The Dynamics and Impact of Domestic Violence, Substance Abuse, or Mental Health Disorders When There is a Co-occurrence of Child Abuse

Learner Course Guide

DOH Mandatory Training FY 2013-2014

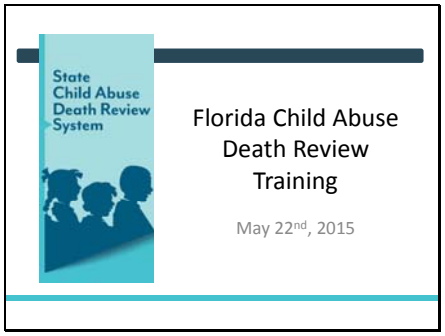
To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.

This page left blank intentionally

Table of Contents

This page left blank intentionally

Slide 1



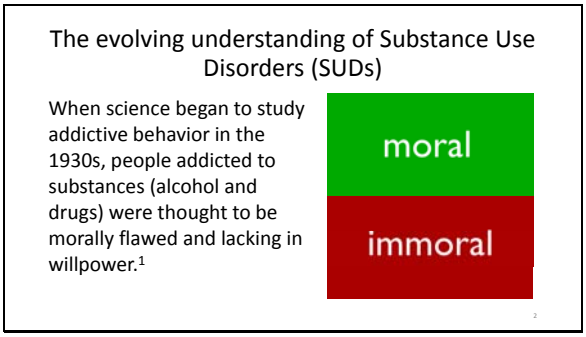
Greetings, my name is Dr. Robin Perry. I am the current chair of the Statewide Child Abuse Death Review Committee. On behalf of all of the members of the Statewide Child Abuse Death Review Committee, I want to welcome all local Child Abuse Death Review Committee members to this webinar training, and thank you for your service and commitment to Florida's children and families. You have been asked to serve on the local committee given your expertise and experience in your field of practice, as such relates to child maltreatment and child fatalities, as well as your knowledge of systems of response and service systems within your local communities. The local committee reviews of child fatalities are meant to be comprehensive and are an indispensable and invaluable element in Florida's effort to eliminate preventable child deaths. Your willingness to serve on a local committee and your contribution to these efforts is greatly appreciated. As you may be aware, Child Abuse Death Review Committees, statewide and local, are multidisciplinary. This is in keeping with the public health approach that looks to promote community and evidence based approaches in all aspects of addressing child maltreatment and fatalities, and encourages continued efforts to connect and collaborate among all national, state, county, and local partners to ensure that there are multilevel and cross-agency policies and coordinated efforts at child maltreatment and fatality prevention. It is important to ensure that local

death review committee members have a developed awareness and knowledge of a variety of factors across disciplines and fields of studies, as such relates to child abuse and possible contributing factors to child fatalities. Toward this end, the state legislature has mandated that training and assistance be provided to all local Child Abuse Death Review Committee members on the dynamics and impact of domestic violence, substance abuse, and mental health disorders when there is a co-occurrence of child abuse. We are pleased to have developed a collaborative partnership with three organizations, whose representatives will be making presentations in this webinar. These organizations and their representatives include: Ms. Ghia Kelly, from the Florida Coalition Against Domestic Violence; Ms. Melissa Witmeier, from the Florida Council for Community Mental Health; and Ms. Pam Peterson Baston from the Florida Child Abuse Death Review Committee. This webinar is meant to serve as an introductory training to these issues. Additional references and links to other resources and training opportunities provided by each of these organizations presenting today will be posted on the CADR website in the near future. Local committee members should familiarize themselves with these resources and with the websites of the representative organizations presenting today.

Slide 2

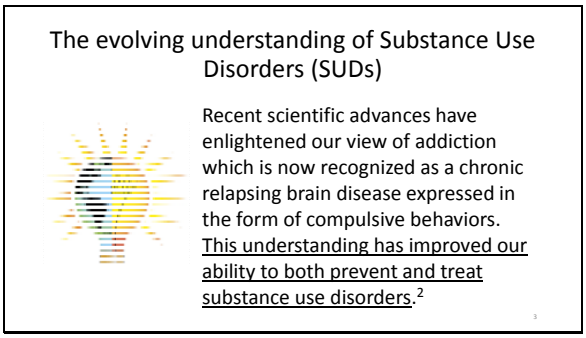
We begin with Ms. Pamela Peterson Baston from the Florida Alcohol and Drug Abuse Association. Ms. Baston began working 35 years ago in a comprehensive drug treatment program in Tampa, Florida, where she worked with youths, adults, and families in all modalities of prevention and treatment, including methadone treatment. After 8 years, she was appointed under two different Florida governors to manage Florida's publicly funded drug prevention and treatment system. In 1995, she moved to Key West, Florida and ran Safeport, the largest family-centered treatment program in the country, that worked with the entire family on issues dealing with concurrent substance abuse and mental health disorders and the child welfare system. Ms. Baston is also a part-time consultant for the National Center on Substance Abuse and Child Welfare. She has worked since 2006 as a reviewer for the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices, where she has reviewed and rated the quality and availability of training and implementation materials for over 85 evidence-based programs. Through a contract with the Florida Department of Children and Families and the Florida Alcohol and Drug Abuse Association, Ms. Baston has developed a series of webinars to train behavioral health professionals and other key stakeholders who interface with the child welfare system to recognize and assess behavioral health disorders as they relate to families in the system. We are honored to have and are very appreciative of Ms. Pamela Baston presenting today.

Slide 3



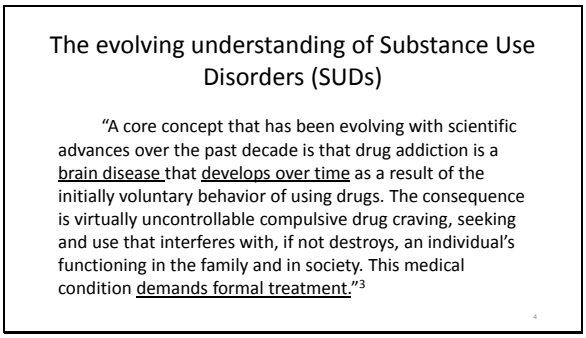
Thank you. We have about 30 minutes to cover a very important topic, and a topic that is very complex, so we will do the best we can to get through this and I have provided a number of helpful resources at the end of the presentation, which I would encourage you to pursue after the training. When science first began to study addictive behavior in the 1930s, people addicted to substances, and when I use the phrase substances I am referring to both alcohol and other drugs, were thought to be morally flawed and lacking in willpower.

Slide 4



Recent scientific advances, however, have enlightened our view of addiction which is now recognized as a chronic relapsing brain disease expressed in the form of compulsive behaviors. This understanding has improved our ability to both prevent and treat substance use disorders.

Slide 5

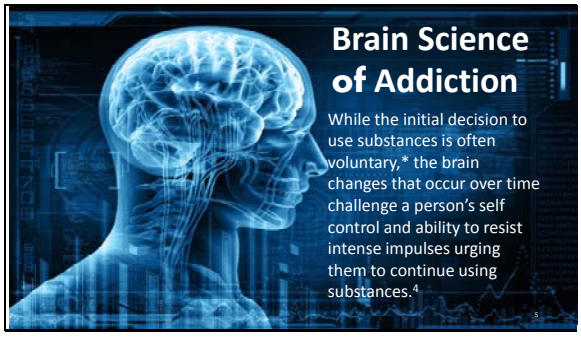


This is my favorite definition of addiction, you will probably see many of them over time, and I have underlined what I believe to be the key elements of this definition: "A core concept that has been evolving with scientific advances over the past decade is that drug addiction is a brain disease that develops over time as a result of the initially voluntary behavior of using drugs. The consequence is virtually uncontrollable compulsive drug craving, seeking and use that interferes with, if not destroys, an individual's functioning in the family and in society. This medical condition demands formal treatment." I want to stop here a minute and talk about some of the features

of this definition. One is that we now do recognize substance use disorders as a brain disease - and I'll cover this a bit more in a minute - that it develops over time, most of the cases that come into the child welfare system involve families that have parents that have used drugs sometimes for a decade or more, and this is not the only problem they have. Yet, I am always surprised when we see a recommendation for treatment that might be a very brief short-term treatment episode, or they will say let's put this person in drug testing and just keep an eye on them, that will help. At that point you need to recognize that these are very complex problems developed over many years and they are not going to get better quickly without the proper amount of treatment and support, and we will cover this a bit more in a few minutes. Treatment is required, formal treatment, this is the kind of problem that does not get better with a drug education class or urinalysis monitoring and that kind of a thing. Also, I do want to mention that in this definition where it is mentioned that the drug use is initially voluntary, in the 35 years that I have done this work, it is not uncommon for me to come across adults who, as children, were forced to use drugs by their parents. The parents would give them the drugs to keep them quiet when they were little, or gave them drugs when they were very young teenagers as a way to party with them, and there are also many instances with young girls in particular where they are sexually abused and given drugs by the perpetrator to make them more compliant with the abuse. I say this so that even though sometimes it is very easy to be

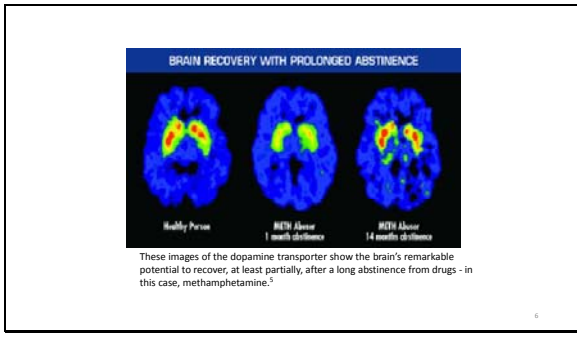
upset with drug users or angry, how can they do this and that to their child, how can they value the drugs over their own children, these situations are usually far more complex than that and it does not always start with voluntary use.

Slide 6



Brain science of addiction: While the initial decision to use substances is often voluntary, the brain changes that occur over time challenge a person's self-control and ability to resist intense impulses urging them to continue using substances. In addition to this not always being voluntary, even when it is voluntary the brain changes that happen with the person's use can become so complicated and compulsive that they are unable to stop their use even when they want to, even when their children are being held in the balance in the case of out of home placement of their children in child welfare.

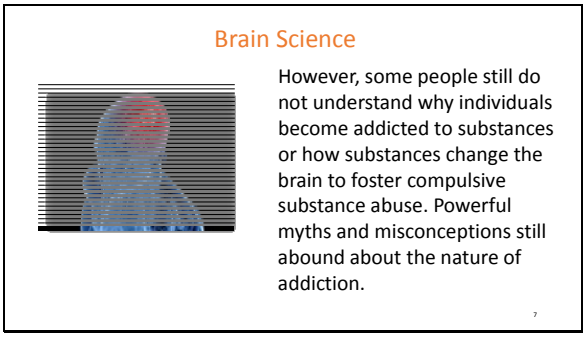
Slide 7



Here is an example of a PET scan, I am not a medical professional but I just want to point a couple of things out here on these brain scans. The brain on the left is the brain of a healthy person, and you will see the orange-red coloration there, and that is a healthy brain. Then you will see the one in the middle is of a methamphetamine user about one month into abstinence and you can see how different their brain looks and they have had a lot of dopamine depleted, and dopamine would be the reddish-orange color. They don't have the ability to have pleasure unless they are using drugs. Often

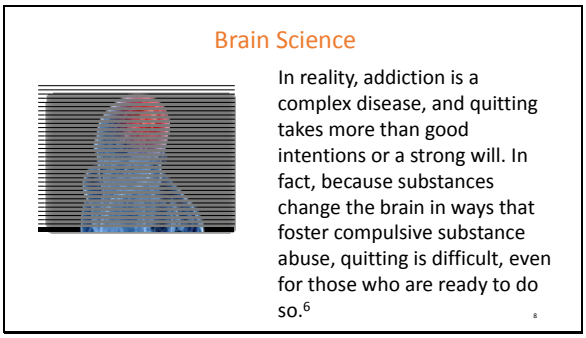
a person like that may seem very detached from their child, may not seem to bond with their child, they have no affect, and that is often because the dopamine has been depleted from their brain from the drug use and it takes time for that to come back. You will see in the very last brain image on the right, the example of what their brain can look like at about 14 months after they have not used in this case methamphetamine. The brain imaging will be different for each drug used; this is just an example of methamphetamine.

Slide 8



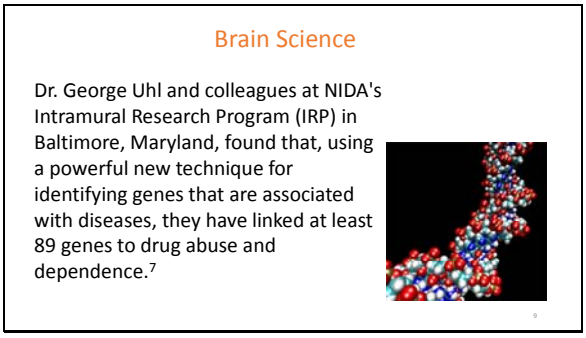
Even with this brain science, some people do not understand why individuals become addicted to substances or how substances change the brain to foster compulsive substance abuse. Powerful myths and misconceptions still abound about the nature of addiction.

Slide 9



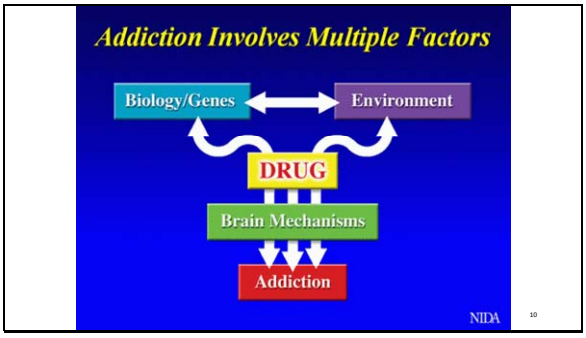
In reality, addiction is a complex disease, and quitting takes more than good intentions or a strong will. In fact, because substances change the brain in ways that foster compulsive substance abuse, quitting is difficult, even for those who are ready to do so.

Slide 10



Dr. George Uhl and colleagues at NIDA's Intramural Research Program in Baltimore, Maryland, found that using a powerful new technique for identifying genes that are associated with diseases, have linked at least 89 genes to drug abuse and dependence. The important point here is that this is not even just about involving the brain and the compulsions that go with drug use, but that genes play a very powerful role in determining a person's likelihood of starting down the path of substance use or continuing. If they are from a family that had substance use in the past, or alcoholism and such, they may be more predisposed to that.

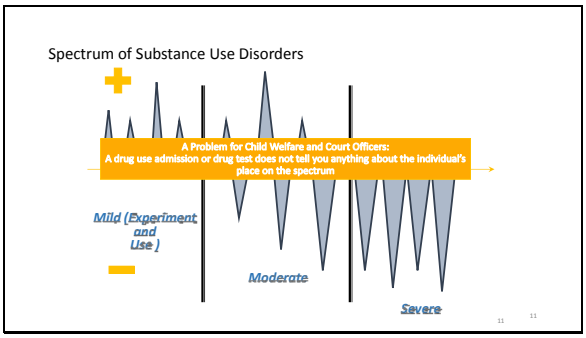
Slide 11



If you were to have two people sitting side by side that were alike in every way, age and body mass and every other way, and one came from a family that had a history of alcoholism or drug use and the other did not, and they both consumed substances at the same time and the same amount, the one that came from the family with the predisposition with all of the alcoholism or drug use, has a much greater chance that when they use that substance, different bells and whistles, to put it simply, will go off in them that will not happen with the other person. The other person might be able to pick it up, put it down, and not think even about it again, where when the person with the family history uses they get very reinforced by that use. Their body physically handles that drug differently, they have

more of a need and a compulsion to use that drug, so these are very complicated situations and this graphic depicts that. It shows that addiction to substances involves both the biology and the genes of the person, the environment in which they live, so even if the person doesn't have a family history but they live in a drug-infested environment where drugs are readily available in their neighborhood, they have to pass multiple drug deals every day to go to school, go to work, or just live. If they live in a family environment that is characterized by chaos and a lack of structure, and maybe even with behaviors in the home that are inappropriate happening, that also increases the likelihood of their involvement with substances. Then you have the drug itself. Not all drugs are created equal. Some drugs like cocaine and methamphetamine and heroin are much more compelling and have much more association with compulsive behavior and the need to continue using again and again than does for example, marijuana. Every drug is different and that drug interacts with the biology of the person and the environment, then you have the brain effects, what happens to that particular person with that particular drug, and all of these things work together to affect the substance use disorder or addiction.

Slide 12



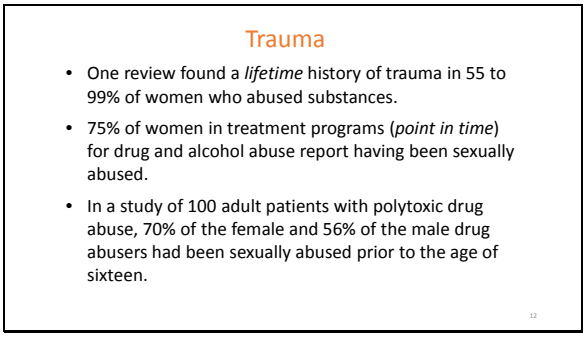
This is a graphic, we have some fly-ins here, I have to see if I can get this for you. What happens is if you look at the far left of the spectrum and you see that you have got these little arrows, trouble spots so to speak, of use, going in the upward positive direction, meaning that at this point someone's drug use is occurring but it is not causing dysfunction in their life. So you think about somebody who might be starting down a path of drug abuse, maybe they start with alcohol or marijuana, and they are able to manage their use. They are still able to go to school or to work or to parent, they might be using recreationally or periodically, and even if they are someone with a family history, for the first few times they might not develop any problems. As they move down to the right on this spectrum, you will see that problems will begin to develop. They might have some good days and some bad days, and you will see these little arrows or spots below the threshold of functionality so they are beginning to have some problems, but they also have some good days. They are struggling but they may be managing, and eventually as they move further into use, they develop the degree of dysfunction that they develop a full substance use disorder that will require treatment. This is a very simplistic graphic, and what needs to be said here is that, let's take alcohol for an example, we all may know an individual in our lives who may have had a problem with alcohol for 30 or 40 years and still managed to get up every day and go to work, put a roof over the head of their family, and so it might take years and years before the problem catches up with them and they end up at the end of the spectrum. You can look

at the same spectrum and throw in methamphetamine or heroin or prescription painkillers and they could move through this continuum, this spectrum of drug use problems, in a matter of weeks instead of years. So again, how someone moves through this spectrum will pertain to the drug they used, their family history, their environment, and the way their brain is interacting with the substances. These are very complex matters. With this idea of how these problems develop, what often happens in child welfare systems and in the court is that we drug test and we say the drug test is going to tell us what we need to know. Really when you look at this graphic it becomes clear that a drug test tells you almost nothing. A drug test will tell you two things and two things only. It will tell you whether drugs are present in that urine or blood sample, or saliva, at detectable levels, at enough nanograms or whatever the method is to detect whether drugs are present. It will also tell you which drugs are present, and it only tells you that at that point in time. It does not tell you anything about that parent's ability to function, to safely parent, because you don't know where they are on this spectrum, so while drug testing is an important tool in managing families that are in the child welfare system, it is not an answer to knowing whether or not they have a substance use disorder or whether they used something one time before the test, so we encourage people to look at this as just one piece of the picture. Here we will see the mild experiment and use phase, the moderate experimentation and use phase, and the severe disorder phase where somebody is actually needing substance use treatment.

In terms of trauma, which goes hand and glove with substance use disorders, one research review found a lifetime history of trauma in 55 to 99% of women who abused substances. This means that it is more likely than not that a woman who is identified as having a substance abuse problem will also have current or past trauma going on in her life, which adds a serious complication to her treatment needs. In fact, 75% of women in treatment programs for drug and alcohol abuse report having been sexually abused. In a study of 100 adult patients with polytoxic drug abuse, meaning poly substance use or using more than one substance, 70% of the females and 56% of the male drug abusers had been sexually abused prior to the age of sixteen. So you can imagine the complications that then ensue when you are dealing with somebody who has this double jeopardy, this history of trauma and the drug use. In fact the drug use may very much have happened as a result of them trying to cope with the trauma that they are experiencing. Many women with whom I have worked when I ran the Safeport program, and as well as other kinds of programs in which I have worked or consulted, have told me that using substances was the only way they could get through the degradation, the humiliation, the physical pain of being physically or sexually abused by in many cases the people who were supposed to love them the most and care for them the most, being their own family members. We try so hard not to be judgmental of the women and men who come into our treatment programs because we know that nobody wakes up one day and says that today is a great day to develop a serious drug addiction and to lose my self-respect,

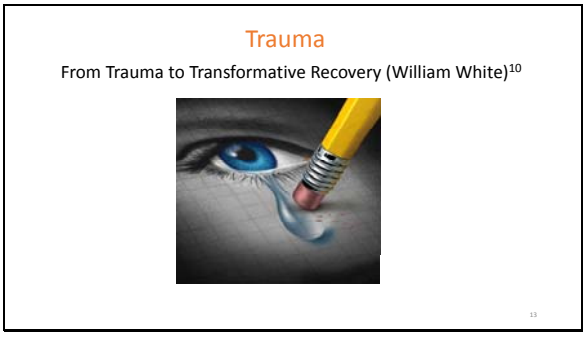
to put my life on the line and potentially lose my own children. These again are very complicated concepts and problems.

Slide 13



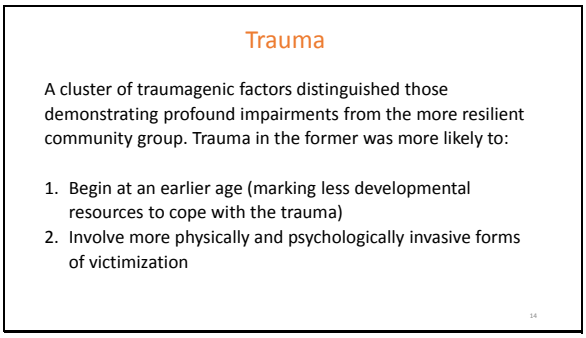
If you have never read any of the writings of William White, he has been in the substance abuse field for many, many decades and he has done a lot of work on the subject of substance abuse and trauma and what we need to do to make recovery happen with families.

Slide 14



In the research that he has done, he identified a cluster of traumagenic factors that distinguish those families and those adults that have profound impairments from those that are more resilient and able to move on. The symptoms and the characteristics of those individuals who have substance use and serious trauma, profound impairments, look like this. Usually the trauma has begun at an earlier age, and that is marking less developmental resources to cope with the trauma, so they are overwhelmed at an early age and they don't have a way to cope with what is happening to them. Also, they involve more physically and psychologically invasive forms of victimization.

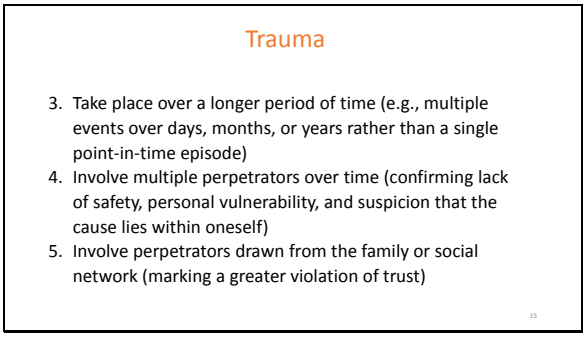
Slide 15



The trauma takes place over a longer period time, multiple events over days, months, or years rather than a single point-in-time episode. It involves multiple perpetrators over time, which really confirms their lack of safety, personal vulnerability, and even a suspicion that the cause must lie within themselves. It is not enough that my father

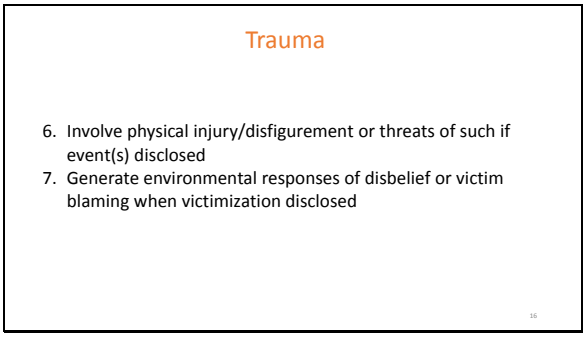
did this to me, and my uncle, and now I go to a party and I am attacked by all of the boys from school in the back room, and they begin to think it is something they are doing or that they deserve or that they caused. Then also the more serious trauma and substance use connections involve perpetrators drawn from the family or social network, which involves a greater violation of trust.

Slide 16



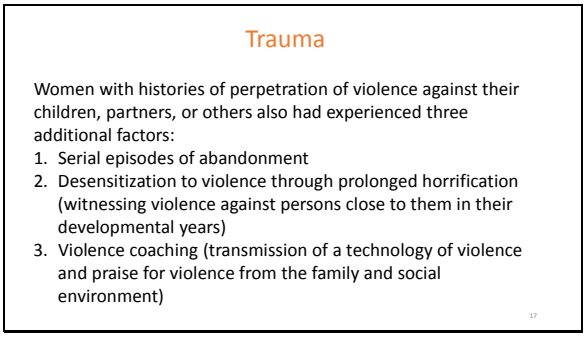
Also the more severe cases involved physical injury, disfigurement, or threats of such if the event of physical or sexual abuse was disclosed. Last, it generates environmental responses of disbelief or victim blaming, so when the victim goes to get help with their problems, he or she is either not believed or they are blamed. So if any of these 7 factors are prevalent along with the substance use, then that marks somebody who is going to have a much more difficult time getting through the trauma and the substance use. This is not somebody you would place into a brief outpatient program. They have serious problems that will need serious treatment and heavier dosage of that treatment.

Slide 17



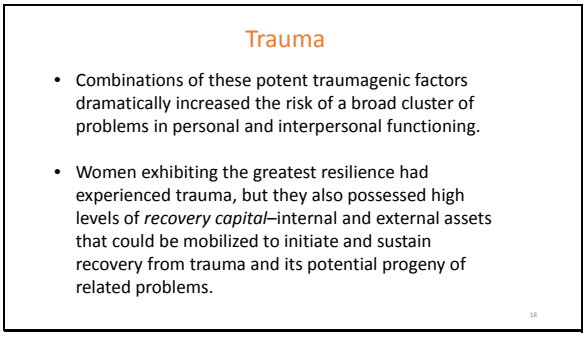
Women with histories of perpetration of violence against their children, partners, or others also had experienced three additional factors: multiple episodes of abandonment; a desensitization to violence through prolonged the horrification, witnessing violence against persons close to them in their developmental years; and violence coaching, meaning that there is reinforcement for the violence in their family and social environment.

Slide 18



Combinations of all of these factors with the substance abuse create a cluster of personal problems and interpersonal functioning difficulties. The women that exhibit the greatest resilience in the research were found that even if they had experienced trauma, they also possessed high levels of recovery capital. They had both internal and external assets and support that could be mobilized to help them through this very difficult journey of recovery from their problems of trauma and their substance use and all of the related problems that go with it.

Slide 19



The combination of multiple traumagenic factors and low recovery capital produced distorted thinking about oneself and the world, emotional distress and volatility, migration from self-medication to addiction, developmental trauma contributing to toxic adult intimate relationships, addiction to crisis, impaired parenting, and chronic self-defeating styles of interacting with professional helper

Slide 20

This is instructive for us as we think about the more serious cases of child welfare and substance use and we are looking back to what we did or did not do with these families, and one of the factors that I would like you to consider is: what were the parental trauma experiences like in the past, and what kind of support did they get to deal with that, and was the dosage and duration of the treatment that they got lining up with the degree of severity of what they were trying to overcome? My experience in 35 years is that even professionals who work in this field with

these families can get very angry at the parents, and it is part of human nature to feel that way when you are seeing the consequences of the children. This is a picture that kind of demonstrates that, you can see on that little girl's face, you can see her trauma right there and you can have incredible compassion for her and for her little sibling that she is holding.

Slide 21

Until … the children grow up to become parents trapped in the same cycle of substance use and child maltreatment that they endured.

20

This happens until they grow up to become the very parents that you now have in front of you in a child welfare situation, trapped in the same cycle of substance use and child maltreatment that they endured.

Slide 22

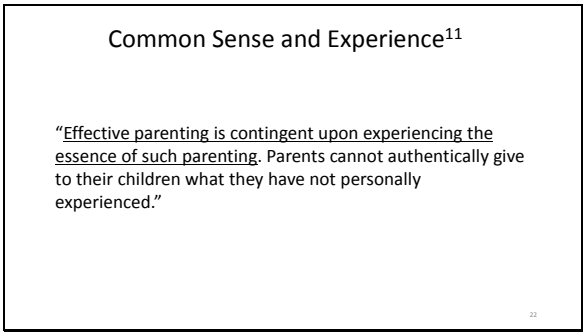
Domains	Mother	11 yr old daughter
Parenting	Born to a teen mom	Born to a teen mom
Transitions	Moved frequently	Moved frequently
Education	10th grade drop out	Kept back in 1st grade
Health	Poor health/possible STDs/possible dental	Poor health, dental
Behavioral Health	SUD-Crack, Alcohol, Marijuana; Trauma/PTSD	Emotional, social, cognitive, Trauma/PTSD, behavior problems
Child Welfare Status	Abused/Neglected Mom in and out of shelters/FC	Abused/Neglected In CW system for 1st time at age 6

21

One of the things I like to do as part of training is to go back and do a retrospective comparison of looking back at in this case, a child just like that, you can look to the right, she was in the far right column. At 11 years old, born to a teen mom, she moved frequently, she was kept back in the first grade, she has poor health, poor dental health, she has cognitive social problems, emotional problems, trauma, post-traumatic stress disorder, behavioral problems, and she is a victim of abuse and neglect and in the child welfare system for the first time when she was 6 years of age. If we look at what her mother's experience was, what was her trajectory through life,

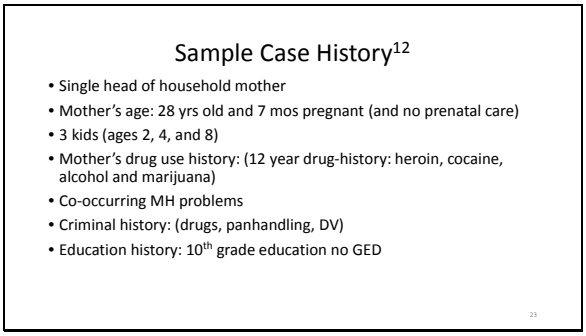
you see that mom was born to a teen mom, and she moved frequently, and she was a tenth grade drop-out, and she has poor health and STDs, and her behavioral problems involve crack, alcohol, marijuana, and of course while her 11 year old has not gotten onto that path yet, you know that is a pathway that is very likely given what else lines up here in this comparison, and that mom herself was abused, neglected, and in and out of shelters and foster care. So we see that unless we understand how complex these situations are and how generational these issues are, we are not really going to address the root problems and succeed.

Slide 23



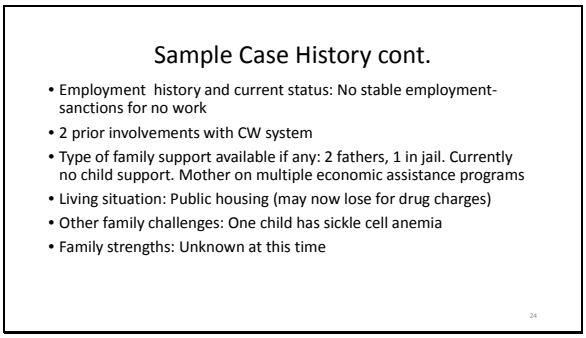
This is one of my favorite quotes, and this is also from Bill White, and he says "Effective parenting is contingent upon experiencing the essence of such parenting. Parents cannot authentically give to their children what they have not personally experienced." This is very profound but also very common sense in nature. How can we expect a child who grew up in what I just described, in terms of the trauma in the background, all the frequent moves, the lack of role modeling, and all of that chaos and expect them to suddenly take a parenting class and emerge as an effective parent. Yes, we want to provide the parenting classes, but we have to provide so much more in the way of modeling and nurturing and support if we expect success.

Slide 24



This slide is another one of my favorites, this is an actual sample that came from New Jersey, but I guarantee you could pull this case out of any state in America and find the same kind of scenario. I was trying to convince the state of New Jersey with whom I was working that they were not providing treatment at a significant dosage or duration to address the serious problems, so we pulled a sample case and we found out that a typical case in New Jersey was a single head of household mother, 28 years old, this woman happened to be 7 months pregnant, no prenatal care, had 3 kids ages 2, 4, and 8. I always stop there and say any of you that are parents, can you imagine what it is like to be a single mom, 7 months pregnant and have a 2, a 4, and an 8 year old underfoot? You can just imagine the chaos in a healthy family, and you add to this a 12 year drug history, all kinds of serious drugs, co-occurring mental health, criminal history, a tenth grade education, no GED, limited employment.

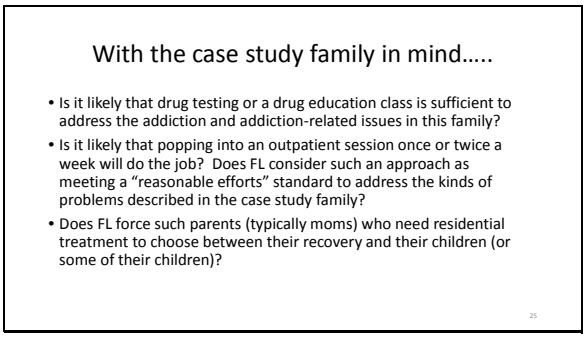
Slide 25



No stable employment history, prior child welfare involvement, multiple fathers, some in jail, offering no child support, mom is on multiple economic assistance, she lives in public housing which she may now lose because of her drug charges, and she has all kinds of other family problems including in this case a child with sickle cell anemia. They could not even find strengths to identify. If we take someone like this, and then we say we have caught you with this drug problem through a child welfare report, and we may take your kids – or maybe we already have – and we are going

to have you pop into outpatient treatment for an hour or two a week and we expect you to get well and get your kids back. One of the recommendations that I always make is to make sure we have a good handle on how in-depth the problems are and what it is that we are trying to do and if that is reasonable.

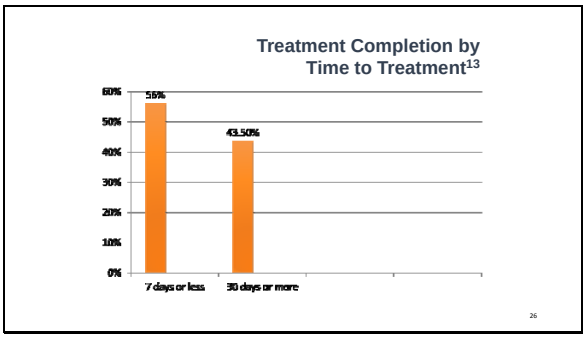
Slide 26



In fact there is a term called reasonable effort that judges wrestle with all the time if they are determining whether or not to terminate parental rights, they have to determine whether reasonable efforts were made to get that parent to be in a healthy parenting situation and to be effective with their children and to be safe. While that is a judicial term, reasonable effort, I think every one of us should be challenged with that same threshold. Is it reasonable to expect to send a parent to a drug education class, or a drug test only, or a brief outpatient session, that this is going to address the depth of the problems that I showed on the prior slide, which represent a very typical kind of family scenario? One of the questions that we ask is if you have a program, like the one I used to run in Key West, that allows mom to bring her children with her to treatment in the case of residential treatment, which is a likely level of care. That, or intensive outpatient, for moms or dads with the kind of history that we just talked about. Are they even able to bring their children with them, especially if it is residential? Or, do our programs further

traumatize moms by saying they can bring their baby but not their toddler, or they can bring their baby and their toddler, but the 10 year old has to go somewhere else because they are not designed to serve older children. This is my soapbox that I will quickly move off of to get this done in time, but basically my belief is that we should be designing programs after the families that we have, not forcing parents to fit into the mold that we have available in the community. We have a long way to go in Florida and in every state, and I say that even when I manage the state publicly funded treatment system. Under my watch, we built a lot of family focused programs, but many of those have diminished over time with funding cuts. These are yet the kind of programs that many of these families need, especially if we are going to treat the entire family and make sure we stop that progression into the next generation.

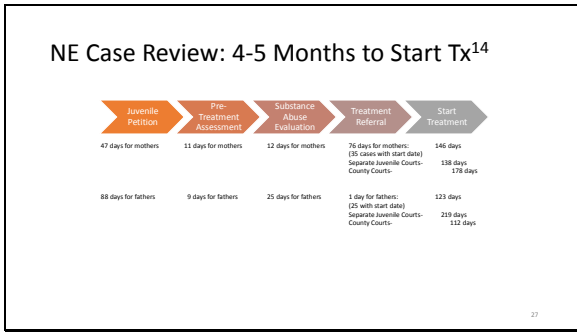
Slide 27



One of the other issues with publicly funded treatment and privately funded treatment is that it often takes us too long to get the person into treatment. I want to stop here and tell you, if you're not already aware, every research study is a little different, but anywhere between 50 to 75 to 80 percent of all families in the child welfare system have substance use as a factor. Again, we would be in a situation where we would be ruling it out, not ruling it in, or at least in my view that is how we should be looking at this issue. It is more often there than not. What happens though, is if you look at cases, even though we know every research study points to the fact that this is prevalent

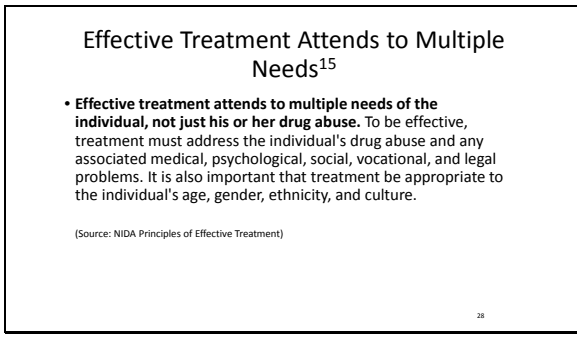
in the case, it may not be the most important factor, it may not be the only factor, but it is there operating in the background. It is working and sabotaging the other efforts that you are trying to make with that family if it is not addressed quickly and head-on. By quickly, I mean soon, not in a quick manner, but that it is identified in a timely fashion. Yet, even in cases when you look back, and you see whether substance use was identified, when it is, it is often identified halfway through the case, and if the children are in out-of-home care, that time clock is already burning up while we are fooling around trying to figure out if mom or dad has a problem. Even when we identify it, when we look at how long it takes them to get to care, you will be shocked to see that in some cases it is 100 days or six weeks, and it should be 72 hours, or something very quick. This is an urgent problem. This is one study that shows that if it takes 7 days or less, you have a 56% success rate with that person. If it takes 30 days or more, your success rate drops dramatically. This is only one study, so I don't want to hang a lot of emphasis on this, but we do know that not only does the time it takes to get to treatment effect whether you ever make it, because there are so many ways you can become distracted, but it also affects your outcome. It almost dooms you to fail if it takes too long to get there.

Slide 28



I would say that is not a reasonable effort. We should be doing everything that we can to make sure there is that recovery support, whether it is a peer recovery support worker that takes that person by the hand, helps them get into treatment, and then sets the stage for the best positive outcome. This is a case from Nebraska. This is a real-life study that they did a couple of years ago when the drug treatment system was assuring everybody that they were getting clients into treatment from the child welfare system within 2 weeks. Everybody kept saying it is 2 weeks, and we kept finding out from the clients that is was not 2 weeks, so we actually had a study done. The court improvement money funded the study and it found that it actually was taking 146 days to start treatment. That is almost half a year. I won't bore you with all of the details, but there is a study that backs this up if you ever wanted to see it. I always recommend that states take a look at what is really happening out there.

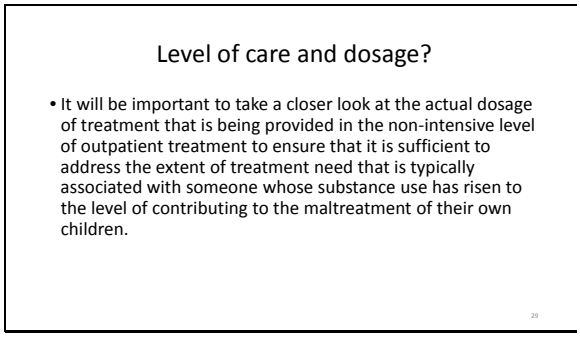
Slide 29



Real quickly, and I will wrap this up in just another five minutes or so, once you get to treatment, then we have to make sure that the treatment is effective, that it is attending to all of those multiple needs of the individual, not just the drug use. Drug use is not the only problem, and I have never in 35 years met a person with a drug problem where that was the only problem. These are very complex issues, and so to be

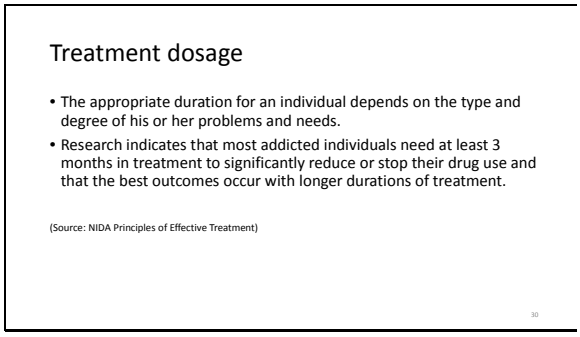
effective it should address the drug problem, and medical, psychological, social, vocational, and legal problems, and their trauma, and co-occurring mental health, and be gender-specific, be age-relevant, be appropriate to their ethnicity and culture. These are all factors, this is from NIDA, the National Institute on Drug Abuse, and is a principle of effective treatment.

Slide 30



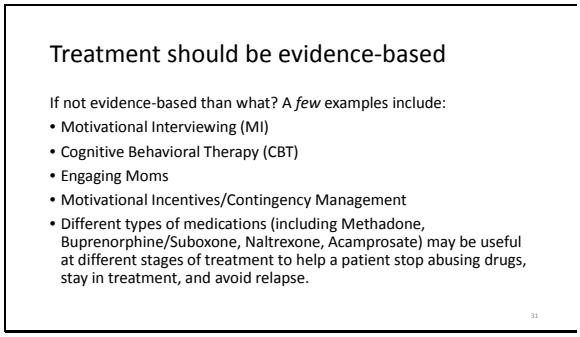
The treatment needs to be the right level of care. You don't put somebody that needs residential into drug education, or do a low-level outpatient. You have to look at, what is that actual level of care and dosage? Did they get enough duration and the right level of care? So that way, we are not trying to cure cancer with a bandage and set them up to fail and put them and their children at risk.

Slide 31



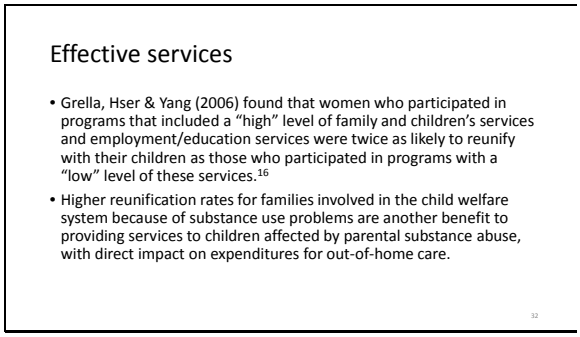
Again, the dosage should be a minimum of – the research is pretty clear that unless you have at least 90 days, you almost should not bother because it takes that long for the brain to the brain to even begin healing enough for the person to be able to absorb what it is that they are in treatment to learn. Hopefully treatment is longer than that, but often we have managed care agencies working against us, insurance companies working against us, and this is not a problem the drug treatment community can solve alone.

Slide 32



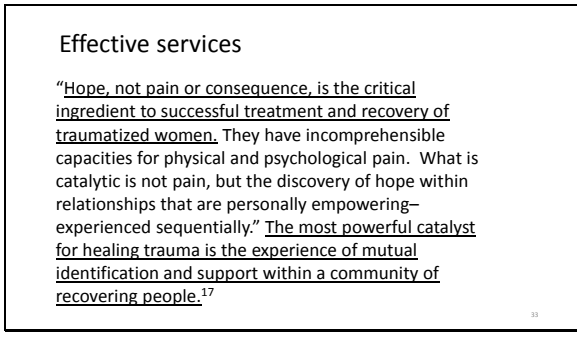
We all need to advocate for the proper level of care, and duration and dosage. It should be evidence-based, and I always say that if not evidence-based, than what is it? Why would we put anyone in a treatment program that hasn't been proven effective? These are just a few examples of evidence-based programs, motivational interviewing, cognitive behavioral therapy (CBT), engaging moms. There are motivational incentives that can be used, and if the person is using heroin or other opioids including prescription painkillers, then they may not only need treatment counseling and such, but they may need a medication such as methadone, buprenorphine, or naltrexone or others as an addition to the counseling that they are getting. I just want to say here that could also be a whole webinar on medication and treatment. I know people have heard different things about medication assisted treatment, and the bad things that they may have heard are probably coming from providers that might not be the best quality, or might be doctors who are out there running pain clinics, that might be feeding the problem. A well-run appropriate methadone clinic, or even a medical doctor that can give the buprenorphine medications or naltrexone, that is providing the right level of medication for the client and monitoring that client, you would not have the kinds of problems that you might have heard about.

Slide 33



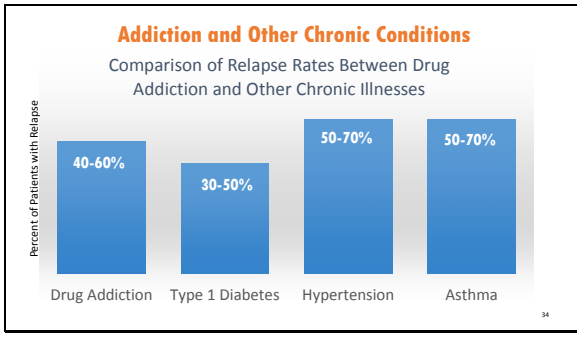
Just a few more points here that if there is a high level of family involvement then the outcomes are usually better, this has been determined through lots of research, and that higher reunification rates for families involved in the child welfare system happen when there is more of a family focus and those children who have been adversely affected by their parents' drug use are also able to benefit from their parents' treatment and from the services that they get.

Slide 34



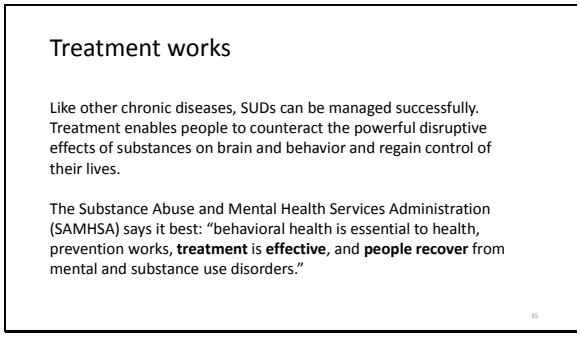
Instead of being punitive, "hope, not pain or consequence, is the critical ingredient to successful treatment and recovery of traumatized women. They have incomprehensible capacities for physical and psychological pain." But, "the most powerful catalyst for healing trauma is the experience of mutual identification and support within a community of recovering people."

Slide 35



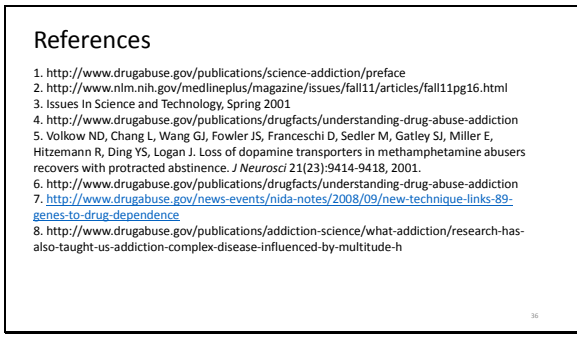
I can't emphasize enough the need to have that supportive community, it is not just enough to go to treatment. Relapse will happen, we know that it happens. We have to plan for it, just like every other health condition and here is a slide that shows diabetes, hypertension relapse rates at 30 to 70% and asthma at 50 to 70% and there is drug treatment relapse at 40 to 60%.

Slide 36



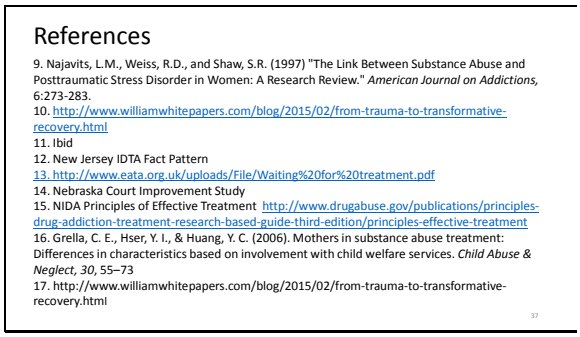
This is like any other medical condition. It is something that might take clients multiple times to get through, like any other medical problem, but treatment does work. Like other chronic diseases, substance use disorders can be managed successfully. Treatment enables people to counteract the powerful disruptive effects of substances on the brain and their behavior and get control of their lives again. The quote from the Substance Abuse and Mental Health Services Administration says it best that "behavioral health is essential to health, prevention works, treatment is effective, and people recover from mental and substance use disorders."

Slide 37

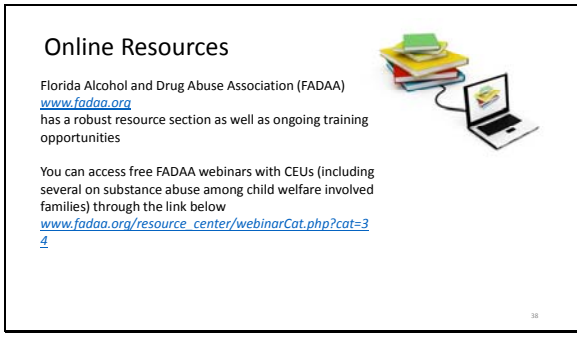


So we hope that you will give them that opportunity in any way you can through your various roles, and we will look at that as a critical condition of whether they have a true shot at addressing their substance use problem. These are references here if you wanted further information.

Slide 38

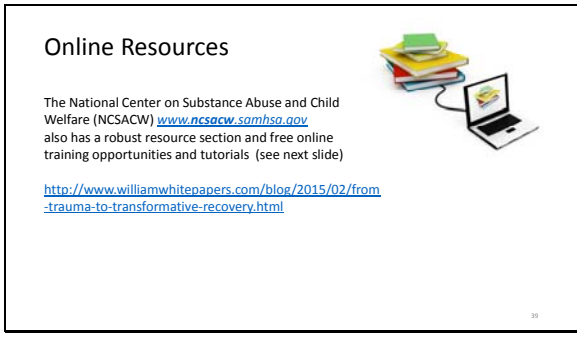


Slide 39



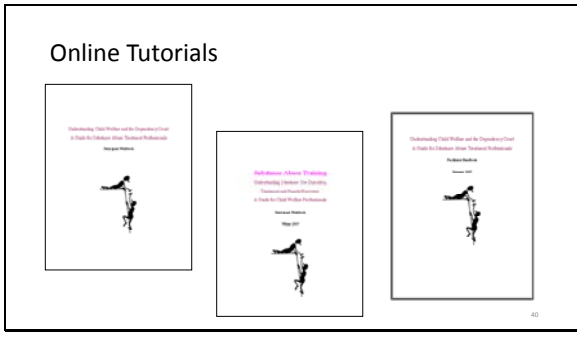
Here are some online resources, the Florida Alcohol and Drug Abuse Association here has some additional free webinars, many of them I have narrated, that can give you additional information on this subject.

Slide 40



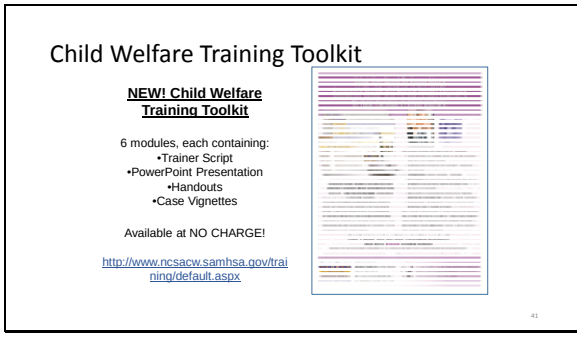
The National Center on Substance Abuse and Child Welfare has free training as well and all kinds of resources and tutorials and handouts. Then this William White paper is here, this last one has a lot of trauma background.

Slide 41



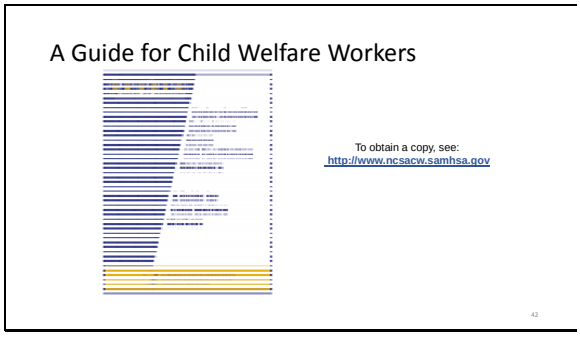
These are the online tutorials from the National Center that you can download.

Slide 42



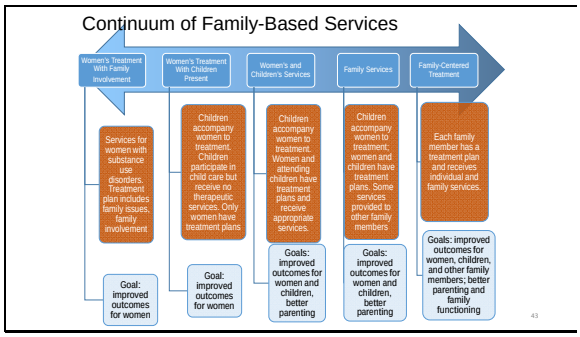
There is a child welfare toolkit.

Slide 43



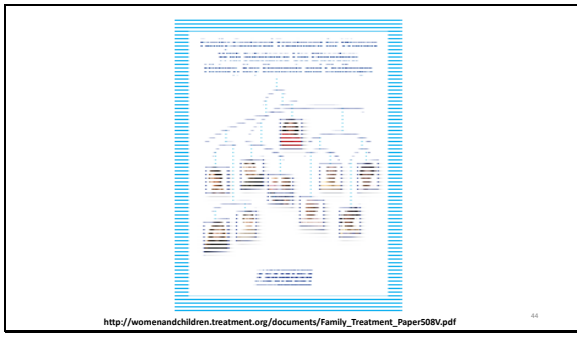
There are documents like this on how to understand substance use and facilitate recovery with child welfare staff.

Slide 44



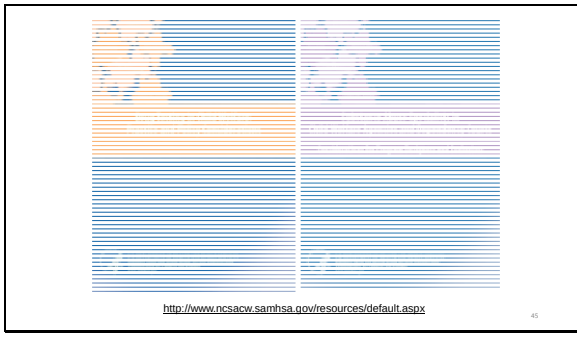
This is a continuum of family-based services that shows you what a true family treatment program looks like. On the far right, which is family-centered, and how it looks at various other stages of development.

Slide 45



Then this is an excellent document that will show you what true family treatment looks like.

Slide 46

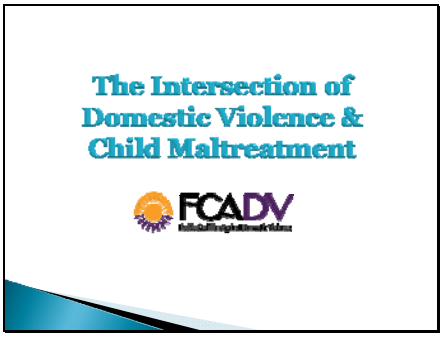


A couple other documents here.

Slide 47

So if you have any questions about this presentation, there is a phone number to call FADAA or my phone number listed as well. I appreciate your time and attention to this and hope that it was helpful to you. Thank you, Ms. Baston, for your presentation and your insights. We greatly appreciate your willingness to collaborate with us on this initiative. Thank you.

Slide 48

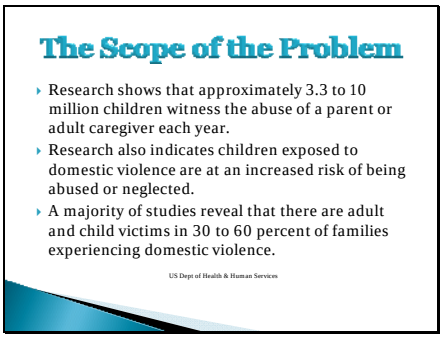


Our next presenter is Ms. Ghia Kelly. Ms. Kelly is the child welfare initiatives manager for the Florida Coalition Against Domestic Violence. She originally started with the Florida Coalition Against Domestic Violence as a domestic violence and child advocacy specialist. In her current role, Ms. Kelly is responsible for the planning and supervision of the Florida Coalition Against Domestic Violence's child welfare initiative and child protection investigation project. As an expert in the intersection of domestic violence and child welfare, she serves as a resource for the Florida Coalition Against Domestic Violence regional committees, appropriate caucuses, and oversees child advocacy related projects and events. She also establishes relationships at the state level with key individuals and agencies that address the complex issues related to the needs of battered women and their children, and serves on various statewide committees and leadership teams including the statewide Child Abuse Death Review Committee. Ms. Kelly provides training, technical assistance, and consultations to domestic violence center staff, collaborating with child welfare agencies, and other partnering agencies. Before coming to the Florida Coalition Against Domestic Violence, Ms. Kelly worked at Refuge House, Tallahassee's certified domestic violence and

rape crisis center, as a training and community education program director for 3 years, and for an additional 3 years served as a sexual violence counselor and a sexual assault nurse examiner's coordinator. During that time she also contracted with Florida Therapy Services as a master level therapist, where she provided in-home mental health services to adults and adolescents. She also has experience working with incarcerated women and those with substance abuse issues. We appreciate Ms. Kelly's willingness to participate in this initiative and welcome her today. Thank you for taking time today to join this webinar as we look directly at the intersection of domestic violence and child abuse. We only have a limited amount of time for this webinar, so I won't be able to be as exhaustive as I would like as we discuss this issue, but at the end of the presentation I will give further resources for you to look at and get more information. As Dr. Perry has already identified, I work for the Florida Coalition Against Domestic Violence, and for those who are not familiar with FCADV, we are the membership organization for the certified domestic violence centers in the state of Florida. Our role is to provide funding for those centers and also to make sure that the services that are provided for battered women and their children are up to standard. My role at the coalition is very unique in that I am

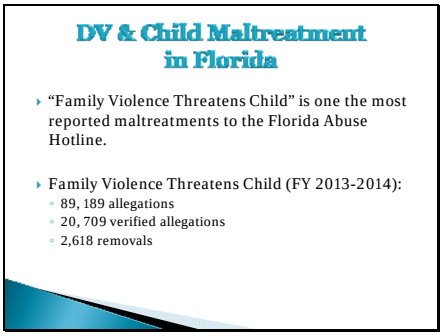
able to work very closely with the Department of Children and Families on the statewide level to look at services again that are implemented in the child welfare system, particularly for victims of domestic violence and their children. I can say very confidently that I have a lot of experience in the field and working directly with child welfare professionals in issues related to domestic violence and some of the challenges in those particular cases. Our agenda for today is really simple, we are going to look at the basic dynamics of domestic violence, we are going to define it from a working perspective, and we are also going to look at some of the best practices as it relates to working with families that are experiencing both domestic violence and child welfare issues.

Slide 49



Let's look at the scope of the problem. Research shows us that approximately 3.3 to 10 million children witness the abuse of a parent or adult caregiver each year in the United States. Research also indicates that children that are exposed to domestic violence are at an increased risk of being also abused or neglected. The majority of studies reveal that there are about 30 to 60 percent of families that are experiencing both the victimization of an adult in the home and also a child. That information is coming directly from the U.S. Department of Health and Human Services.

Slide 50



In our state, in Florida, "Family Violence Threatens Child" which is our domestic violence maltreatment, is one of the most reported maltreatments to the Florida Abuse Hotline. When we look at the statistics directly from the DCF Child Welfare database FSFN, in fiscal year 2013-2014, we were able to see that there were 89,189 abuse allegations directly related to the maltreatment of family violence threatens child. 20,000 of those were verified allegations of family violence threatens child. Also in that fiscal year there were 2,618 removals of children from families because of domestic violence

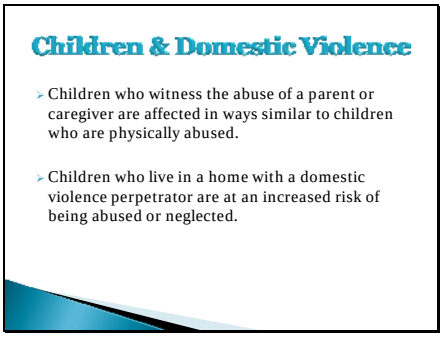
Slide 51

I want to move forward in making sure we are on the same page in defining what domestic violence is. Please note that the definition that I'm using is a working definition, which I think is very helpful for this presentation, but if you want the legal definition of domestic violence, which is slightly different, you can reference Florida Statute 741.28 for the legal definition, but again for the purposes of this webinar we are going to look at the working definition which comes from the Office on Violence Against Women. Domestic violence is defined as a "pattern of abusive behavior in any relationship that is used by one partner", specifically an intimate partner, "to gain or maintain power and control over another intimate partner." I want to pause for a minute and just look at

this definition. The key word that I want to point out is “pattern.” Typically in a domestic violence relationship, there will be a pattern of behavior. It may not always be physical violence, it may not always manifest in the same way, but the perpetrator has a pattern. The victim will be very aware of this pattern, and we will talk a little bit more about the expertise of the victim in these situations. The other words that I want to point out in this definition are “power” and “control.” Oftentimes when we think of domestic violence, we like to attribute it to things such as substance abuse, or stressors such as unemployment, or financial issues, or mental health diagnoses. When you look at domestic violence as a behavior, it is directly related to the person’s choice to be violent and also their need to be in power and to be in control. We want to make sure that we are not defining domestic violence solely on the basis of someone having a substance abuse issue, a mental health diagnosis, or their being other stressors in that family system. However, substance abuse, mental health, and stressors can exacerbate the violence, but it does not cause the violence. So I think it is very, very important to understand that when you talk about domestic violence, the root cause of the violence is going to be the power and control issue. We say that because when you look at the dynamics of domestic violence, if

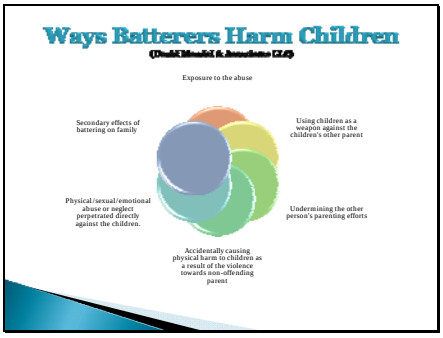
you were to take away the substance abuse or take away the stressor, the violence and the need to control would still maintain and be there. It is about power and control and not about some of the other issues that may exacerbate the violence or increase the perpetrator's violence.

Slide 52



When we look specifically at children and domestic violence, what we see in the research is that children who witness the abuse of a parent or caregiver are affected in ways similar to children who are physically abused, and that is really profound in that a child witnessing violence against a parent and not being a target of the perpetrator's violence is impacted in the same way as if that child was actually targeted by the perpetrator. Also children who live in a home where there is violence are also at an increased risk of being abused or neglected, and that goes back to the perpetrator's need to be in power and to be in control. Everyone in that family system, in that home, is going to succumb to that, is going to have to align with those needs of that perpetrator to be in power and to be in control. Children are often victimized in addition to the adult victim.

Slide 53



I want to discuss some of the ways that the batterers' behavior harms children. This comes from David Mandel and Associates, and for those who have never heard of David Mandel and Associates, they are the creators of the Safe and Together Model which is a practice model that has been embraced by the Department of Children and Families in our state as the practice model for domestic violence cases. If you would like more information, then you can visit David Mandel and Associates website, it is endingviolence.com, and they will have more information specific to the Safe and Together Model, but I have pulled this as a resource for our discussion today. As we look at the slide, we see that there are various ways that the batterer's choice to be violent will harm children, because we have to first identify that it is the perpetrator's violence that is causing harm to the children. I say that very intentionally because a lot of times what we discover in domestic violence and child welfare cases is that workers will look at the victim's choice to remain in the relationship, the victim's choice not to get an injunction, or the other things, as the source of concern when it is the perpetrator's choice, parenting choice, to be violent that is the real concern and that really is the pathway to harm as it relates to child welfare. The first thing that we see is that the exposure to the

perpetrator's abuse, first and foremost impacts children and harms children in various ways. The exposure alone causes harm. We also see that children are used as a weapon or pawn in the domestic violence relationship. The perpetrator will use the child as a means to control the victim who is also a parent in that home. We will also see children being used to spy on the parent who is the victim. We have seen cases where perpetrators will put cameras or microphones to record the whereabouts of a survivor, things like that. Children are often used in that game that the perpetrators are playing when it comes to domestic violence. Children are used to actually insult the victim, to partake in the physical violence. We often do trainings with a survivor, who is nationally known, by the name of Susan Still and she is most known for her story that was featured on the Oprah show and also on 20/20 with Diane Sawyer, and her perpetrator actually had the children videotape his violence toward their mother. That is just an example of how children are used in the power and control. The other thing that we see often is that perpetrators of domestic violence will often undermine the other person's parenting efforts, so in a case of domestic violence it is not uncommon for the parent who is a victim of the violence to not be able to parent in the way that she would like to because of the perpetrator's

need to control that situation. So the undermining, again, is very, very common in these cases. The accidental harm that is caused to children, we often see that kids get caught in the middle of the violence, particularly adolescent boys. They are more likely to try to intervene and get in the middle of the violence, and they can also be harmed accidentally by doing that. We also see that children that are in homes where there is a perpetrator of violence, they are more often the victims of sexual abuse and physical abuse, and/or neglect. That is another way that the violence of the perpetrator harms children. Lastly we see that there are also secondary effects on the child that come specifically from the battering behavior, so children will often exhibit behavioral or attitudinal, cognitive, they are impacted cognitively as it relates to the violence. You will see that children will be afraid, will be more aggressive in some cases. Children will not be able to focus in school, they may have bad dreams, have bed-wetting issues, and so all of these are related directly to the violence that they are experiencing in the home. Again, this is going to the effects of the violence, it is very different for each child. We will talk a little bit about the factors that play into those things. No child is impacted the same way, even in a home with multiple children, what we see is that children are impacted differently. You may have one child

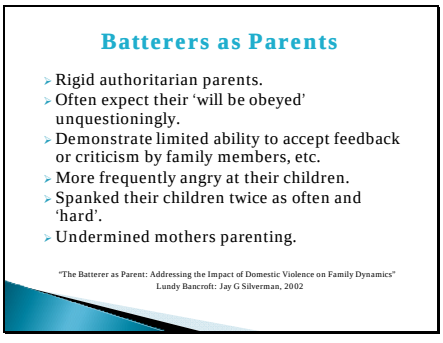
who is very aggressive and is now mimicking the behavior of the perpetrator, and there may be another child in that home who is withdrawn and depressed and kind of zones out and goes to another place in their mind, mentally, to be able to cope with the violence. So we want to make sure that we understand that the trauma and the effects of the trauma are very unique and very different for each child that is involved.

Slide 54

You want to also keep in mind, again like I just said, that children are impacted very differently and the child's level of resilience is going to be dependent on certain factors including their relationship with their non-abusive parent, it is going to also depend on the presence of, even if they don't have a parent who is present in their life other than the perpetrator, then also the presence of other supportive family members or friends, or teachers, just another supportive adult in their life is highly important. Their trauma history, how long has the violence been going on? How long have they been the targets of the abuse? All of these factors are going to play into and determine that child's level of resilience. I want to again reiterate that in domestic violence cases, it is a best practice from a research perspective that children remain, whenever possible, in the care of a non-abusive parent. So if you have a victim of domestic violence who is

not maltreating the child in any other way other than the perpetrator's violence, that is the only maltreatment in that home, then the best practice would be to keep that child safe with that non-offending parent whenever possible. We understand that removals are sometimes unavoidable, there is no way to leave a child in a home safely, and so we understand that is something that happens, but the goal in these cases is to keep the child with the non-abusive parent because research shows that that promotes stability, it promotes the nurturance, it strengthens the attachment to that non-abusive parent, and it is the single most important factor to that child's resilience. So we want to make sure that removals should be the most intrusive, and should be a last option in these cases if there is the presence of a non-abusive parent in that home.

Slide 55



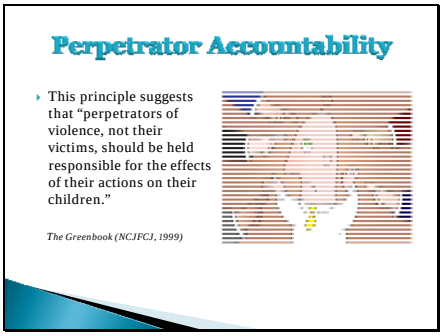
I want to look specifically at batterers as parents, and this is taken directly from a book entitled "The Batterer as Parent: Addressing the Impact of Domestic Violence on Family Dynamics" and the author is Lundy Bancroft who has done tons of work as it relates to child welfare and domestic violence. So what Lundy saw was that in his research and in his work with perpetrators of domestic violence, particularly male perpetrators, what he saw was that batterers were typically more rigid,

authoritarian parents and that goes back to the whole discussion that we had about power and control and their need to be in control and to be in power, not only of the adult victim, but of everyone in that home. What Lundy also saw was that batterers often would expect that everyone in the home, particularly the children, would obey them unquestionably, so there is no question when the parent said to do X, Y, and Z. Everyone in that family system was expected to obey without question. Lundy also saw that batterers demonstrated the limited ability to accept feedback or criticism by family members, so there was no discussion about the parenting. There was no opportunity to have a discussion with the perpetrator about things that needed to change in the home. This is true for the children as well as the adult victim. In my experience in working with battered women, we also see that battered women are often treated like children in the home and in some cases actually treated worse than the children. The children were actually treated with somewhat more respect than the adult victim. The adult victim was treated more so as a slave, they had no power, they had no voice. They were not able to tell the children anything, they were not able to lead or guide the children in any way. We see that a lot in the cases of domestic violence. Also, we see that the batterers were more likely to be

more angry at their children. We know that anger in itself does not cause the violence, but what Lundy realized in his research or saw as a theme was that batterers were often more angry or exhibited more anger in working with their children. They also spank their children twice as often and twice as hard so the corporal punishment was more likely to be seen in cases of domestic violence, and also the level of violence was intensified in these households as well. Again as we stated earlier, batterers are known, one of their tactics is to undermine the parenting efforts of the victim. Lundy also backed up this in his research, that they oftentimes would not allow the victim parent to act in the role of a parent, they did not participate in any of the decision making. In my personal experience working with battered women, what I would often see is that battered women were expected to, because of the rigid gender stereotypes we often see of batterers, women were expected to cook, clean, and care for the children on a day to day basis, so the bathing, the feeding, the homework and things like that, but they were not allowed to discipline the children in any way. So they were not able to have a voice in what time they went to bed, they could not disagree if the batterer was allowing the children to eat tons of candy, and things that may not be the best options for children. I often saw as well that

batterers would typically have the children to align with them because of the lack of boundaries, so they were allowed to go to bed whenever they wanted to. Anything that the victim tried to implement as structure for the children was undermined and so that the children would align with the abusive parent in that situation because of the lack of discipline or the lack of boundaries as it relates to their parenting.

Slide 56



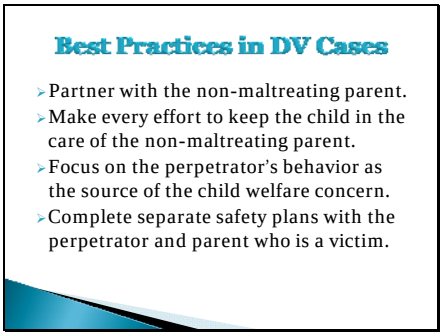
It is so important in these cases of domestic violence that the focus shifts from the victim parent and what she is not doing. We see a lot of that historically, that our child welfare system was a mom-focused system historically. In our work with the Department of Children and Families we have had to have conversations about that, that in our society, not just in our system, but in our society, we don't hold mothers and fathers to the same parenting standard. We are a lot harder on mothers, we have a lot higher expectations of mothers, and there is a lot of reasoning behind that, but fathers, even good fathers, are not given the credit that they deserve, and when it comes to violent fathers we either don't engage them or we treat them as if they are not important to the issue of child safety. That, as we know, is very harmful because fathers especially in domestic violence cases, if we want children to be safe then we are absolutely going to

have to change and target the behavior of the abusive parent. For years we have focused solely on mom, focused solely on the victim leaving the relationship, or getting court intervention, calling the police, all of things, and we fail to invest in the perpetrator and not only to hold him accountable, but to engage him. We are shifting away from just looking at the mom in cases, because if we are going to achieve the goal of child safety, then the perpetrator's behavior has to be the source and the focus of our investigations, of our therapy, of our treatment, whatever it is that we are putting into place to assist this family. This is not to say that the victim does not have, or will not have issues, other challenges such as substance abuse or mental health issues that absolutely need to be addressed in the court of child welfare's involvement with the family, but again when it comes to the violence, the victim should not be held responsible for ending that. First and foremost it is impossible because you are dealing with another person's choice. We have to focus on the perpetrator's behavior and how we stop the violent behavior. The only way we are going to have any ability to do that, or even to have a conversation about that, is to engage that perpetrator. What you see now is a definition of perpetrator accountability, and it is a term that we use a lot in our work as it relates to the intersection of domestic

violence, and just our work in the battered women's movement in general, because there has historically been a lack of accountability, not just in the child welfare system, but also in our law enforcement, also in our courts. We are seeing that change as we move forward and as we begin to progress in our work in domestic violence and ending domestic violence, but it's still largely an issue in our child welfare systems, not just in Florida, but nationally. As a definition, perpetrator accountability really suggests that "perpetrators of violence, not their victims, should be held responsible for the effects of their actions on their children." When you read it, it makes so much sense, but we have not done that historically, and there is a lot of reasoning for that, particularly in the child welfare system. What we see is that oftentimes child welfare workers are not properly trained on how to engage violent men. We also see that there is an element of fear when it relates to interfacing with violent offenders, especially if the perpetrator has an extensive history with law enforcement, or arrests, or violent crime. That fear is legitimate. It is a skill to be able to engage perpetrators, and that has been a general lack of training for child welfare workers in that area. What we have heard from child welfare workers, in my work with them, is that it is typically just a lot easier to engage mom. She is

typically the one who actually is involved with the children, who will actually comply when the threat of removal is placed before her, and so it is just easier to engage her to put her feet to the fire so to speak. That is actual language that I have heard and to focus solely on her because of our expectations of mothers. So what we see is perpetrators are often non-engaged, not held accountable, and so we see this revolving door in our child welfare system of these perpetrators. If he leaves one family, then we see him show up as a boyfriend or a parent in another case with another family. If we are going to be effective in these cases of domestic violence and cases where child safety is an issue, we have to begin to shift our focus to the perpetrators of this violence. This definition comes directly from a piece of work that was done from NCJFCJ and it's titled "The Greenbook". It's looking at court interventions in domestic violence cases and it's really a staple in the work that we are doing. That is also a good resource for those who would like more information on the intersection. It is called "The Greenbook" and you can easily Google it, and it will pop up and there are actually downloads available of this electronically. It is actually a really good piece of information to read and how to better understand it.

Slide 57



As we look at best practices, and again I can't be as exhaustive as I would like to because of the short amount of time that we have, but what we have seen in DV cases is that some of the best practices include first and foremost partnering with the non-offending parent, or non-maltreating, non-abusive parent. These are going to be best practices for child welfare, for workers of child welfare, and not only for child welfare but also law enforcement, other agencies that interface with survivors of domestic violence. It is so important and it is very crucial that we partner with survivors as opposed to re-victimizing or blaming the victim for the violence. There is no other victim that we blame for being victimized, but we do that in cases of domestic violence. A better approach, an approach that would actually make the work of that worker less stressful in working with survivors is to partner. When we say partner, we are talking about building a relationship and rapport with that survivor from a place of concern but not of judgment or blame. What we have shifted away from is blaming the victim for the violence, expecting her to end the perpetrator's violence, and things like that to a more partnering relationship in that we support her and we say that we have concerns for her children but we know that it is not your fault. What we have seen is that survivors respond a lot better to that approach versus

being blamed and that is for a very apparent reason. When a person feels supported, and not blamed, they are more likely to comply. Partnering should be the default position in these cases of workers. They should automatically have a conversation with the survivor to ask "how can I assist you in what you have already been trying to do to keep your children safe? We understand that despite your efforts, despite all of the things that you have done to try to keep your children safe," whether that is formal or informally. Safety planning in these families, with the Department or law enforcement or whoever is wanting to support those efforts. Also identifying that survivor's strengths is huge, and not only identifying but accurately documenting what she has been doing to protect her children, because we thought that this was something that was lacking in a general sense, that child welfare workers were not able to assess DV first and foremost, but document what was really going on as it relates to the violence. We saw blanket statements a lot of the time, such as "parents engage in domestic violence" which is not an accurate depiction of what is happening. In our work with child welfare from a statewide level, we have really been working to build their capacity for assessment, for proper assessment, really being able to identify patterns of power and control, to identify the primary

aggressor based on power and control, and not solely on the incident of violence. Also, helping them to have language around domestic violence, around the perpetrator's pattern of coercion because there is not always physical violence on a daily basis, so we have to be able to document the other ways and the other tactics that batterers use to gain and maintain that power and control, such as sexual violence, forcing the survivor to have sex when they don't want to, and that is also a risk factor for homicide. When we look at the work done by Dr. Jacqueline Campbell and the risk assessments in DV cases, we saw that women that were killed were also most often raped by their perpetrator. So looking at sexual violence, looking at intimidation, looking at verbal and emotional, looking at financial abuse as well, really builds the capacity to see the large picture. This is totally in alignment with the safety methodology that has been employed by the Department of Children and Families in Florida because they are really highly encouraged to accurately assess and get domains of information which equates to having a larger picture of that family and what is really going on. The other thing we identify as best practice is to make every effort to keep that child safe with that non-abusive parent. If that is at all possible, then that should be our goal because if child safety is our goal, that is going to be

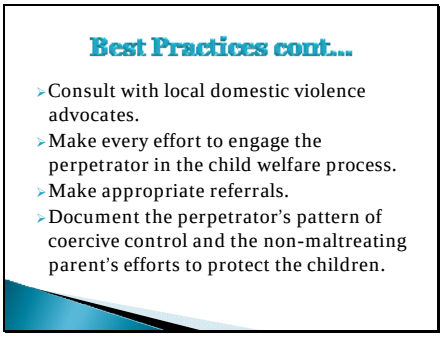
the safest place, but we also have to make sure we are implementing interventions that also protect the adult victim. So if we can protect them together, in the long-term view, those children are going to be more likely to be able to recover and to be more resilient and to rise above the violence that they have experienced, so that is hugely important. Removal, as we know, is traumatic in itself for children that are removed from homes. That doesn't always guarantee safety long-term. Whenever we can protect mom and those children from the perpetrator's violence, then that would be a best practice. We want to focus on the perpetrator's behavior as the source of our child welfare concern, and we have already had a lengthy discussion around perpetrator accountability. That is going to be a key piece to working with these families. I heard something really impactful from an adult who was a survivor of childhood domestic violence. He witnessed the abuse of his parent, of his mother at the hands of his stepfather. This person is now an adult, and what he said to me was very powerful. What he said to me was that as a child, when he was removed from the violent home, the message that he received was that when you do bad things, you get away with it, because the perpetrator was not held accountable. He also said that he felt that he and his mom were actually the ones that were in

prison. That was really powerful to me to hear it from someone who had witnessed it firsthand, and he said he felt like he had been in prison. The removing of him from his mother and her safety and her security was very traumatizing, and the message that it conveyed to him was that he had done something wrong or that his mom did something wrong. He never saw the stepfather held accountable, a night in jail here or there but nothing long term. I think that all of the work that we do at the Coalition is to promote that message that survivors need to be supported, and not blamed, and all of the work that we are doing is to help ensure that other systems that we work with are actually promoting that as well, and working in a way that is not blaming and that is not re-traumatizing the victim in any way. Another best practice is to complete separate safety plans with the perpetrator and with the parent who is a victim. This is really key. This past July of 2014, there was new legislation passed in Florida that mandates child protection investigators to complete separate safety plans in cases of domestic violence. The new safety methodology is very focused on being family-centered which is not in itself a bad practice, but when it comes to domestic violence, being family-centered can be harmful because of power and control dynamics. One example is in the family-centered approach, there

would be one safety plan for the family and every member of that family would have to agree to this safety plan, particularly the parents. When we talk about power and control, if you were to apply that in DV cases, that can be very harmful to survivors because they won't have a voice. The plan won't be, because of their fear, because of intimidation, because all of these things, they won't really be able to discuss any issues or voice any of their opinions as it relates to the safety plan. Then it will be the plan of the perpetrator. So it was highly important for us to advocate for there to be separate safety plans in these cases. That is in legislation currently, so it is a mandate. It does not say that CPIs will consider, it does not say that they may, but it says that they shall complete separate safety plans because it is about safety. Even though the legislation only specifies safety plans, we encourage that everything in DV cases be separated as much as we absolutely can. For example, case plans should be separated if that is possible, because of power and control dynamics. If the perpetrator is aware of the things that mom is doing to keep herself safe or as treatment, and we had a discussion about substance abuse earlier, it is not uncommon for perpetrators to sabotage the victim's sobriety by harassing, by stalking, by failing to give her access to the car to make it to her NA meetings or things like

that. It is important that we are always aware of how the power and control is manifesting and so I would say separate everything, separate safety plans, separate case plans, or at least considering what that might look like if you are not able to do it in a formal way. I highly encourage workers to have separate meetings if you have a case that you know that there has been dynamics of domestic violence. It really is a best practice because you are able to have a safe conversation with a survivor not in the presence of the batterer. So even if it is substance abuse treatment, if it is mental health treatment, it is a really good practice if there is any inkling that there is domestic violence in a family, that you meet separately first to just assess what is going on. It really gives the survivor the ability to feel safe about discussing what her concerns may be or what is really happening in that family.

Slide 58



There are other best practices including consulting with your local domestic violence advocates. We have 42 certified domestic violence centers in Florida and so for every county there is one that serves their area. It is so important if you are going to be effective in DV cases that we rely on the expertise of those in our communities who are experts, not only in domestic violence, but if there are other situations that are co-occurring such as domestic violence and mental health, really bringing those

experts to the table as well because the more people that we have at the table and the more expertise, the better we are going to do in our planning for this family. The more likely we are to intervene in ways that will be successful long-term, engaging those who work directly with the perpetrator, such as your batterer intervention programs and such, your law enforcement. It is just we have to shift to a coordinated response and that is really the message that we are giving in our work in our state around domestic violence and child welfare. There is only so much that a CPI can do, there is only so much that a domestic violence advocate can do. There are other players that are hugely important to holding perpetrators accountable, such as your probation and parole, such as your BIP providers, your state attorney personnel. All of those people are going to be necessary in helping to keep that family safe. It is not just a one system situation, and we have historically worked in silos in these cases, to where we were serving the same families but not working together. Working together is not always about information sharing, because there are confidentiality and privilege limitations as it relates to the information released from domestic violence advocates. It is really having them at the table to staff and at least give their expertise when discussing a case anecdotally and discussing what may be the

best intervention is highly encouraged because collaboration is key to assisting battered women and their children and helping them to be safe. We want to also make every effort in these cases to engage the perpetrator in the process, not just to blame, not just for intervention, but engagement at a really basic level, to make him an important piece of the puzzle, to communicate to him that his choice to be violent directly impacts the child's safety, the safety of his children or the children that are in his care. We have to begin to engage fathers and to make them a part of the process of keeping children safe. Making appropriate referrals is also hugely important in these cases. For example, in a case of domestic violence, a referral to anger management is not going to be an appropriate referral. Why? It is because when we define domestic violence, it has everything to do with power and control and very little to do with anger. Batterers are often very good at being in control of their anger. We see that there will be situations where batterers will physically assault their victims, police come a few minutes later and he is well-composed, he is able to come to the door, there is no sign that he was out of control or had any anger management issue, and so if you send a batterer to anger management you are only making him more powerful and giving him more tools to be in control. We

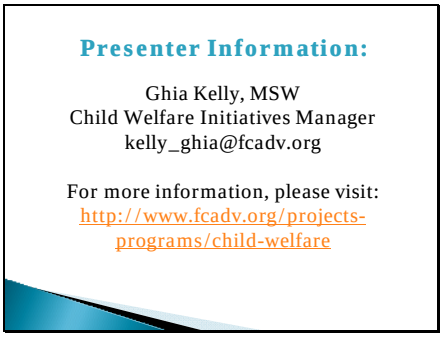
want to make sure that the referrals that we are implementing in these families are appropriate. The focus of the child welfare concern should be the perpetrator's violence. If there are co-occurring issues that the survivor has, then you want to address those concurrently but mandating survivors into domestic violence services is not a best practice because it is not anything defective with her that makes her a victim, it is the person's choice to be violent against her. So we want to make sure that we are utilizing our services of our domestic violence centers but that we are not mandating them in some sort of way because there is not a treatment element as it relates to domestic violence services. The priority for domestic violence shelters and their services, the key most important thing, is safety. You want to make sure that you are referring to your local domestic violence centers with those things in mind. It is about safety, it is about safe shelter, and it is about supportive advocacy on behalf of survivors. We also lastly want to document effectively, and I talked a little bit about this earlier in the presentation, but documentation goes a long way. It really follows a family from case to case. If this case that they are currently in closes without any findings, or something like that, and they come back into the system, then that documentation is going to follow them. So we want to make sure that

we are documenting what is happening in that family accurately, that we are not making blanket statements that mother and father are engaging in violence because that is not accurate. It is one person's choice to exert power over another person in cases of domestic violence. Again, these are cases of domestic violence. There are some relationships with two people that are in what we call toxic relationships, and two people may have anger management and the violence is mutual. It is not an issue of power and control, and so we want to make sure we are properly assessing for that. In those cases, that would be different and the interventions would be different. It may be appropriate to refer both of those people to an anger management course of some sort, but if you have elements of power and control that one person is in power, one person is controlling another person, then you want to make sure that you are making appropriate referrals and that you are documenting what is happening in that family and the impact accurately because that is going to be huge as it relates to accountability and serving that family in a way that is going to provide safety on a long-term basis. Domestic violence survivors have risks associated that are not just related to the batterer, but there are life generated risks that they also experience. There is a direct correlation between domestic

violence and homelessness, domestic violence and poverty, domestic violence and suicide. There are so many other risks that survivors have so we have to make sure that we are aware of the ways in which the violence is manifested and the long-term effects that it might have on the family. We want to move away as much as possible in mandating survivors to get injunctions, mandating them to leave the home, because a woman's lethality skyrockets when she separates. We want to make sure that we are not forcing her to do that as a means to child safety because that could in fact put her in more danger, at a greater risk for being killed by the batterer. Understanding dynamics and understanding from that survivor's perspective, what is the best option? We often say in the battered women's work that the survivor is the expert in the violence. She is the expert on that batterer. Survivors often have to study the batterer, that is how they survive, and that is why we use the term survivor, if we really want to know how to keep children safe, what interventions may endanger that survivor and her children, then you want to talk to her. She is going to be the source of that. Again, I also want to clarify throughout this presentation, you heard me use feminine language to reference the survivor and then to use 'he' as we are referencing the perpetrator – that does not mean that a female or

woman cannot be the perpetrator of domestic violence, because it is about the power and control and so that is absolutely possible and if that is in fact the case, then the perpetrator would be the woman, but what we see is that women are most often victimized as it relates to domestic violence and sexual violence. So I am very intentional when I use that language, but I do not want that to mean or to have that be misconstrued to think that women cannot be batterers of domestic violence because we honor and own the fact that it can absolutely can be possible, but typically you are going to see women are abused at higher rates than males when it comes to domestic violence and sexual violence. I would like to point that out.

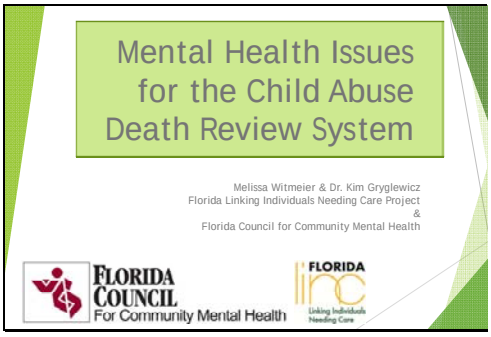
Slide 59



That is actually the last bit of information that I have in this time frame, but on this slide you will see I did give my information where I can be reached if there are any questions or any further trainings that you, or an agency that you are connected or affiliated with, want more training, that is the role of the Coalition. We do provide training and technical assistance, not just to our domestic violence centers, but also to our community partners. A lot of times the training that we provide can be done at no fee, or no cost, to those that are requesting, so you can email me if you have any other questions. I also

noted a website that we have and this is our child welfare toolkit, it is actually through our FCADV website, but the link that I have included is directly to our child welfare toolkit. It has more information about the projects that we have statewide as it relates to domestic violence and child abuse. It also has tons of resources and videos and also links to the Safe and Together Model that I referenced earlier. If you want more information about that model, you can go to www.endingviolence.com. Thank you for your time. It was a pleasure to be able to share this information with you, and have a good day, thank you. Thank you Ms. Kelly for your presentation and your insights on this important topic.

Slide 60

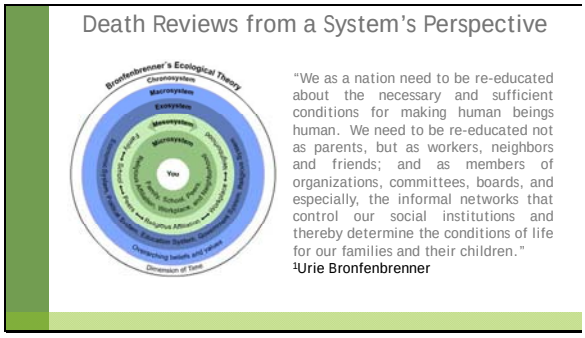


Our next presenter, representing the Florida Council for Community Mental Health, is Ms. Melissa Witmeier. Ms. Witmeier is the Director of Training and Community Engagement for the Florida Linking Individuals Needing Care Project. Ms. Witmeier has extensive knowledge and training experience in the area of mental health and suicide prevention. She has worked as a program coordinator and trainer on 3 federally funded mental health suicide prevention grants in the state of Florida. She has specialized training in crisis management, suicide risk assessment and safety planning, and she is a certified trainer and suicide awareness and prevention

instructor for the Question, Persuade, Refer, as well as the Question, Persuade, Refer, and Treat program models. Further, she is a certified applied suicide intervention skills training instructor. During the last 4 years, Ms. Witmeier has trained over 10,000 professionals and community members in various suicide prevention and mental health intervention trainings throughout the state of Florida. She has presented at various international, national, and state level conferences including the American Association of Suicidology Conference, the Suicide Prevention Resource Center, the Substance Abuse and Mental Health Service Administration Conferences, as well as the annual conferences for the Florida Council for Community Mental Health and the Florida Alcohol and Drug Abuse Association. We are thankful for Ms. Witmeier's willingness to provide and participate in this webinar, and look forward to her presentation today. Thank you Dr. Perry. As Dr. Perry said, my name is Melissa Witmeier, and I am the Director of Training and Community Engagement for the Linking Individuals Needing Care Project, or as we call it, the Florida LINC Project. This is a grant funded through the Substance Abuse and Mental Health Services Administration. This is our third grant, and I have been working on the grants for the last 6 years. It's a

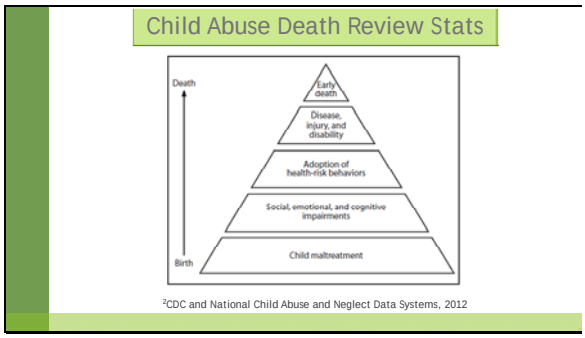
collaborative project with the Florida Statewide Office of Suicide Prevention, the Florida Council for Community Mental Health, the University of South Florida and the University of Central Florida, all of which is a part of a nationwide youth suicide prevention and early intervention program to link people at risk to services. I personally have worked in suicide prevention and intervention for over 15 years in various capacities, but feel my time as a hotline crisis counselor and trainer and on-call supervisor helped me to understand why child abuse deaths are occurring. During those 7 years, along with working on the local suicide and crisis hotline, I also answered calls in the evening on the Florida Parents Anonymous Hotline, and spoke to many desperate and frustrated parents. Years later, after adopting our youngest daughter from China, I became one of them: a parent that struggled with and continues to deal with our own daughter's journey through mental illness. I will share a little bit about that with you later.

Slide 61



As a child death reviewer, it is important to consider the context in which the death occurs: how the family and child's environment play a role in the circumstances leading to that death; risks to mental health manifest themselves at all stages in life. How those systems play a role in mental health is something that must always be considered. Bronfenbrenner's Ecological Model is used to view this development as the product of transactions between an ever-changing person and an ever-changing environment. The model serves as a way to see how people can interact with this system and how it affects each person. By organizing the different systems, you can see how much those systems influence a person. The closer a system is to an individual, the more it has an impact on that person. When investigating a death, please take the time to look at each system surrounding the child and family and how it played a role. The microsystem is the first system within the model. Everything within it has a direct impact on how the person has been shaped. It contains the family, friends, the neighborhood, their religion, and the workplace. When we think about how someone's direct environment has molded them, we will have a better understanding of the person within. The mesosystem connects the micro- and exosystems through the diffusion of those walls.

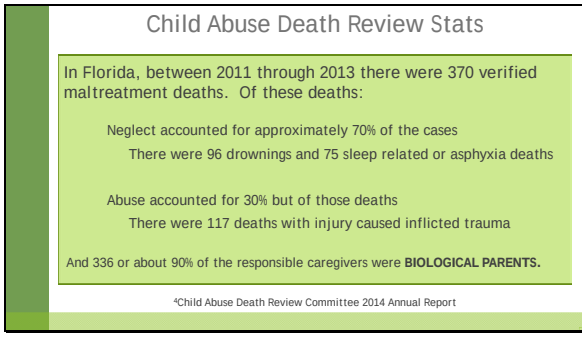
Slide 62



They will interact. The exosystem contains the education, economic, government, political and religious systems. The macrosystem has our overarching beliefs and values. These change through lessons learned in life. From altruism to autonomy, to emotional well-being or morality or knowledge or loyalty, our values are deeply personal, but often stem from the environment from which we came or are headed. Before we begin talking about mental health issues surrounding child abuse deaths, I would like to reiterate some of the child abuse death statistics. In 2012, a total of approximately 1,600 children were reported to have died as a result of maltreatment in the United States. Also in 2012, state child protective service agencies received an estimated 3.4 million reports of alleged abuse involving an estimated 6.3 million children. Following the investigations, nearly 700,000 children were confirmed as having been abused. However, many cases are never reported to authorities. The actual scope of child abuse is much greater. For example, data from a national survey in 2011 of children and adult caregivers suggests that 14% of children are abused each year, and 26% experienced abuse at some point during their childhood. Children under the age of 1 were most vulnerable, and accounted for about 41% of all fatalities. About 85% of abuse fatality victims were under the age of 6 years. Most child

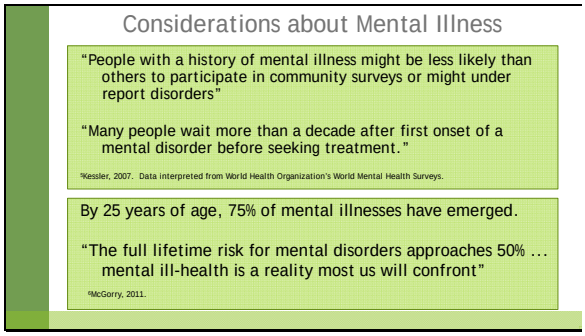
fatalities were the result of abuse by one or both parents. Mothers acting alone were the perpetrators in 1⁄3 of child abuse and neglect related fatalities. It is also important to know the leading indicators of fatal abuse are interrelated with poverty, domestic violence, and substance abuse.

Slide 63



Now let's take a look at the state of Florida. During a 3-year period, with 370 verified children abuse deaths, approximately 70% were from neglect and 30% were from abuse. Let's think for a moment what environmental factors may play a role in a child or infant drowning, suffocating on soft bedding, or sufficient trauma leading to a death of a young child. I'd like to share with you some information about a family I know. The mom, while trying to juggle getting dinner on the table, evening chores, and a pesky phone call that came through, left her infant and 2 ½ year old son in the bathtub to play and finish up. While playing with toys, the older boy kicked the baby seat and tipped it over, and the young boy, not understanding death or drowning, watched his brother die. His mom walked in to find her son face-down in the water and the chaos that followed. The mother lives with regret and blame from the choices she made and her son lives with the memories and struggles to this day. Do we really wonder where their mental health issues, anger, and/or sadness may have come from?

Slide 64

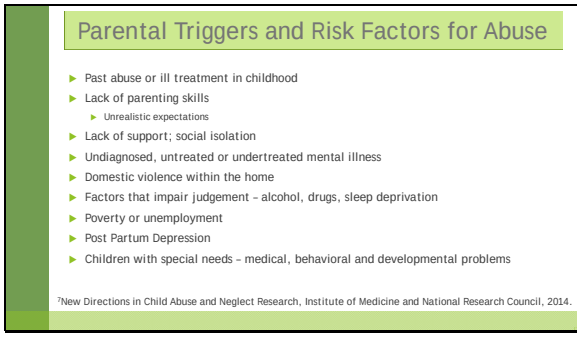


Was she a bad parent, a neglectful parent, or one under so much stress that the risk of walking out of the bathroom never even dawned on her? Did she have a mental illness? Did it matter, or could his death have led to a mental illness that put her and her other 3 children at risk too? It is difficult to gather information when looking at mental health disorders and fatal child abuse. People do not feel safe talking about their problems openly. We know that mental health is incredibly stigmatized. Society does not allow us to talk openly about our problems without severe ramifications. In the military or police force, they often feel as if they will be put on leave or terminated if they talk about their issues. So many are left sitting in silence with little or no coping skills or a community safety net. This alone puts them at great risk for suicide. Approximately 50% of our most in need wait a decade to talk to someone or never talk at all. It puts us all at risk. As the child of a firefighter, I understand this dilemma. Living with an emotionally and verbally abusive alcoholic was very, very difficult. He saw horrific death and trauma and never talked about it. This left him feeling isolated and alone with only his liquor to turn to. He was the definition of comorbid.

Slide 65

So, what can we do to help? From my years of training and working with people in crisis, the first step when talking to people is to listen with an open mind and no judgment. It is not inherent in us, and many of our caregivers, including our clinicians, are not adequately prepared to listen or leave their own personal biases and beliefs at the door. This is a skill that is learned. Many rush to judgment and inflict more stigma and trauma on the situation. Our goal to keep people safe from abuse and death, homicide and suicide, is to educate on preventative measures before it occurs, provide linkages to support systems, teach coping and parenting skills, and ask questions that allow people to talk about how bad it really gets.

Slide 66

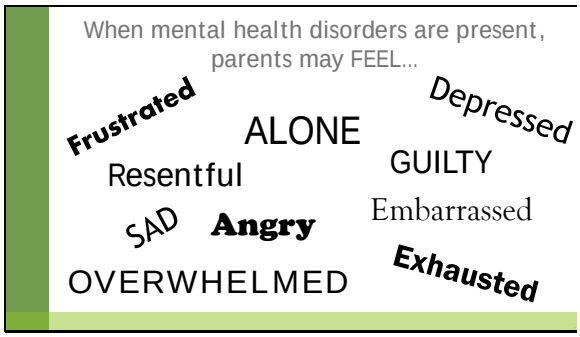


What are some of the most common risk factors or triggers that lead to abuse? What are those factors, that if left unidentified, could lead to abuse that results in a death? We need to know that past behavior is predictive of future behavior. If parents experienced abuse, they are much more

likely to abuse children. Some caregivers never learned the skills necessary for good parenting. The amount of care and attention infants require may far exceed what parents thought they would need to give. Imagine a teen or immature parent not ready for their first child. Isolation from family or friends can be very stressful, especially when dealing with a child with emotional, mental, or behavioral issues. In fact, other major life stressors such as moving, unemployment, or the birth of another child are present in many families who fatally maltreat a child. Parents that struggle with their own mental illnesses may not be able to deal with children when difficulties arise. They oftentimes have trouble caring for themselves and are even less likely to care for others. If abuse is occurring between parents, it will likely move towards the children. Many children who die from physical abuse have been abused over time, but a one-time event can also cause death. The most common reason given by caretakers who fatally injure their children is that

they lost patience when the child would not stop crying. Another common reason given by the abusers includes bedwetting, fussy eating, and disobedience. As you can see here, stress is an undercurrent that we see throughout the list.

Slide 67



When young children are the most likely victims of child abuse deaths, it is important to understand the circumstances that may be happening within a household. Families with special needs children often feel very isolated. No one understands what is happening in the home. When they try to talk about it with friends and family they are often rejected. We have to wrap our heads around what the parents may be dealing with - a child that will not eat, or eats everything uncontrollably, screams every time they are touched or will not let the parent out of their sight, cries incessantly or has no emotion, threatens the life of the parent or another child in the house, lies about everything or nothing of importance, steals food or favorite items, purposely hides things of

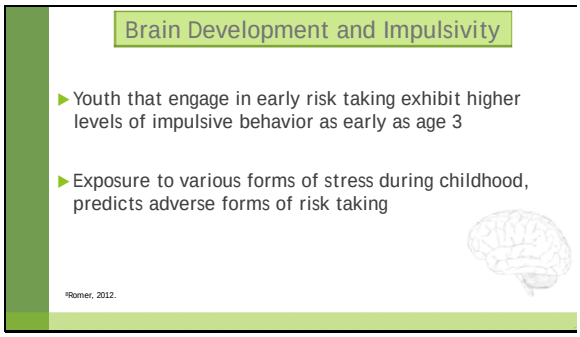
importance like keys or jewelry or phones – what might those parents be feeling? What about the parent that has bipolar disorder but it has not been diagnosed, or a father that has returned from war with PTSD, or the teenage mother whose own mother abandoned her to the foster care system when she was 4? How do we begin to understand what happens behind closed doors?

Slide 68

The topic of adolescent or young adult mental illness and impulsivity should be discussed in tandem. It is important for us to learn about brain development and how this impacts choices that are made, especially if a family is also struggling with a person with mental illness, either the child, the parent, or both. For example, if a rambunctious 3 year old is bouncing off the walls, not following instructions or listening, refuses to pay attention to his or her parent while the parent sleeps all day and only interacts with the child in the evening, are we looking at an adolescent and a parent with a mental disorder, just one, the other, or neither?

What other environmental effects should we find out about?

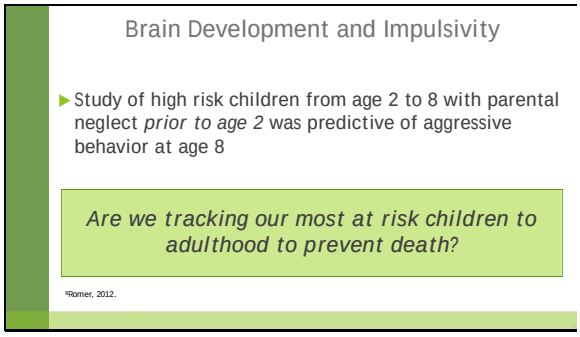
Slide 69



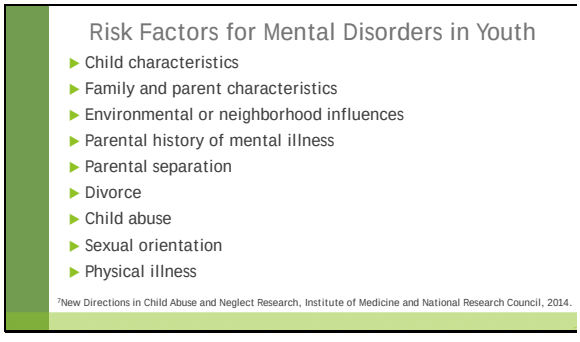
Exposure to violent events in a child's life can lead to lasting physical, mental, and emotional harm, whether the child is a victim or a witness. Children who are exposed to violence are more likely to suffer from attachment problems, anxiety, and depression, to have aggression and conduct problems, academic and cognitive problems, delinquency and involvement in the child welfare and the juvenile justice systems. When we observe children or young adults engaging in risky behavior, it is an indicator that should not be overlooked. We may see acting without thinking, impatience, and sensation seeking. More recently we are seeing increased patterns of self-harm behavior like cutting, burning, or picking, to help cope with internal pain and conflict. Looking back at the drowning case, the young survivor between the ages of 3 and 6, was aggressive towards others, loved the thrill of riding his bike off of

ramps and jumping off the staircases. What other risk factors might have been present during those years? Both children and adults should be able to openly discuss past neglect, abuse, or violence as it is predictive of future behavior and mental illness. If we do not open the lines of communication, the patterns of poor parenting may continue. A key question to ask as you are investigating a death or a family is: how are we linking the family to help, and are we tracking our most at risk to prevent this from happening again? Prevention works. Research has shown that home visiting for first time mothers, comprehensive early education, and family support reduces child abuse and neglect.

Slide 70



Slide 71



Risk factors that are present do not mean a person will have a mental illness. They are events that may lead to problems, like the drowning of a sibling. An individual's mental health can be influenced by events or circumstances occurring before their birth or even their conception, from a family history of mental

illness or other environmental factors like alcohol, stress, or toxins being present. The risk of mental health illnesses interact within us and within our environment over our entire life. Risks to mental health manifest themselves in all stages of our lives. They include family violence or conflict, negative life events, and a low sense of connection to schools or other learning environments. Childhood years are vital for developing life skills, so preventing the possibility of mental health disorders begins with our youngest children and in the environment we live as shown in Bronfenbrenner's model.

Slide 72

Let's begin a discussion of specific disorders that cause great stress within families. First, let's talk about autism. More than 500,000 people in the United States have been diagnosed with some form of autism. Autistic disorder is a neurological and developmental disorder that usually appears during the first 3 years of life. A child with autism appears to live in their own world, showing little interest in others and a lack of social awareness.

They show consistent routine and engage in repeating odd and peculiar behaviors. They often have problems in communication, avoid eye contact, and show limited attachment to others. It can prevent a child from forming relationships with others due to not understanding emotions. Consider the parent in this. Kids may also resist cuddling and want to play alone, be resistant to change and have delayed speech development. Finally, they also tend to exhibit repeated body movements and have unusual attachments to objects. Identification of autism has occurred as early as 1, however the median age is 6 years when children begin school. That is 6 years of time that parents are left wondering what is happening. While researching autism and creating this presentation, the story here, from Wisconsin was reported. I thought this was apropos for our discussion, could this have been our next child abuse death?

Slide 73

There is strong evidence to show that attachment to a primary caregiver for social and emotional development is critical. Separation from the primary caregiver due to parental absence or rejection leads to anxiety, stress, and insecurity. Children are not born with attachment disorders, it is a response to early childhood trauma, abuse or neglect ,often related to foster care or adoption. As infants, we totally rely on our caretaker to feed us, change us, and most of all respond to our cries, to hold us, to talk to us, and look at us when we smile so we feel loved. If we are severely neglected, food comes occasionally and randomly, not when we cry from hunger pangs. Diaper rashes and urine burns cause pain and we give up crying because nothing happened, or we got punished. Survival for RAD kids might mean stealing or tricking people because they desperately need human interaction and are not getting love. They will invoke anger just to confirm that they exist and are in control.

Our daughter lived in an orphanage for the first 10 months of her life. When she came home, she refused to be held by screaming and hitting, would throw explosive tantrums if she did not get her way, and would sit in time out completely zoned out, living within her safety box. You see her in the picture to the right, trying to steal food out of our pantry after refusing to eat her fruits and vegetables at the table, and having been excused from the table, decided to wander into the pantry. Her sister busted her as she was trying to take a granola bar and decided to give her the teaser in hopes that by smiling, she would get what she wanted. When the granola bar was taken away and the fruits and vegetables reintroduced, hysteria erupted, but I would not give in and our home has been a battlefield for 11 years. From diamond earrings and keys to the safe being hidden when she was angry, to lying about everything and nothing because it was easier than telling the truth. Today it was signing up for an Instagram account after being told she was not old

enough to have one, to not reporting or lying about bad grades. It does not stop, it does not end, and there are few resources for us. Parents feel at the end of their rope with no place to return except to return their children. In foster care, that is an option, but for parents who have adopted, it can be a dark abyss.

Slide 74

Children with conduct disorder usually have little concern for and repeatedly violate the basic rights of others and rules of society. Conduct disorder causes children and adolescents to act out their impulses in very destructive ways. They feel angry, irritable, frustrated, and hostile and often act out by bullying, getting in fights, stealing, lying or running away. Similarly to other disorders, we may see aggression towards people and animals, destruction of property, theft, and getting in trouble with the law. These behaviors are often the precursor to antisocial personality disorder, which is not diagnosed until the individual is 18 years or older. How do we parent these children?

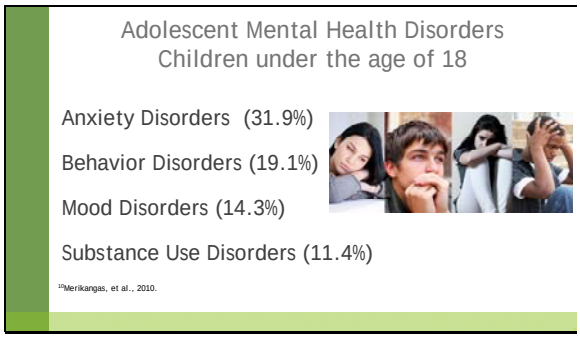
Why do we expect parents to have the knowledge to care for at-risk youth with no training? When I had my first child, there were no parenting classes required. No one cared what I did or did not provide. Thinking to my second child, I am thankful I had the knowledge and maturity to seek the help of others. Many are not as fortunate.

Slide 75

During adolescence, mental disorder is more likely to develop or become apparent. With this group, we know they are likely dealing with peer pressures, drug use, and sex as well as the influence of social media. Impulsivity is at its peak when freedom is right around the corner, whether that be driving or going out alone, or preparing to leave for college. The question to ask here is what was happening within the child and parent relationship, and how did those stressors lead to a child abuse or neglect or death? Thinking about our loss survivor example earlier, today the boy who lost his brother is in high school

involved in drugs, sexually active, gets in fights, and has recently been caught cheating on an AP exam. His mother calls him a handful. Within this age group, I need to identify the risks of suicide for our LGBTQ, lesbian, gay, bisexual, transgender, and questioning youth, is incredibly high. Their sexual orientation places them at great risk of abuse due to social isolation, rejection from family, friends and faith, and trauma, which often leads to thoughts, plans, and attempts of killing themselves. Our LGBTQ youth are at 4 times greater risk of dying by suicide than their peers.

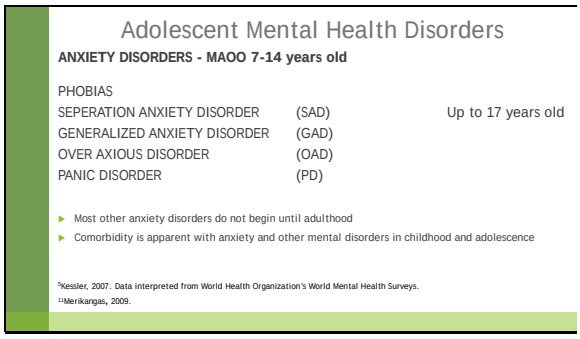
Slide 76



If children under the age of 18 are diagnosed with a mental health disorder, they typically have an anxiety, behavior, mood, or substance abuse disorder. Clinicians often do not want to label children and stigmatize them, but without a diagnosis it can be very difficult to get services through systems like a 504 plan in the school. At this age, children regardless of a mental illness can be defiant, arrogant, frustrating, and disobedient as they try to

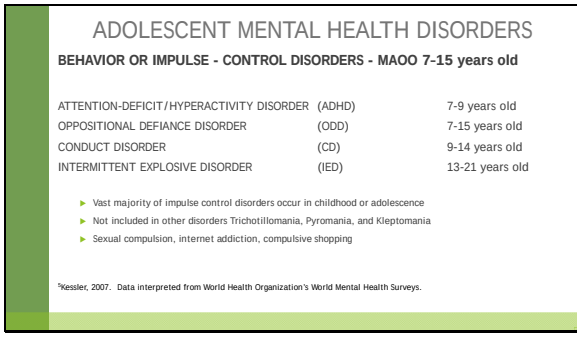
make their way into adulthood. Adding a mental illness into the mix can be a recipe for disaster.

Slide 77



If children under the age of 18 are diagnosed with a mental health disorder, they typically have an anxiety, behavior, mood, or substance abuse disorder. Clinicians often do not want to label children and stigmatize them, but without a diagnosis it can be very difficult to get services through systems like a 504 plan in the school. At this age, children regardless of a mental illness can be defiant, arrogant, frustrating, and disobedient as they try to make their way into adulthood. Adding a mental illness into the mix can be a recipe for disaster.

Slide 78

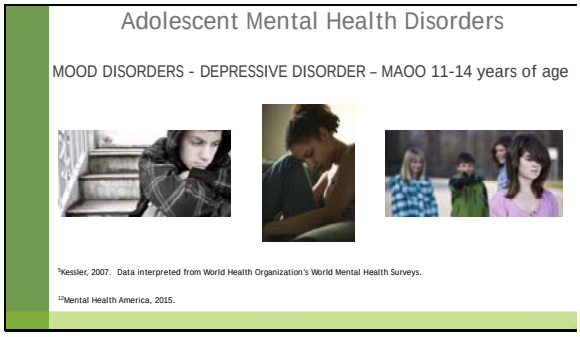


People with an impulse-control disorder can't resist the urge to do something harmful to themselves or others. These disorders include addictions to alcohol or drugs, eating disorders, compulsive hair-pulling, stealing, fire-setting and rage. Usually a person feels increasing tension or arousal before committing the act.

However, the person will feel gratification or relief afterwards. Then the person may blame themselves, or feel regret or guilt. These acts may not be planned, but do generally help them with their immediate stress. Most people feel a loss of control over their lives and this is the answer. When my daughter went through FCAT testing last year, she began pulling her hair out. I noticed a small bald spot on the top of her head one day after school. We quickly helped her by contacting her teaching, pulling her hair back into ponytails, gave her rubber bands to snap her wrist, stress balls to squeeze, and talked with her about the everyday life stress that she was dealing with. We gave her concrete coping skills because I knew what to do. She has learned to control the urge, but we can see when her anxiety is back. Her hair immediately goes back up into a ponytail. She tells us the pain, and then pressure, and then release of the hair coming out makes her feel better and in control. This also is a common statement heard from cutters or youth

who are engaged in self-harm behavior. Most parents, though, don't have a clue what to do.

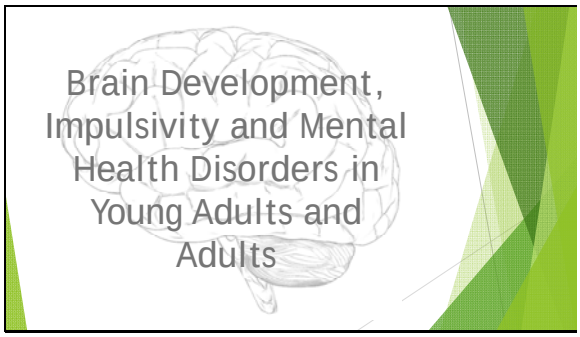
Slide 79



When working in middle and high schools, I can see mood and depressive disorders in full force. They are the most common disorders among our youth. With the breakup of a significant other, loss of friends, bad grades, bullying, terrible home lives, or fear of punishment, our children face situational depression often. When puberty begins, their emotions seem to be on an extreme roller coaster ride. The question for parents is when is it normal, and when has it taken a turn down the wrong path? The once loving, happy child that watched TV and played games with her family now locks herself in the room not to be seen. For many, talking about suicide should be a conversation had immediately. Unfortunately, stigma continues to stop families and society from acknowledging this issue. Parents may be left asking more questions of themselves and less from their children.

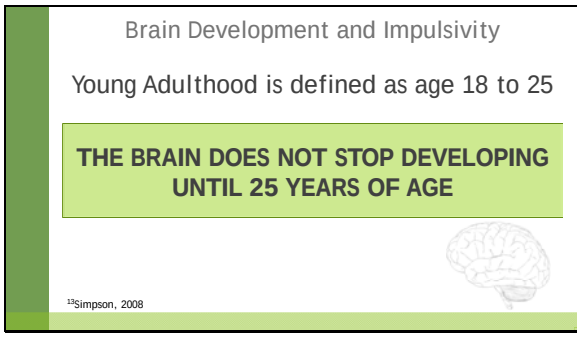
With over 5,200 known adolescent suicides in 2013, and it being the second leading cause of death, this conversation needs to begin.

Slide 80



We are now turning a corner away from our children and looking at adults with mental health disorders. Keeping in mind a statistic that was shown earlier, remember that by age 25, 75% of mental illnesses have emerged, and approximately 50% of all people will have a mental illness in their lifetime. This next section will examine people 18 years and older.

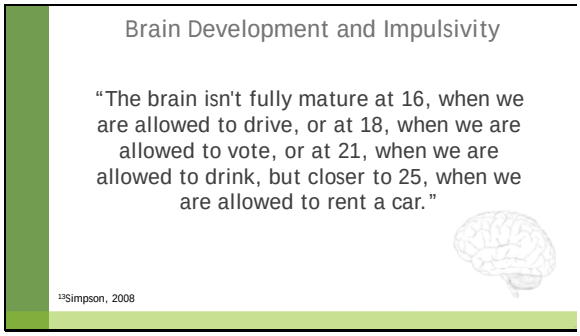
Slide 81



It is imperative that we remember that our young adults between the ages of 18 and 25 are continuing to grow and mature into adulthood. During this time period, they are developing abstract thinking, a right and wrong framework, building instrumental relationships, experiencing the intensity of emotion, and engaging in sensation seeking, all of which puts them at great risk or harm. In this age group, suicide is the second leading cause of death after accidents.

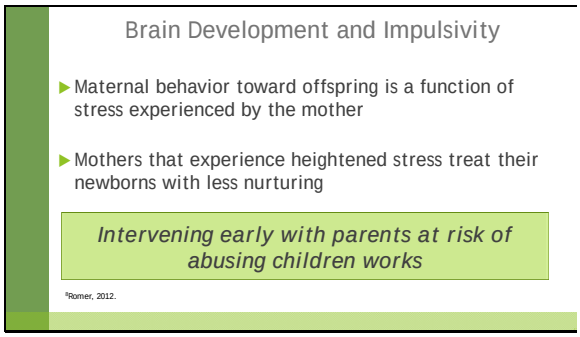
Ask yourself: are young parents neglectful of their children because they are not mature enough to take care of themselves, much less someone else? Remember, they may also be neglectful because it is very difficult for them to put the X-box controller down, or the phone down. They are still incredibly impulsive.

Slide 82



"The brain isn't fully mature at 16, when we are allowed to drive, or at 18, when we are allowed to vote, or at 21, when we are allowed to drink, but closer to 25, when we are allowed to rent a car." We cannot force our brain to mature faster or find a shortcut.

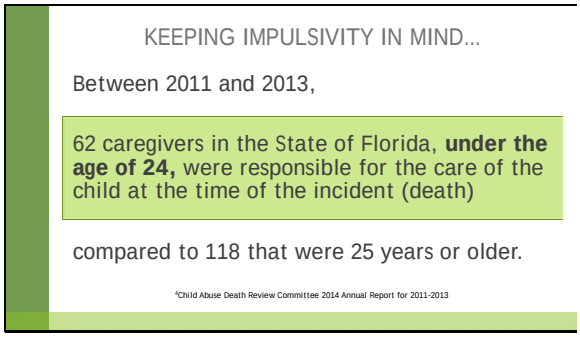
Slide 83



If they are impulsive and stressed due to a lack of knowledge or skill or resources, how does that translate to their parenting of an infant or toddler that screams, cries, needs attention, won't sleep, won't eat, or won't stop eating. Most deaths were associated with a parent's unrealistic expectation of their children, and parents' perception of their children's provoking behaviors. The moms often felt rejected by their children

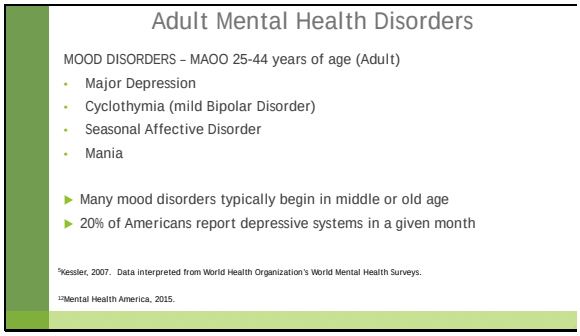
or interpreted their children's behavior as intentionally provoking them. Remember, prevention works. Young parents need training and resources to cope with their stress.

Slide 84



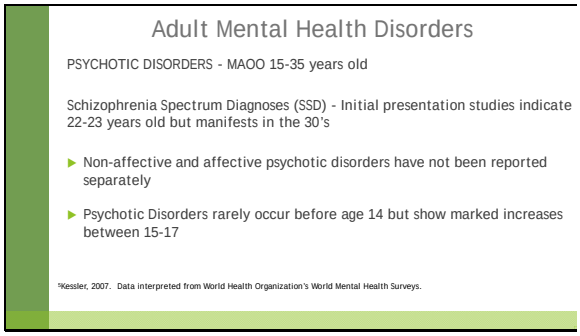
Lack of prevention can put children at great risk. In the 2014 Child Abuse Death Review Annual Report, it stated that 1⁄3 of our caregivers at the time of a child death were under the age of 24. These are young adults responsible for the care and well-being of a child or adolescent, when they themselves have not fully matured. Impulsivity, defined as actions based on sudden desires, whims, or inclinations rather than careful knowledge, the sheer fact that their brain is not fully developed, may be a major undercurrent of why children die by abuse or neglect. Let's take a look at some of those disorders that impact parents.

Slide 85



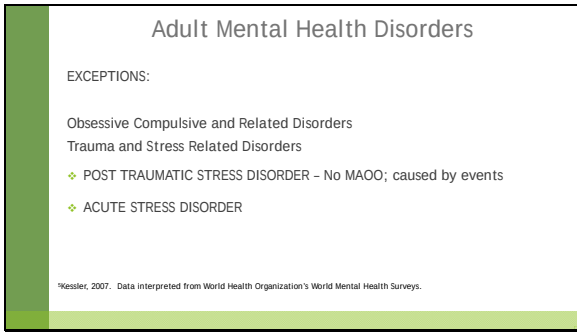
Mood disorders encompass many issues such as major depressive, dysthymic, and bipolar disorder. Approximately 21 million American adults suffer from these disorders. Major depression is the most common mood disorder. This illness can cause debilitating mental or physical pain or suffering. It often prevents normal daily function. While some people with depression only experience one episode of depression in a lifetime, or situational depression due to job loss, divorce, or another life event, most endure multiple episodes. Without treatment, therapy, or coping skills, how does a person or parent effectively deal with this disorder? Think of someone with depression parenting someone with say reactive attachment disorder. How might that look? Keep in mind that for some, depression is sadness, and for others it is anger. Are you asking the right questions to determine which one it is?

Slide 86



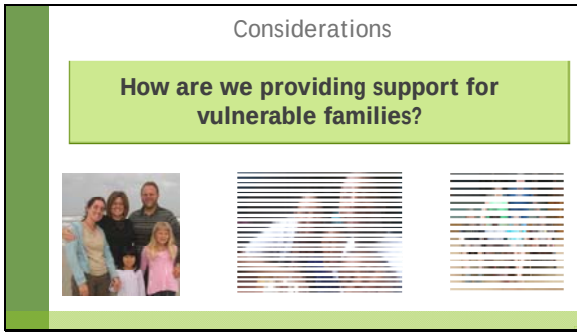
The typical onset of the first schizophrenic break is at 22. What were you doing at 22? Partying at college, parenting a child, starting your career, or working for several years already? At 22, most people do not expect the sudden onset of such a serious mental illness and families are often less than prepared for this. These mental illnesses alter a person's ability to think clearly, make good judgment, respond emotionally, communicate effectively, understand reality, and behave appropriately. When symptoms are severe, people with schizophrenic disorders have difficulty staying in touch with reality and often are unable to meet the ordinary demands of daily life, possibly like parenting a child. However, even severe psychotic disorders are treatable if the person and family seeks treatment and does not wait 10 years before reaching out.

Slide 87



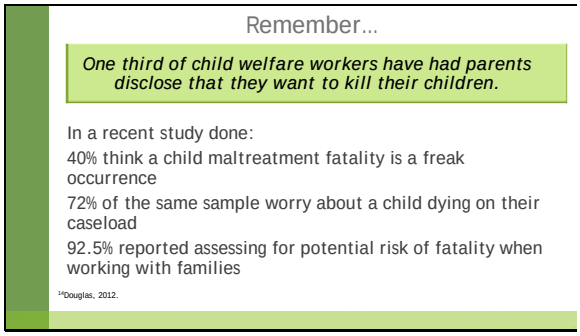
With our military coming home from war, our first responders seeing traumatic events at their jobs, and life events that occur like 9/11 or the Boston bombing, PTSD is real and affecting our families. There is no typical age of onset since it is linked to a traumatic event, but PTSD may begin 3 months after an event or not surface for years. Society is beginning to understand the effects of PTSD, but the impact it has on our children is severe. Most are not sharing their feelings because people keep their problems behind their closed front door. I also want you to consider for a moment a parent with OCD, and how they deal with a young child or children in the house, food thrown on the floor, walls colored on, toys strewn about, cabinets open and the contents pulled out everywhere. How do you cope? Although mental health and its implication on child abuse deaths have not had significant research done, it is critical that we try and understand and listen to those parents and children that may be working through their own mental illness.

Slide 88



So how do we help families working through mental illness? We provide outlets for them to talk and we try and understand the frustration that they may be dealing with. We recognize that young adults with undiagnosed mental illnesses may be having children with mental illnesses, or healthy children, that overwhelmed foster families parenting numerous children with undertreated or untreated mental illness may be overwhelmed, overextended, and exhausted, and that adoptive parents that receive a child with fetal alcohol syndrome or reactive attachment disorder with no follow-up from their adoption agencies puts them at great risk.

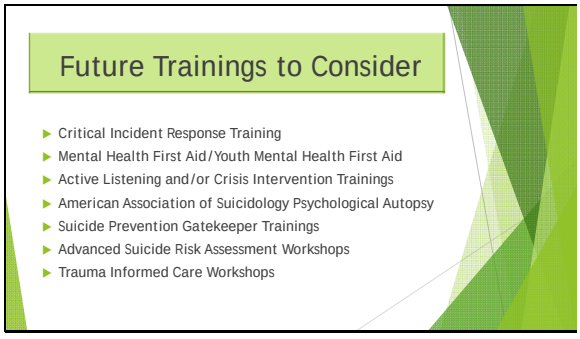
Slide 89



Families are telling us that they are at their limit when they say things like “I want to kill this kid.” In fact, about 1⁄3 of parents are saying these words. Are we taking the time to do a thorough risk assessment of these families by a qualified, trained professional that knows how to listen non-judgmentally? With 40% of our child protective

investigators saying that a child abuse death is a freak accident and 72% saying they are worried about a child dying and 95% saying that they are assessing, the numbers just don't add up. If we are assessing and doing an excellent job linking families and children to services and providing resources with adequate follow-up and follow-through, why are we so worried? When training clinicians in suicide risk assessment and intervention skills, most are terrified to talk to someone that is at risk and fear asking the suicide question. Some have never asked the suicide question at all, ever. If we are too afraid to listen to suicide, are we also too afraid to hear the dark, murky feelings of parents and children dealing with mental illness?

Slide 90



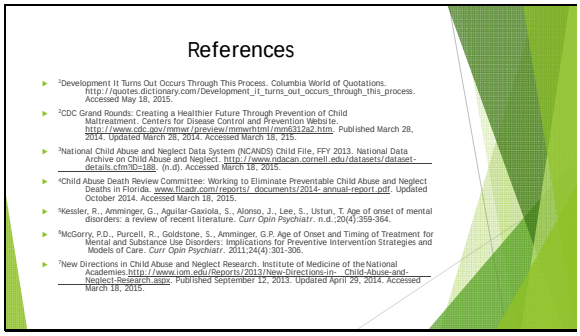
Training alone does not work. People need to practice their skills. Active listening is learned by practicing. Suicide interventions are done well only by practicing and listening to a parent at their wit's end by a child, or a terrified child at

home who doesn't know how to talk to anybody. We have to practice. I am a huge advocate of role plays. Knowledge based workshops are only helpful if you practice implementing the information. These trainings that I have listed here are excellent content-based workshops, and I implore each of you to look at this list and find trainings that can help you understand much more fully mental health and suicide risks. Even with these trainings, it is important that we practice. With 15 years of suicide intervention skills, I still feel it is essential to sharpen my skills by practicing with others.

Slide 91

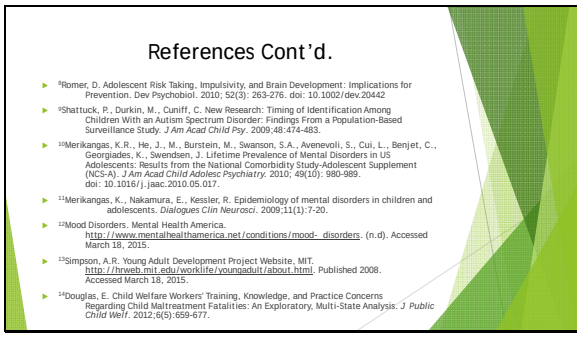
If you have any questions about the information presented today, please do not hesitate to contact me at the email provided here. I would be happy to discuss trainings and opportunities for you to participate in mental health and suicide prevention, intervention, and/or post-vention and role-play workshops in the future. Thank you so much for your time.

Slide 92



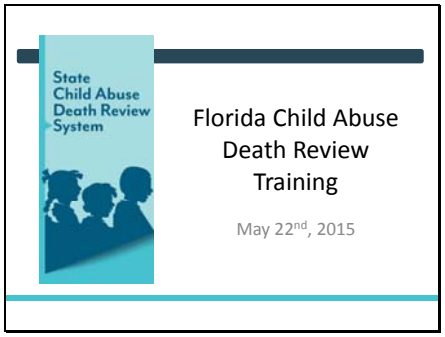
I have also included in here references from the presentation,if you would like to go back through and take a look at these articles that I have pulled information from.

Slide 93



Thank you again for listening and taking the time.

Slide 94



Thank you Ms. Witmeier for your very informative presentation and thoughts on this salient topic, and a very special thank-you to all of our presenters and to you, all local Child Abuse Death Review Committee members that have viewed this webinar and will utilize additional resources to better advance your knowledge about the dynamics and impact upon our children and families of domestic violence, substance abuse, and mental health disorders when there is a co-occurrence of child maltreatment. Thank you for

your service to Florida's children and families, and have a good day.