from the Newborn Epigenetic Study (NEST) prebirth cohort participated in the study. Cotinine concentrations were used to objectively measure prenatal and childhood smoke exposure when youth were aged 3-13 years. Multivariable regression models were used to estimate associations of prenatal and childhood cotinine concentrations with performance on the National Institutes of Health (NIH) Toolbox and attention-deficit/hyperactivity disorder and behavioral symptoms, measured using the Behavior Assessment System for Children, 2nd edition (BASC-2).

Results: After adjusting for confounders, childhood cotinine concentrations were associated with poorer cognitive performance on tasks measuring cognitive flexibility (B = -1.29; P = .03), episodic memory (B = -0.97; P = .02), receptive language development (B = -0.58; P = .01), and inhibitory control and attention (B = -1.59; P = .006). Although childhood cotinine concentration was associated with higher levels of attention problems (B = 0.83; P = .004) on the BASC-2, after adjustment for confounders, the association is nonsignificant. Although associations for maternal cotinine concentrations were null, an interaction was detected between prenatal and childhood cotinine concentrations on the NIH Toolbox Picture Vocabulary Task (P = .02).

Conclusions: Our findings suggest that childhood tobacco smoke exposure may lead to poorer attention regulation and language acquisition, complex visual processing ability, and attention problems.

Integrating responses to caregiver substance misuse, intimate partner violence and child maltreatment: Initiatives and policies that support families at risk for entering the child welfare system (2022)

Abstract

Complex trauma is a significant public health problem in the United States (U.S.), occurring in families with chronic and compounding exposures to traumatic stressors like substance misuse, intimate partner violence (IPV) and child maltreatment (Cook et al., 2017). Yet, few programs exist to treat their intersection, challenging our ability to respond effectively and restore positive trajectories for children and families. In this context, there is a need for innovative approaches to treat these intersecting

phenomena. In this conceptual paper, we identify three innovative programs that offer integrative approaches to these intersecting challenges. We analyze common elements among these programs, offering a theoretical foundation for fundamental elements of transformative services. Finally, we consider how the Families First Prevention Act could be leveraged for states to adopt and implement these programs. The goal of this conceptual paper is to advance empirical and practical discussions regarding programmatic and policy options for more effectively responding to substance misuse, and IPV in families, and the associated traumas incurred by maltreated children and their caregivers.

Protective factors against child neglect among families in poverty (2022)

Abstract

Background: Despite neglect being the most common form of maltreatment, it is still understudied relative to other maltreatment types. Further, there is limited evidence on mechanisms through which to prevent child neglect and on mechanisms that might buffer the risk of poverty.
Objective: The current study estimated how different protective factors decreased subtypes of neglect, both physical and supervisory, across early childhood and in relation to poverty.
Participants and setting: The final sample included 2980 mothers from the Fragile Families and Child Wellbeing Study.
Methods: The current study used linear regressions in a structural equation modeling framework to estimate how protective factors at years 1 and 3 were related to neglectful parenting at years 3 and 5, as well as whether protective factors buffered the association between poverty and neglect.
Results: Mothers' perceived instrumental social support, part-time employment, and full-time employment were associated with less physical neglect at both time points (β range from −0.15 to −0.05; all $p < 0.05$). Perceived instrumental social support was also related to less supervisory neglect at both times ($\beta = -0.05$, $p < 0.05$ for both times). Perceived instrumental social support significantly moderated the association between poverty at year 1 and physical neglect at year 3 ($\beta = 0.06$, $p < 0.01$).
Conclusions: These findings provide important information to practitioners and policymakers on potential mechanisms to reduce neglect, as well as reducing neglect among economically disadvantaged families

Perinatal depression, PTSD, and trauma: Impact on mother–infant attachment and interventions to mitigate the transmission of risk (2019)

Abstract

Early interactions between infants and their caregivers are fundamental to child development, and the parent-infant relationship is believed to provide the foundation for healthy and secure attachment relationships and for infant mental health. Over time, these secure attachment relationships become the backbone for positive child outcomes across development. Abundant research to date confirms that parental mental illness, including depression and PTSD following trauma exposure, may have a detrimental impact on parenting quality and subsequent early child relationship formations. This review paper summarizes the literature on the role of sensitive parenting and a healthy mother-infant relationship in establishing a secure mother-infant attachment bond, which in turn is critical for the child's healthy socioemotional and cognitive development. The review also highlights the roles of maternal perinatal depression, PTSD, and/or exposure to interpersonal violence or childhood maltreatment onto parenting, bonding, and child attachment style towards the caregiver. The final section discusses existing therapeutic interventions and approaches that bolster early parenting practices and early maternal-child relationships. Specific emphasis is placed on relational interventions that address bonding and attachment disturbances in the context of maternal perinatal mental health risk and trauma.

Overview of Sexual Violence Issues

Sexual violence – a sexual act committed against a person without their consent (CDC 2014, 2022b)– involves rape and any other unwanted sexual contact or experience, including when the victim is unable to consent or unable to refuse consent. Understanding the concepts of consent, including the inability to consent and the inability to refuse consent is critical for recognizing and addressing sexual violence.

- **Consent**: the words or overt actions displayed by a person who is legally or functionally competent to give informed approval
- **Inability to consent:** when a freely given agreement to have sexual intercourse could not occur due to the victim's age, disability, lack of consciousness or awareness, etc.
- **Inability to refuse:** when a disagreement to engage in a sexual act was inhibited due to the use of pressure, coercion, weapons, physical violence, etc.

(CDC, 2014)

Sexual Violence Behaviors

Sexual violence can take many forms and involves a range of contact and non-contact sexual behaviors targeting victims. Contact behaviors involve physical contact, while non-contact behaviors do not require physical contact. Perpetrators commit both types of these behaviors without the victim's consent (Rape, Abuse, & Incest National Network [RAINN], 2023e).

Key Takeaways: Sexual Violence can be *Contact Sexual Violence*, or *Non-Contact Sexual Violence*

(RAINN, 2023f; West Virgina Foundation for Rape Information & Services [WVFRIS], n.d.).

Contact Sexual Violence

Contact sexual violence involves unwanted physical contact. These behaviors are often violent, and perpetrators may use force, threats, or manipulation to commit sexual violence (National Sexual Violence Resource Center [NSVRC], n.d.-a). Contact sexual violence include:

- Rape, which is forced penetration of the victim's body
- Attempted rape
- Intentional touching of the victims' body parts directly or through their clothing
- Unwanted kissing

(RAINN, 2023f; WVFRIS, n.d).

Non-Contact Sexual Violence

Non-contact sexual violence involves behaviors that do not require physical contact or touching. This can occur online and can happen without the victim's knowledge or consent (WVFRIS, n.d.). These behaviors are also harmful and upsetting to the victim. Non-contact behaviors include:

- Performing sexual acts on a webcam without the consent of the person involved
- Sending unwanted text with sexual messages, images, or videos
- Pressuring the victim to send explicit images of themselves
- Unsolicited or unwanted sharing of pornographic videos or images
- Using technology or social media to track the victim
- Sharing private images or videos of the victim without their consent

(WVFRIS, n.d.).

Brief Overview of the Effects of Sexual Violence

Sexual violence can lead to a multitude of physical and psychological negative outcomes for victims. Effects of experiencing sexual violence include the following:

- Psychological symptoms such as depression, anxiety, PTSD, and suicidal thoughts
- Sexually transmitted infections
- Reproductive, gastrointestinal, and cardiovascular health problems
- Negative health behaviors such as smoking, and alcohol and drug abuse
- Feeling embarrassed, ashamed, or afraid to tell the police
- Difficulty maintaining personal relationships
- Experiencing additional forms of violence
- Unwanted pregnancy

(CDC, 2022b; Florida Health, n.d.)

Age at First Sexual Violence Victimization

Sexual violence can occur across the lifespan, from childhood through adulthood. Most victims of all forms of contact sexual violence reported that their first victimization happened before they were 25 years old. **Between one third and one half of victims of contact sexual violence reported that their first victimization was during childhood (prior to 18 years of age)** (Basile et al., 2022).

Sexual Violence and Neurobiology of Memory and Trauma

Neurobiology helps us understand how trauma impacts the brain's functioning during and after an assault. It can help explain:

1. Why victims can have trouble remembering details of an assault
2. Why victims remember events out of order
3. Why victims suffer from problems such as confusion, hyperactivity, and mood swings.
4. Why some of a victim's clearest memories of violence may involve sensory information (like smell, sounds)

Memory Formation

First, consider the process of typical memory formation before examining factors that contribute to memory impairment. Put simply, an individual's memory is composed of information that is perceived and stored for later retrieval.

- Information is first received through our senses—what a person sees, hears, smells, feels, and understands.
- Emotions and emotional memories are regulated primarily by the amygdala.
- The bits of information from the senses and emotions are then encoded by the hippocampus so that time, place, and sequence of events are part of the memory, along with a coherent narrative with context and perspective.
- These explicit memories can then be consolidated and stored into long-term memory.

(Brown et al., 2019; Johns Hopkins Medicine, 2021)

Trauma disrupts the brain's normal processing of memories

Researchers have found that victims' memories of highly traumatic interpersonal events such as sexual assault are less clear, demonstrate a reduction of chronological order, and are often not as well remembered (Brown et al., 2019) as other negative memories. For comparison, researchers studied reactions to incidents including shootings (McLaughlin & Kar, 2019), seeing a victim of an accident, and verbal accounts of other traumatic events.

Here's how researchers describe the disruption of memory functions during traumatic events. The amygdala and the hippocampus, which typically work together to organize memories, are flooded with stress hormones during highly traumatic events. Traumatic memories are often first stored as sensory information (i.e., sight, smell, sound, touch, and taste) in the amygdala, which is primarily responsible for the regulation of emotion and emotional memories. When a person experiences an intense trauma like violence, their amygdala encodes sensory fragments from the environment. This means that some of the clearest memories for victims may involve sensory information regarding the event. In addition, these fragmented memories are linked by the amygdala to intense feelings felt during the event, like fear, anger, and threat. Such sensory

fragments can be triggers for intense fear at a later time (Johns Hopkins Medicine, 2021).

Normally, the hippocampus can give emotional memories from the amygdala some context, narrative, and perspective (Brown et al., 2019). But if a memory is formed during a very stressful or traumatic event, stress hormones cause the amygdala to be overactive, and overwhelm the hippocampus's ability to function properly. This can prevent successful encoding of narrative/cognitive memories and can result in sensory, fragmented memories (Cozolino, 2017).

The brain's process of storing memories is complex. However, because traumatic memories are often first stored as sensory information (i.e., sight, smell, sound, touch, and taste), some of the clearest memories for victims may involve sensory information regarding the event. At the same time, because the hippocampus provides syntax (or speech) context to memories, when the hippocampus is impaired by stress hormones, victims may not clearly remember exactly what was said during a traumatic event (Torrisi et al., 2019).

Finally, victims of trauma sometimes report "flashbulb" or tunnel memories attributed to high levels of stress. Flashbulb memory involves very vivid memories that can occur during a traumatic event when a burst of adrenaline strengthens the pathways that encode and store core memories (McGaugh, 2000). Flashbulb memories often capture the initial moments of a traumatic event. Tunnel memories are memories where the central details are clearer than the memory of the peripheral information (the environment, others present, and the sequence of events) due to high levels of stress (Arntz et al., 2005; Mickley Steinmetz et al., 2012).

Key Takeaways:

- Sexual violence victims may have fragmented and incomplete memories of the assault shortly after it occurs, because of the impact of intense trauma on memory formation and consolidation.
- Memories may continue to come back or consolidate over time.
- The fact that there may be differences between a statement taken soon after a sexual assault and one taken weeks later is not an indication of untruthfulness. It is a normal function of memory formation during trauma.

References

Arntz, A., de Groot, C., & Kindt, M. (2005). Emotional memory is perceptual. *Journal of Behavioral Therapy and Experimental Psychiatry, 36*, 19-34. https://doi.org/10.1016/j.jbtep.2004.11.003

Basile, K. C., Smith, S.G., Kresnow, M., Khatiwada S., & Leemis, R.W. (2022). The national intimate partner and sexual violence survey: 2016/2017 Report on sexual violence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/nisvs/nisvsReportonSexualViolence.pdf

Brown, D., Belli, A., Qureshi, K., Davies, D., Toman, E., & Upthegrove, R. (2019). Post-traumatic stress disorder and self-reported outcomes after traumatic brain injury in victims of assault. *PLoS One, 14*(2), e0211684. https://doi.org/10.1371/journal.pone.0211684

Centers for Disease Control and Prevention. (2014). *Sexual violence surveillance: uniform definitions and recommended data elements.* https://www.cdc.gov/violenceprevention/pdf/sv_surveillance_definitionsl-2009-a.pdf

Centers for Disease Control and Prevention. (2022). *Fast facts: Preventing sexual violence.* https://www.cdc.gov/violenceprevention/sexualviolence/fastfact.html

Cozolino, L. (2017). The neuroscience of psychotherapy: Healing the social brain (Norton Series on Interpersonal Neurobiology). WW Norton & Company.

Florida Health. (n.d.). *Sexual violence prevention*. Florida Department of Health.https://www.floridahealth.gov/programs-and-services/prevention/sexual-violence-prevention/index.html

Johns Hopkins Medicine. (2021). Brain anatomy and how the brain works. https://www.hopkinsmedicine.org/health/conditions-and-diseases/anatomy-of-the-brain

National Sexual Violence Resource Center. (n.d.-a.). About sexual assault. https://www.nsvrc.org/about-sexual-assault

McGaugh, J. L. (2000). Memory—A century of consolidation. Science, 287, 248–251. https://doi.org/10.1126/science.287.5451.248

McLaughlin, K., & Kar, J. A. (2019). Aftermath of the parkland shooting: A case report of Post-traumatic Stress Disorder in an adolescent survivor. Cureus, 11, e6146. https://doi.org/10.7759/cureus.6146

Mickley Steinmetz, K. R., Scott, L. A., Smith, D., & Kensinger, E. A. (2012). The effects of trauma exposure and Posttraumatic Stress Disorder (PTSD) on the emotion-induced memory trade-off. Frontiers in Integrative Neuroscience, 6, 34. https://doi.org/10.3389/fnint.2012.00034

Rape, Abuse, & Incest National Network. (2023e). Perpetrators of sexual violence: Statistics. https://www.rainn.org/statistics/perpetrators-sexual-violence

Rape, Abuse, & Incest National Network. (2023f). Sexual assault. https://www.rainn.org/articles/sexual-assault

Torrisi, S. A., Leggio, G. M., Drago, F., & Salomone, S. (2019). Therapeutic challenges of post-traumatic stress disorder: Focus on the dopaminergic system. Frontiers in Pharmacology, 10, 404. https://doi.org/10.3389/fphar.2019.00404

West Virginia Foundation for Rape Information and Services. (n.d.). Understanding sexual violence. https://www.fris.org/SexualViolence/SexualViolence.html

Therapeutic Supervised Visitation

Introductory Meeting: January 31, 2024, 12:00 PM

Agenda–Items to review:

1. Florida definition of TSV
2. Supervised Visitation Network's definition of TSV See
3. Issues to discuss:
    a. Cost associated with TSV
    b. Therapeutic goals
    c. Requirements of court order
    d. Hybrid models of TSV and facilitated/supportive supervised visitation
    e. Confidentiality of notes
    F. Therapy confidentiality of conversations with parents and child
    g. Recommendations to the courts
    h. Who is entitled to do TSV?
4. Potential alignment on the following issues:
    a. Requirements of court orders
    b. Programs can provide hybrid TSV and supportive SV services
    c. Other areas:
5. Schedule next meeting: February 15 4:00PM

Web Meeting Notes:

- Supreme Court of Florida Minimum Standards for Supervised Visitation Program Agreements were discussed: https://familyvio.csw.fsu.edu/sites/g/files/upcbnu1886/files/documents/Supreme_Court_Standards_for_SV_from_1998.pdf
- Definition FL. Supreme Court: Therapeutic Supervision is the provision of therapeutic evaluation or therapeutic intervention to help improve the parent-child interactions. Therapeutic supervision may only be provided by order of the court and only by *trained certified or licensed mental health professionals*.
- **Discussion about the clinical licensure that is included in this definition is reserved for the Meeting on Feb. 15 at 4 pm.**
- Immediate consensus on the following: In addition to being a licensed mental health clinician, anyone conducting TSV in Florida must have *additional* training on Supervised Visitation.
    - There are specific safety concerns in therapeutic supervised visitation that "regular" clinicians may not be aware of.

Anyone providing therapeutic supervised visitation in Florida must **also** complete 24 hours of training covering at least:

a) Florida's minimum standards;
b) Provider policies and procedures;
c) Safety for all participants;
d) Mandatory child abuse reporting;

e) Professional boundaries, conflict of interest, confidentiality, and maintaining neutrality;
f) Basic stages of child development;
g) Effects of separation and divorce on children and families;
h) Grief and loss associated with parental separation and removal from the home due to child abuse and neglect;
i) Working with diverse communities;
j) Family violence, including domestic violence and the effects of domestic violence on children;
k) Child abuse and neglect, including child sexual abuse;
l) Substance abuse;
m) Provisions of service to parents and children with mental health and developmental issues or other physical or emotional impairment;
n) Parent introduction/re-introduction;
o) Parenting skills;
p) Assertiveness training and conflict resolution;
q) How and when to intervene during visits or exchanges to maintain the safety of all participants;
r) Observation of parent/child interactions;
s) Preparation of factual observation notes and reports; and
t) Relevant laws regarding child custody and visitation and child protection.

(*list is not final; just a draft*)

Those on the webinar offered consensus that trainings can be done remote/virtually as needed. However, participants also offered that direct observation is an **essential part** of experience; therefore, before offering TSV, the provider must have direct observation experience (NOT WEB or film, or facetime).

Those on the webinar offered that INTAKE could be done by video/electronic means.

- Present Consensus that providers can offer BOTH services of supervised visitation (including supportive, educational, and facilitative visitation) and therapeutic supervised visitation on their menu of services. Families only receive these services separately (not concurrently/at the same time). However, a family could receive supervised visitation in one session, and TSV in a separate session with the same family members.
- Present Consensus on the following: TSV can only be conducted by court order. *However, future participants may add thoughts to this issue.*
- Present consensus is that TSV must include a therapeutic GOAL; that parents must have those goals shared with them, and that progress notes are available to parents.
- Confidentiality: Present consensus that there is no confidentiality kept by the TSV provider. Next session must expand on this.

Meeting February 15, 2024, 4:00 PM

Web Meeting Notes: Therapeutic Supervised Visitation

- Follow up on confidentiality issues
- Follow up on what the therapeutic goals may include
- What about recommendations to the Court?

Florida: Evaluative. Evaluative reports provide an assessment which offers professional opinions and recommendations as to the observed contact between the parent and child. Such reports should be completed by a licensed mental health professional or otherwise qualified professional. *Without prior approval from the chief judge, or from the court, a program should not offer a report that provides recommendations or expresses opinions, specifically an opinion about the appropriate future course of access between a parent and child who have been supervised by a program.*

Begin discussion on what kinds of professionals and interns may provide TSV.

1. **Confidentiality Considerations**:
   - Maintaining confidentiality is a cornerstone of therapeutic relationships, and this principle holds significant importance within traditional therapeutic settings.
     - However, within TSV, it's crucial to recognize that a broader audience, including courts, officers, and lawyers, will have access to these notes.
     - This necessitates a delicate approach to handling and wording the notes to ensure sensitivity to all involved parties.
   - Emphasize the need for delicacy in note-taking, focus on larger issues instead
     - For instance, rather than directly quoting an upset parent, the focus should shift to addressing broader parenting challenges that may have surfaced during the session, with a commitment to addressing these concerns within TSV.
   - It's imperative to transparently communicate the lack of confidentiality to parents from the outset, ensuring that program policies explicitly state this.
     - This includes obtaining parental acknowledgment of this lack of confidentiality through signed program policies.
   - Clear differentiation between the confidentiality expectations in individual therapy versus TSV sessions is essential.
   - Regarding child disclosures of abuse or fear, while confidentiality to the parent may not be maintained, the issue will be addressed sensitively while ensuring mandatory reporting obligations are met.
     - E.g., if a child wants to report or talk about abuse/fear, I won't tell the parent, but will talk about the issue with the parent.

    - The child's comments will be part of the record and may lead to mandatory reporting.
- Intake records should explicitly state the therapist's obligation as a mandatory reporter of child abuse.

2. **Therapeutic Goals**:
    - Central to the effectiveness of TSV is the establishment of clear therapeutic goals.
        - These goals should reflect collaborative efforts between visiting parents and, where appropriate, the child.
        - An example goal could focus on fostering positive communication and accountability in parental behavior, such as punctuality and active participation.
    - Drawing from attachment-based and trauma-aware approaches like TBRI, goals should encompass empowering the child, enhancing familial connections, and facilitating parental growth in discipline strategies.
        - E.g. of a measurable goal: the mother will use mindful words (not threats) out of two out of three times.
    - Safety measures are in place.
    - Therapists themselves should be held accountable through clearly defined goals.
    - What do Reports look like?
        - Reports should provide a comprehensive overview of visitation progress, including detailed checklists of interactions and summary reports.
        - These reports should include observations on parental engagement, child disposition, and any notable interactions or activities during the visit.
        - Some reports may look like checklists with sections to take additional written notes.
        - For instance (optional), a report to the Case Manager should be submitted within 48 hours following a visit. This report encompasses various aspects including interactions, modeling, suggestions, boundaries set, facilitated communication, assessment of the child's disposition, and a dedicated comments section. It may also detail activities engaged in during the visit, providing a checklist for reference. Additionally, it should note indicators of child discomfort, such as a flat affect, and evaluate whether the parent effectively established appropriate limits, nurtured the child, and offered support throughout the visit.
        - Parents should be informed about the components of these reports during the intake process.

3. **Recommendations to the Court**:
    - When addressing the court, our role is to present evidence and details rather than make recommendations.

- In family court proceedings, we focus on providing accurate and direct observations rather than definitive statements regarding visitation rights.
- What is our purpose with TSV in courts, and how do we guide that?
- Reports submitted to the court may include suggestions for therapy to address mental health or substance abuse concerns, along with evaluations or parenting courses.
- Recommendations should offer a comprehensive view of the family's situation, taking into account factors such as routine and available community resources (financial, housing, medical, food, clothes, SSI forms, educational resources, transportation etc.).
- While refraining from direct safety recommendations, suggestions regarding visitation duration and timing can be offered based on observed routines and family dynamics.
- It's important to provide comprehensive information about medical history and evaluations for both parents and children to relevant providers.

Contact the Clearinghouse at

850-644-1715