

**Sexual Abuse Protection: Parent Treatment (Non-Protecting Parents)
Intake Assessment**

Client Name: *Sample Provider*

Client DOB: *XX/XX/XXXX*

Date of Report: *XX/XX/XXXX*

(Due to Optum TERM within 14 calendar days of the initial authorization start date)

I received and reviewed the following records provided by the PSW (required prior to the intake assessment):

- Detention Hearing Report
- Jurisdiction/Disposition Report
- Copies of significant additional court reports
- Copies of all prior psychological evaluations and Treatment Plans for the client
- All prior mental health and other pertinent records
- Copies of History & Physical and Discharge Summary written by psychiatrist
- For Voluntary Services cases: Summary of case information and protective issues

Facilitator: <i>Sample Therapist</i>	Phone: <i>xxx-xxx-xxxx</i>	Agency: <i>Sample Agency</i>
SW Name: <i>Sample PSW</i>	SW Phone: <i>xxx-xxx-xxxx</i>	SW Fax: <i>xxx-xxx-xxxx</i>
Date of Intake: <i>xx-xx-xxxx</i>		
Service Delivery Type: Telehealth <input type="checkbox"/> In-Person <input checked="" type="checkbox"/>		Service delivery type has been assessed: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
DEMOGRAPHIC INFORMATION		
<p>The client is <i>Choose an item</i> and self-identifies as Female. The client’s preferred language is English. Client states that the reason for referral to treatment is [brief description reflecting client’s understanding for referral]: <i>Client shared her child reported husband had sexually abused her, and client stated to felt confused and not knowing if the report had been true; so when her child told the school, CPS removed her child.</i></p> <p>This case is currently Pre-Jurisdiction. Client is ambivalent about the allegations of sexual abuse.</p> <p>Client or family have immigrated to the United States to escape war, persecution, or poverty <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If “Yes”, describe how immigration history and/or cultural/identity factors may have influenced client’s understanding of the protective issues or willingness to collaborate with CFWB <i>N/A</i></p>		

Treatment Plan Samples Are Purely Fictional Examples and Do Not Represent an Actual Client

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MENTAL STATUS EXAM & ASSESSMENT RESULTS

Mental Status/Psychiatric Symptom Checklist:

The following current symptoms were reported and observed:

- | | | | |
|---|---|---|--|
| <input checked="" type="checkbox"/> Anhedonia | <input type="checkbox"/> Dissociative reactions | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Isolation |
| <input type="checkbox"/> Anxious mood | <input type="checkbox"/> Distorted blame | <input type="checkbox"/> Homicidality | <input type="checkbox"/> Psychomotor agitation |
| <input type="checkbox"/> Appetite disturbance | <input type="checkbox"/> Distressing dreams | <input type="checkbox"/> Hopelessness | <input checked="" type="checkbox"/> Sleep disturbance |
| <input type="checkbox"/> Avoidance | <input type="checkbox"/> Euphoric mood | <input type="checkbox"/> Intrusive memories | <input checked="" type="checkbox"/> Somatic complaints |
| <input type="checkbox"/> Concentration challenges | <input type="checkbox"/> Euthymic mood | <input type="checkbox"/> Irritable mood | <input type="checkbox"/> Suicidality |
| <input checked="" type="checkbox"/> Denial | <input type="checkbox"/> Exaggerated startle response | | <input type="checkbox"/> Other: |
| <input checked="" type="checkbox"/> Depressive mood | <input type="checkbox"/> Fatigue | | |

Screening Tool Results (indicate name and results of all tests administered):

Michigan Alcohol Screening Test (MAST)	Score: 2 Rating: No Apparent Problem
Drug Abuse Screening Test (DAST)	Score: 0 Rating: Problem Not Likely
Other Screening Tool Administered:	Results:
Other Screening Tool Administered:	Results:

Strengths and Barriers (indicate client's readiness to change, barriers to treatment, and strengths):

Level of commitment to attend, participate and change through the treatment program. This commitment may vary from none to a moderate level of commitment at the time of intake:

Client is appropriate for Sexual Abuse Protection group treatment (non-offending/non-protecting parents)
Additional suggestions to SW for adjunctive treatment while client is in Sexual Abuse Protection group (if applicable):
Client has been able to maintain full time employment and be financially independent from husband.

- Client is **not** appropriate for Sexual Abuse Protection group (client to be discharged)
Reason/s client is not appropriate for group at this time:
- Actively abusing drugs & alcohol; chemical dependency treatment is to precede treatment for child abuse
 - Seriously emotional disturbance, requires that appropriate psychiatric and medical care to be addressed prior to group involvement
 - Unable to tolerate involvement in a group (e.g., due to personality characteristics)
 - Other (describe):

Recommended alternative treatment:

Additional information referring party should know, including additional clinical concerns that require adjunctive treatment:

Date SW Notified: *Click or tap to enter a date.*

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DIAGNOSIS

List the appropriate diagnoses. Record as many coexisting mental disorders, general medical conditions, and other factors as are relevant to the care and treatment of the individual.

The Primary Diagnosis should be listed first.

ICD-10	DSM-5-TR Diagnosis
T74.02XA	Child Neglect, Confirmed, Initial Encounter

GOALS TO ADDRESS IN TREATMENT

Based on Levenson & Morin (2001) *Treating Nonoffending Parents In Child Sexual Abuse Cases: Connections For Family Safety*, Table 1.2 Criteria for Determining Non-offending Parent’s Competency for Reducing the Risk of Child Sexual Abuse (CSA).

- Name or describe at least 5 feelings parents have when their child has been sexually abused
- Describe and discuss parent’s own feelings since finding out about the sexual abuse
- Describe strategies the parent has used for expressing or managing these feelings in appropriate, adaptive ways
- Describe the five types of denial of sexual abuse
- Discuss own denial in group, reasons for the denial, and triggers for denial.
- Spontaneously place responsibility for the abuse on the offender
- Describe ways in which sexual abuse affects children
- Spontaneously express empathy in group for the child and what the child has experienced
- Share in group the specific statements and behaviors parent has provided to the child that reflect support, acceptance, and validation
- Identify the emotional and/or behavioral effects of child sexual abuse and how to effectively and appropriately manage them if they appear.
- If sexually abused as a child, can spontaneously describe how own abuse affected parent’s ability to recognize or intervene in her child’s sexual abuse
- Describe offender patterns of grooming, triggers, and/or opportunities/high risk situation
- Describe offender’s relapse prevention plan and how parent will support partner’s relapse prevention plan
- Describe components of safety planning: prevention and intervention
- Describe own prevention plan to keep child safe
- Describe own intervention plan that parent will use if needed to keep child safe
- Spontaneously describe how these prevention and intervention strategies have been implemented or are in process of being implemented
- Name or describe at least 5 feelings parents have when their child has been sexually abused

Additional Treatment Goals (if indicated for this client):

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PROVIDER INFORMATION

Provider Printed Name: <i>Sample Provider</i>	License/Registration #: <i>XXXXxxxxx</i>
Signature: <i>Sample Provider Signature</i>	Signature Date: <i>xx/xx/xxxx</i>
Provider Phone Number: <i>xxx-xxx-xxxx</i>	Provider Fax Number: <i>xxx-xxx-xxxx</i>

If an intern or practicing at the CASOMB Associate level of certification:

Supervisor Printed Name:	License type and #:
Supervisor Signature:	Date: Click or tap to enter a date.

Submit Group Intake and Progress Report Forms to Optum TERM at Fax: 1(877) 624-8376. Optum TERM will conduct a quality review and will be responsible for forwarding approved reports to the SW.

Date faxed to **Optum TERM at: 1-877-624-8376:** Click or tap to enter a date.

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