TERM Treatment Plan Documentation Resources

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Prepared By:

Optum

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Dear TERM Provider:

As a TERM provider, you play a valuable role in the team effort to reduce the risk of abuse and neglect in families involved with the Child and Family Well Being Department (CFWB). In developing treatment plans for your CFWB clients, please keep in mind that different standards of documentation apply due to the legal context and high-risk nature of the clinical work.

Because of the potential impact on legal proceedings and family reunification, it is essential that treatment plans clearly and accurately document the client's progress. This includes addressing relevant focus areas, detailing the clinical interventions and methods used, and describing the client's response to treatment. To enhance readability for non-clinical professionals (e.g., attorneys, judges), a standardized, behaviorally based reporting format should be used.

"TERM Treatment Plan Documentation Resources" were developed as a collection of resources aimed at assisting you with writing treatment plans in this forensic context. The documents contained in this resource are for informational purposes and do not constitute treatment advice. We hope that these resources will help you to work more efficiently to meet the needs of your clients. Ultimately, a well-written treatment plan may also reduce requests for additional information concerning case status, or the need for you to be called to court to provide clarifying testimony.

Please feel free to contact us at 877-824-8376 (Option 1) for any questions about TERM guidelines or processes. We also appreciate any ideas you may have to help us serve you better. Thank you for partnering with Optum TERM in serving the clients of the County of San Diego.

Respectfully,

Optum TERM Team

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Treatment Plan Quality Assurance Checklist

- The Treatment Plan Quality Assurance Checklist is a resource for providers to use to ensure that treatment plans follow TERM guidelines and contain all of the basic elements.

Treatment Plan Quality Assurance Checklist

- ❑ Treatment plan submitted regardless of funding source.
- ❑ Treatment plan submitted according to required timelines regardless of number of sessions.
- ❑ Treatment plan is typed on current template and no section is left blank.
- ❑ The treatment plan addresses all safety/risk concerns and mental health symptoms identified on the CFWB Therapy Referral Form, background records, and provider's clinical assessment.
- ❑ Service delivery type is noted and supported by the treatment plan documentation.
- ❑ Focus of Treatment areas address all the safety and risk concerns.
- ❑ Client progress is documented and related specifically to the identified Focus of Treatment. Documentation includes evidence-informed interventions appropriate to the client's developmental level and cultural and treatment needs. Documentation includes the client's response (or lack thereof) to the identified interventions.
- ❑ Treatment plan updates contain at least one active Focus of Treatment being addressed.
- ❑ Discharge summary reflects circumstances of discharge and the date and coordination with the PSW.
- ❑ Diagnoses are consistent with the available documentation, clinical symptom checklist, and client's presentation. All diagnoses included on the CFWB referral form are considered.
- ❑ Treatment plan is written in impartial and unbiased language.
- ❑ Any recommendations offered are within the scope of provider's license and role as a provider and the clinical rationale is clearly stated.
- ❑ Treatment plan reflects the plan was discussed with the client, either by client signature, or by provider documentation of review with the client if seen by telehealth.
- ❑ Treatment plan is signed by therapist (and by the supervisor for interns). A digital signature is acceptable.
- ❑ Internal consistency within the documentation (i.e. correct name of client/family members, background and clinical information corresponds with the client/family information identified on the referral form, no clinical information pertaining to non-clients).
- ❑ Confidentiality is maintained in the treatment plan documentation and does not include details of an atonement letter, client quotes, or confidential details of a safety plan.

CFWB Treatment Plan Samples

- Included in this resource are sample treatment plans for a parent, a child, and a conjoint therapy case. The treatment plan samples are a mixture of hypothetical examples and are not intended to be a template for treatment plans. While documentation of objective, descriptive behavioral indicators of progress is necessary in order to best inform CFWB and the court, we are sensitive to your time and do not require long narratives. We encourage you to discuss and even make a draft of the content of the treatment plans with your client in session so that completing them takes minimal time on the computer. The sample plans include examples of language to assist you with the level of behavioral detail that will best inform CFWB and the court.

- The applicable **Focus of Treatment** areas should be selected from the drop down menus based on the clinician's review of the CFWB referral form and background records and the client's initial intake assessment. You may also select "Other" when additional areas of focus are indicated and specify the other focus area(s). Additional rows may be added. When the client is a parent, the treatment plan should always include Enhancing Parenting Skills as a focus of treatment to address the parenting concerns identified on the CFWB referral form. When the client is a child, the treatment plan should always include Resiliency Enhancement as a focus of treatment.

- **Initial Assessment** documentation should reflect the clinician's own observations, assessments, clinical impressions, and recommendations based on review of the referral, background records, and initial intake assessment. It should include the intended clinical interventions to address the Focus of Treatment.

- **Progress Update** documentation should reflect the client's progress in treatment in the identified focus area, the interventions utilized, and how the client is responding (or is not) to the interventions. Any adjustments to the clinical interventions utilized should also be addressed. The documentation should provide specific behavioral details and examples showing how the risk has been reduced, and progress has been made by the individual client. This may include changes in the client's attitudes, beliefs, and behaviors as reported by the client, reliable collateral sources, or the clinician's own observations. Generic statements, such as, "client has made excellent progress" will result in a request to update the documentation to include behavioral examples that substantiate the progress.

- Any areas needing additional clarification or documentation may be included in the **Additional Comments** box.

Child and Family Wellbeing
Initial Treatment Plan/Treatment Plan Update: PARENT

Client Name: Sample Parent Client DOB: XX\XX\XXXX Date: 6/20/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

This report is a(n):	☐	**Initial Treatment Plan**	☒	**Treatment Plan Update**	☐ **Discharge Summary**
Modality:	☒	**Individual**	☐	**Conjoint/Family**	

ATTENDANCE

Date of Initial Session: 4/1/2025	Last Date Attended: 6/17/2025	Total Number of Sessions Attended: 11
Date of Absences: 5/6/2025	Reasons for Absences: Client was sick. She cancelled her appt in advance	
Service Delivery Type: Telehealth ☒ In-Person ☐	Service delivery type has been assessed and continues to be clinically appropriate: Yes ☒ No ☐	

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

☒ CFWB Background Records (e.g. case plan and pertinent court reports)
☐ Copies of available prior psychological/psychiatric evaluations and treatment plans
☒ CFWB Release of Information
OR
☐ I have not received CFWB background records. Date records requested from PSW: Click or tap to enter a date.

ASSESSMENT OF RISK FACTORS

Risk assessment should be ongoing and include all risk factors documented on the 04-176A and known to the provider. Risk factors that will be a focus of treatment must be documented in the clinical progress sections below. Please refer to Clinical Risk Documentation guidance in TERM Treatment Plan Documentation Resources.

Dates of Assessment: 6/30/2025

- ☒ Suicidal ideation
- ☐ Suicidal plan
- ☐ Suicidal intent
- ☐ History of self-harm/attempt
- ☐ Homicidal ideation
- ☒ History of harm to others/attempt
- ☐ History of trauma or abuse
- ☐ Reasonable probability of significant deterioration in an important area of life functioning

Distress, disability, or dysfunction in:

- ☒ Social/Relational
- ☐ Occupational
- ☐ Other important activities

Child and Family Wellbeing
Initial Treatment Plan/Treatment Plan Update: PARENT

Client Name: Sample Parent Client DOB: XX\XX\XXXX Date: 6/20/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

- ☐ Homicidal plan
- ☐ Homicidal intent
- ☐ Substance abuse
- ☐ Reasonable probability of not progressing developmentally as appropriate

CLIENT SYMPTOM CHECKLIST

The following *current* symptoms were reported and/or observed:

- ☐ Angry mood
- ☒ Anhedonia
- ☐ Anxious mood
- ☐ Appetite concerns
- ☐ Avoidance
- ☒ Concentration challenges
- ☐ Denial
- ☒ Depressive mood
- ☐ Derealization
- ☐ Distorted blame
- ☐ Distressing dreams
- ☐ Euphoric mood
- ☐ Euthymic mood
- ☐ Exaggerated startle response
- ☐ Fatalistic cognitions
- ☒ Fatigue
- ☒ Fear of being alone
- ☐ Flashbacks
- ☐ Grandiose cognitions
- ☐ Hallucinations
- ☐ Helplessness
- ☒ Hopelessness
- ☐ Hypervigilance
- ☒ Intrusive memories
- ☐ Irritable mood
- ☐ Isolation
- ☐ Memory challenges
- ☐ Physiological reactions to trauma reminders
- ☐ Psychomotor agitation
- ☒ Sleep disturbance
- ☐ Somatic complaints
- ☐ Other:

TREATMENT PROGRESS

INSTRUCTIONS: It is essential that therapists working with CFWB parents accept the true finding of the Juvenile Court as a fact of the case. If CFWB offers the family Voluntary Services instead of filing a petition with the Court to take jurisdiction, a true finding does not apply; however, the therapist is expected to accept the allegations of abuse as facts of the case.

Identify the applicable focus of treatment area from the drop-down menu. Document progress since last treatment report. Progress should include information pertaining to evidence-informed interventions utilized and client's response to the clinical interventions (i.e., changes in the client's attitudes, beliefs, and behaviors as reported by parent, SW, and behavior observations of parent in sessions). Documentation of progress reflects therapist's clinical assessment of progress rather than client's direct statements or quotes. For each update, please include new progress in applicable section and do not delete previous entries. Please note when a treatment area is no longer an active focus of clinical attention.

Add/delete rows as needed.

Child and Family Wellbeing
Initial Treatment Plan/Treatment Plan Update: PARENT

Client Name: Sample Parent Client DOB: XX\XX\XXXX Date: 6/20/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

FOCUS OF TREATMENT: Enhancing parenting skills

Initial Assessment: 4/1/25 - The client acknowledged the concerns regarding her neglect of her child's needs that led to CFWB involvement and expressed a willingness to work on enhancing her parenting skills. Client reported she is also participating in a weekly parenting class. Treatment will include the client developing an understanding of her children's developmental stages and having reasonable expectations for her children's behaviors. LCSW will utilize psychoeducation to teach and enhance positive parenting skills learned in the client's parenting class, and CBT interventions to identify and dismantle any cognitive distortions that she has regarding her child's behavior.

First Update: 6/20/25 - The client is making meaningful progress in this area. Sessions have included psychoeducation regarding co-regulation with her 4 year old child, and strategies to support and redirect when the child becomes dysregulated. She is benefiting and shows a positive response to the psychoeducation on child development and CBT strategies, and has shared how she is incorporating these in her parenting. Her responses reflect a growing shift from viewing the child's tantrums and emotional dysregulation as an attention seeking or defiant behavior, to demonstrating empathy to these behaviors as an emotional response to past trauma and as age appropriate development. She is beginning to prepare proactively for visits with her child by planning for age appropriate activities to do together, and thinking about how she will respond if the child becomes upset, by getting down on child's level, offering calming words, and role model breathing.

Second Update:

Third Update:

Fourth Update:

FOCUS OF TREATMENT: Mental health stabilization

Initial Assessment: 4/1/25 - Client presents with flat affect and depressed mood, tangential thoughts, slow speech, and reported having trouble sleeping. Client has experienced these symptoms nearly every day for the past several months, and meets criteria for a diagnosis of Major Depressive Disorder. Client reported believing her symptoms are currently related to her child's removal, however noted she has experienced previous depressive episodes in the past. Client signed an ROI for her psychiatrist. Her psychiatrist reports meeting regularly with her and states she is taking her medication as prescribed. Client verbalized some insight into situations which trigger her depressive symptoms. She was unable to identify a coping skill that she can access when her symptoms arise. LCSW will utilize a combination of psychoeducation to teach and model coping skills and emotional regulation strategies, and CBT interventions to identify cognitive distortions and replace negative thought patterns with healthier thoughts.

Child and Family Wellbeing
Initial Treatment Plan/Treatment Plan Update: PARENT

Client Name: Sample Parent Client DOB: XX\XX\XXXX Date: 6/20/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

First Update: 6/20/25 - Client is making consistent progress in reducing her depressive symptoms. She currently presents with a more euthymic mood and congruent affect, and is experiencing no adverse affects to her medications. Her sleep has improved and she has been able to go to work on a consistent basis. Client has been utilizing thought stopping strategies, the ABC strategy, and grounding exercises. The client's mood log has demonstrated an increase in emotional regulation. The client is beginning to see herself as capable of financial independence and capable of improving her parenting skills, and feels hopeful for the future of her family. She has implemented a walking routine with a neighbor and is benefiting from increasing her support system.

Second Update:

Third Update:

Fourth Update:

FOCUS OF TREATMENT: Safety planning for risk factors

Initial Assessment: 4/1/25 - Client reported that in 2022 she experienced symptoms of depression due to relationship conflict and thought she would take a bottle of Tylenol. Client shared she took several pills and then changed her mind. She reported no prior history of psychiatric hospitalization. Risk assessment was completed in initial assessment and she denied any current suicidal ideation, homicidal ideation and auditory or visual hallucinations. Safety planning will be addressed throughout the course of treatment as needed, and client was provided with the Access & Crisis Line number in the initial session. Due to client's previous history of suicidal ideation, ongoing risk assessments will be completed, as well as collaboration with the client's psychiatrist and PSW.

First Update: 6/20/25 - Risk assessment has been completed in each session and the client has consistently reported no current feelings of SI or indications of risk of self harm. The client acknowledged that she was in a dark place in 2022 when she previously experienced SI, and that she currently feels she has much to live for, including her child. She has gained insight into her emotional triggers, which include feeling overwhelmed, feeling lonely, and feeling ashamed, and can now identify two coping strategies that help when she begins to feel this way. She continues to add to her safety plan, and knows she can reach out to her neighbor or the Access and Crisis Line if she feels unsafe. The client reports her medication has also helped stabilize her mood.

Second Update:

Third Update:

Fourth Update:

FOCUS OF TREATMENT: Trauma processing

Child and Family Wellbeing
Initial Treatment Plan/Treatment Plan Update: PARENT

Client Name: Sample Parent Client DOB: XX\XX\XXXX Date: 6/20/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

Initial Assessment:	4/1/25 - The client reported a history of childhood trauma, including exposure to intimate partner violence and parental substance abuse as a child, as well as a history of being a victim of interpersonal violence in her most recent relationship. The CFWB referral indicated a past diagnosis for Post Traumatic Stress Disorder. Client is reporting some trauma related symptoms, including recurrent intrusive thoughts regarding past trauma and inability to concentrate. LCSW will continue to assess if diagnostic criteria is met for PTSD. LCSW will help the client develop a genogram to identify intergenerational patterns of intimate partner violence and identify cultural belief systems regarding IPV and substance abuse. LCSW will utilize CBT, narrative therapy, and teach relaxation and grounding strategies to support the client in processing traumas experienced as a child and as an adult, and explore how they may be impacting her.
First Update:	6/20/25 - The client has begun to process past trauma and has completed an ACES questionnaire with a score of 8. As she has increased her capacity for emotional regulation and developed new coping strategies, she has been more open to sharing details regarding her past traumas from childhood and adulthood. She benefitted from completing a genogram and was able to draw connections from her own exposure to parental substance abuse and IPV as a child to her own adult relationships. She is able to acknowledge that her parents did not meet her needs for physical and emotional safety growing up, and has developed a deeper understanding of unhealthy relationship patterns she was modeled. She is continuing to explore how these affect her current thoughts and behaviors, and is working on identifying clear protective actions she can take now as a parent herself to provide her children with a different experience.
Second Update:	
Third Update:	
Fourth Update:	

FOCUS OF TREATMENT: Intimate partner violence prevention

Initial Assessment:	4/1/25 - The client acknowledges being the victim of interpersonal violence which has contributed to CFWB involvement. She reported she has been involved in two prior domestic violence relationships and described feeling overwhelmed by the current involvement with child welfare. She feels blamed and ashamed for what has happened. Treatment will focus on supporting the client in increasing her understanding of the effects of IPV on children, understanding the power and control wheel and relating it to her own situation, identifying red flags for unhealthy relationships, increasing her support system, and developing a safety plan for protecting herself and her children if/when needed. LCSW will utilize a combination of psychoeducation, bibliotherapy, motivational interviewing.
First Update:	6/20/25 - The client has been motivated to address her past relationships and is in the action stage of change. She has demonstrated a high level of insight and self-awareness, and has maintained no contact with her former partner. She has benefited from psychoeducation and

Client Name: Sample Parent Client DOB: XX\XX\XXXX Date: 6/20/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

bibliotherapy on IPV and is now able to verbalize some understanding of the stages of the cycle of violence. She has been exposed to the Power and Control Wheel and is beginning to identify red flags for unhealthy relationships from her former relationships. Her articulations demonstrate a growing shift from feeling blamed to feeling more empowered and supported to make positive changes for herself and her child. She also has been provided various community resources by this clinician. She will continue to work on this measure and expand her safety plan, and work towards increasing her support system to include 5 safe contacts.

Second Update:

Third Update:

Fourth Update:

DISCHARGE SUMMARY

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

Reason for Discharge:

☐ Successful completion/met goals ☐ Poor attendance ☐ Office of Child Safety Case Closed

☐ Other (specify):

PARENT SIGNATURE

I have discussed this treatment plan with my provider.

Parent Signature: _____ Date: _____

For telehealth services: Please review the treatment plan with the client and document the date.
Date reviewed: 6/13/2025

DIAGNOSIS

List your diagnostic impressions of the parent. Record as many coexisting mental disorders, general medical conditions, and other factors as are relevant to the care and treatment of the individual. All diagnoses identified on the CFWB referral should be included as endorsed, rule out, or criteria not met. If diagnosis was made by previous provider and is being maintained by history, state so.

The Primary Diagnosis should be listed first

ICD-10 Code	DSM-5-TR Diagnosis
F33.1	Major Depressive Disorder, Recurrent Moderate, without Psychotic Features
T74.11XD	Spouse or Partner Violence, Physical, Confirmed, Subsequent Encounter

Child and Family Wellbeing
Initial Treatment Plan/Treatment Plan Update: PARENT

Client Name: Sample Parent Client DOB: XX\XX\XXXX Date: 6/20/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

Z63.0	Relationship Distress with Spouse or Intimate Partner
F43.10	R/O Post-Traumatic Stress Disorder, Unspecified

ADDITIONAL COMMENTS

Any recommendations offered are within the scope of provider's role as a TERM provider and the clinical rationale is clearly stated.

4/1/25: The client has signed an ROI for this LCSW to collaborate with her other treatment providers, including her psychiatrist and IPV group facilitator. Client does not have access to a vehicle, therefore telehealth will be utilized to support accessibility. The client has been assessed as appropriate for telehealth treatment due to having a private secure space and reliable technology to access telehealth, and demonstrates sufficient stability to engage in this modality. The client is also reporting financial stress due to now being a single income family. The client could benefit from referrals to additional resources that may be available to her through CFWB, such as resources for food, child care, and health care access.

6/20/25: Client has had reliable child care for her 4 year old during therapy sessions while child is in school, however during the summer she needs support to make an alternate plan for care during sessions.

PROVIDER SIGNATURE

Provider Printed Name: XYZ Therapist	License/Registration type and #: LCSW #12345
Signature: *XYZ Therapist*	Signature Date: 6/20/2025
Provider Phone Number: 000-000-0000	

REQUIRED FOR INTERNS ONLY

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

Submit Initial Treatment Plan/Update as per the authorized reporting schedule to Optum TERM at Fax: 1(877) 624-8376. Optum TERM will conduct a quality review and will be responsible for forwarding approved Quarterly Progress Reports to the Protective Services Worker.

For Medi-Cal funding: Authorization for continued services is dependent on Medical Necessity review of the treatment plan. Providers will be notified of determination within fourteen (14) business days of treatment plan submission.

Child and Family Well-Being
Initial Treatment Plan/Treatment Plan Update: CHILD/YOUTH

Client Name: Sample Child Client DOB: XX/XX/XXXX Date: 1/5/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

This report is a(n):	☐	**Initial Treatment Plan**	☒	**Treatment Plan Update**	☐ **Discharge Summary**
Modality:	☒	**Individual**	☐	**Conjoint/Family**	

ATTENDANCE

Date of Initial Session: 9/1/2024	Last Date Attended: 12/15/2024	Total Number of Sessions Attended: 10
Date of Absences: 10/13/2024, 11/17/2024	Reasons for Absences: Client sick, Therapist vacation	
Service Delivery Type: Telehealth ☐ In-Person ☒	Service delivery type has been assessed and continues to be clinically appropriate: Yes ☒ No ☐	

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

☒ CFWB Background Records (e.g. case plan and pertinent court reports)
☐ Copies of available prior psychological/psychiatric evaluations or treatment plans
☒ Copy of the latest CANS
☒ Consent to Treat (04-24P or 04-24C)
☒ CFWB Release of Information
OR
☐ I have not received CFWB background records. Date records requested from PSW: Click or tap to enter a date.

ASSESSMENT OF RISK FACTORS

Risk assessment should be ongoing and include all risk factors documented on the 04-176A and known to the provider. Risk factors that will be a focus of treatment must be documented in the clinical progress sections below. Please refer to Clinical Risk Documentation guidance in TERM Treatment Plan Documentation Resources.

Dates of Assessment: 12/15/2024

- ☐ Suicidal ideation
- ☐ Suicidal plan
- ☐ Suicidal intent
- ☐ History of self-harm/attempt
- ☐ Homicidal ideation
- ☐ History of harm to others/attempt
- ☒ History of trauma or abuse
- ☐ Reasonable probability of significant deterioration in an important area of life functioning

Distress, disability, or dysfunction in:

- ☐ Social/Relational
- ☐ Academic
- ☐ Other important activities

Child and Family Well-Being
Initial Treatment Plan/Treatment Plan Update: CHILD/YOUTH

Client Name: Sample Child Client DOB: XX/XX/XXXX Date: 1/5/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

- ☐ Homicidal plan
- ☐ Homicidal intent
- ☐ Substance abuse
- ☒ Reasonable probability of not progressing developmentally as appropriate

CLIENT SYMPTOM CHECKLIST

The following *current* symptoms were reported and/or observed:

- ☐ Abusive to animals (not better explained by sensory seeking behaviors)
- ☐ Aggression
- ☐ Anger
- ☐ Arguing
- ☐ Appetite concerns
- ☐ Attention span concerns
- ☐ Bullying
- ☒ Concentration challenges
- ☐ Crying easily
- ☐ Destroying property
- ☐ Developmentally inappropriate sexual behaviors
- ☐ Disinhibited attachment
- ☐ Dissociative behaviors
- ☐ Inappropriate defiance
- ☐ Eager to please
- ☐ Eloping behaviors
- ☐ Excessive sensory seeking behaviors
- ☐ Fatigue
- ☐ Fire setting
- ☐ Gastrointestinal concerns
- ☐ Hyperactivity
- ☐ Hypertonia
- ☐ Hypervigilance
- ☐ Hypotonia
- ☐ Irritability
- ☐ Lonely
- ☐ Lying
- ☐ Nightmares
- ☐ Screaming
- ☐ Self-esteem problems
- ☐ Separation anxiety
- ☐ Shyness
- ☐ Sleep problems
- ☒ Somatic complaints
- ☐ Stealing
- ☐ Stimming behaviors
- ☐ Stubborn
- ☐ Temper tantrums
- ☐ Unexplained fear
- ☐ Withdrawn
- ☒ Worry
- ☐ Social isolation
- ☐ Other:

Client Name: Sample Child Client DOB: XX/XX/XXXX Date: 1/5/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

TREATMENT PROGRESS

INSTRUCTIONS: Identify the applicable focus of treatment area from the drop-down menu. Document progress since last treatment report. Progress should include information pertaining to evidence-informed interventions utilized and client's response to the clinical interventions (i.e., changes in the client's attitudes, beliefs, and behaviors as reported by caregiver, SW, collateral contacts and behavior observations of client in sessions). Documentation of progress reflects therapist's clinical assessment of progress rather than client's direct statements or quotes. For each update, please include new progress in applicable section and do not delete previous entries. Please note when a treatment area is no longer an active focus of clinical attention.

Add/delete rows as needed.

FOCUS OF TREATMENT: Exposure to domestic violence and there are behavioral and/or emotional issues

Initial Assessment:	9/1/2024 The child was exposed to domestic violence between mother and the father, including strangulation. Child called the police which led to CFWB involvement. The client has identified the following feelings: sadness and anxiety when she thinks of being separated from her siblings, anger toward father for the domestic violence toward her mother, and confusion regarding lack of protection from her mother. The client has various cognitive distortions of the domestic violence between parents being her fault. The client has been able to identify getting an upset stomach when discussing memories of domestic violence witnessed. Interventions will include TF-CBT, art therapy, and Imagery.
First Update:	12/15/2024 The client is in the beginning stages of participating in appropriate TF-CBT worksheets to identify generalized thoughts and feelings. She has also utilized feelings face charts to identify feelings she has had in various situations. "Stop, Think, and Relax" therapeutic board game has been introduced and appears to assist client with increasing her ability to recognize the concept of cognitions. The client is beginning to differentiate between cognition and feelings. Age-appropriate worksheets have been introduced with the client for increasing recognition of when distorted cognitions take place, thought stopping, and replacing with more balanced thoughts.
Second Update:	
Third Update:	
Fourth Update:	

FOCUS OF TREATMENT: Other (please document specific focus) Increase safety skills and develop an individualized safety plan

Initial Assessment:	9/1/2024 The CFWB case plan involves reunification, and the parents are engaged in treatment per collateral report. The Client has not had the opportunity to develop any safety plan related to the DV she was exposed to. She appears to guard relevant information to procuring her safety. Interventions will include psychoeducation, TF-CBT, play therapy.
First Update:	12/15/2024 She has currently identified 2 safe adults in her life that she can turn to in the event she feels unsafe. She is working on different safe words she can use with various people in her life. The client can identify 9-1-1 as a safe number to call and is currently memorizing personalized safe phone numbers. She has utilized the "red flag/green flag"

Client Name: Sample Child Client DOB: XX/XX/XXXX Date: 1/5/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

	props to identify various unsafe situations. The dollhouse has also been used by the client, where she appears to re-enact witnessing domestic violence scenarios. The client is attempting to work through the trauma of domestic violence she has witnessed through her play therapy, as well as identifying safety skills during such play. This therapist has utilized age-appropriate books with client that discuss various abuse situations to increase client's general/and personal knowledge of abuse situations and domestic violence dynamics. To date, the client has been able to identify screaming, hitting, and choking as part of domestic violence dynamics she witnessed.
Second Update:	
Third Update:	
Fourth Update:	

FOCUS OF TREATMENT: Resiliency enhancement

Initial Assessment:	9/1/2024 Client identifies as smart, funny, and a good friend. Interventions to include art therapy and TF-CBT (feelings identification, feelings thermometer). Ongoing assessment as to whether a caregiver will be available to engage in the trauma narrative portion of TF-CBT. Focus will be around enhancing the Client's natural strengths in support of positive self-image.
First Update:	12/15/2024 Client completed a vision board to support decision-making and goal setting. Her goal for the next year is to join a sport, baseball likely, and to earn better grades by studying and surrounding herself with positive influences. She's identified her baseball coach and math teacher as positive influences.
Second Update:	
Third Update:	
Fourth Update:	

FOCUS OF TREATMENT: Recent placement change

Initial Assessment:	9/1/2024 The CFWB case went from Maintenance to Reunification when the TRO was violated 4 months ago. Since moving into a foster home, the Client's symptoms intensified, complaining of more stomach aches and trouble concentrating at school. Caregiver shared that the Client worries about the future, including whether her parents will be successful in their mandated treatment. Interventions to include art therapy and imagery.
First Update:	12/15/2024 Client completed a vision board that allowed her to process feelings related to her regulation in the family home vs how she feels when surrounded by people she's identified to be safe. Therapist led client through guided imagery exercise to support regulation around anxiety that her parents will not maintain her safety. She benefited from visualizing her grandmother's home in the mountains.
Second Update:	
Third Update:	
Fourth Update:	

Child and Family Well-Being
Initial Treatment Plan/Treatment Plan Update: CHILD/YOUTH

Client Name: Sample Child Client DOB: XX/XX/XXXX Date: 1/5/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

DISCHARGE SUMMARY

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

Reason for Discharge:
☐ Successful completion/met goals* ☐ Poor attendance ☐ Office of Child Safety Case Closed
☐ Other (specify):

TREATMENT PLAN REVIEW

☒ I have reviewed this plan with the youth in an age/developmentally appropriate manner. Date of review: 12/15/2024

DIAGNOSIS

List your diagnostic impressions of the child/youth. Record as many coexisting mental disorders, general medical conditions, and other factors as are relevant to the care and treatment of the individual. All diagnoses identified on the CFWB referral should be included as endorsed, rule out, or criteria not met. If diagnosis was made by previous provider and is being maintained by history, state so.

The Primary Diagnosis should be listed first

ICD-10 Code	DSM-5-TR Diagnosis
F43.22	Adjustment Disorder with Anxiety
T76.02XD	Child Neglect, Confirmed

ADDITIONAL COMMENTS

Any recommendations offered are within the scope of provider's role as a TERM provider and the clinical rationale is clearly stated.

9/1/2024 Appropriate Release of Information to collaborate with client's caregivers was obtained. Given the client's age (11yo) and developmental stage, in-person is the most appropriate service delivery type. R/O PTSD due to anxiety related symptoms, exposure to dv (including strangulation).

10/12/2024 Caregivers recently requested telehealth due to scheduling challenges, however, based on the interventions that the client is benefitting from, in-person is the recommended service delivery type. This provider

Client Name: Sample Child Client DOB: XX/XX/XXXX Date: 1/5/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

intends to continually monitor and assess the client's readiness and appropriateness for the caregiver's requested service delivery type.

PROVIDER SIGNATURE

Provider Printed Name: XYZ Therapist	License/Registration type and #: 7777
Signature: *XYZ Therapist*	Signature Date: 1/5/2025
Provider Phone Number: 619-000-0000	Provider Fax Number: 619-111-1111

REQUIRED FOR INTERNS ONLY

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

Submit Initial Treatment Plan/Update as per the authorized reporting schedule to Optum TERM at Fax: 1(877) 624-8376. Optum TERM will conduct a quality review and will be responsible for forwarding approved Quarterly Progress Reports to the Protective Services Worker.

For Medi-Cal funding: Authorization for continued services is dependent on Medical Necessity review of the treatment plan. Providers will be notified of determination within fourteen (14) business days of treatment plan submission.

Child and Family Well-Being
Initial Treatment Plan/Treatment Plan Update: CHILD/YOUTH

Client Name: Conjoint Sample - Child's Name Client DOB: XX/XX/XXX Date: 3/15/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

This report is a(n):	☐	**Initial Treatment Plan**	☐	**Treatment Plan Update**	☒ **Discharge Summary**
Modality:	☐	**Individual**	☒	**Conjoint/Family**	

ATTENDANCE

Date of Initial Session: 9/29/2024	Last Date Attended: 3/15/2025	Total Number of Sessions Attended: 17
Date of Absences: 10/13/2024, 1/19/2025	Reasons for Absences: Client sick, family emergency	
Service Delivery Type: Telehealth ☐ In-Person ☒	Service delivery type has been assessed and continues to be clinically appropriate: Yes ☒ No ☐	

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

☒ CFWB Background Records (e.g. case plan and pertinent court reports)
☐ Copies of available prior psychological/psychiatric evaluations or treatment plans
☒ Copy of the latest CANS
☒ Consent to Treat (04-24P or 04-24C)
☒ CFWB Release of Information
OR
☐ I have not received CFWB background records. Date records requested from PSW: Click or tap to enter a date.

ASSESSMENT OF RISK FACTORS

Risk assessment should be ongoing and include all risk factors documented on the 04-176A and known to the provider. Risk factors that will be a focus of treatment must be documented in the clinical progress sections below. Please refer to Clinical Risk Documentation guidance in TERM Treatment Plan Documentation Resources.

Dates of Assessment: 3/15/2025

- ☐ Suicidal ideation
- ☐ Suicidal plan
- ☐ Suicidal intent
- ☐ History of self-harm/attempt
- ☐ Homicidal ideation
- ☐ History of harm to others/attempt
- ☒ History of trauma or abuse
- ☐ Reasonable probability of significant deterioration in an important area of life functioning

Distress, disability, or dysfunction in:

- ☐ Social/Relational
- ☐ Academic
- ☐ Other important activities

Client Name: Conjoint Sample - Child's Name Client DOB: XX/XX/XXX Date: 3/15/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

- ☐ Homicidal plan
- ☐ Homicidal intent
- ☐ Substance abuse
- ☐ Reasonable probability of not progressing developmentally as appropriate

CLIENT SYMPTOM CHECKLIST

The following *current* symptoms were reported and/or observed:

- ☐ Abusive to animals (not better explained by sensory seeking behaviors)
- ☐ Aggression
- ☐ Anger
- ☐ Arguing
- ☐ Appetite concerns
- ☐ Attention span concerns
- ☐ Bullying
- ☐ Concentration challenges
- ☐ Crying easily
- ☐ Destroying property
- ☐ Developmentally inappropriate sexual behaviors
- ☐ Disinhibited attachment
- ☐ Dissociative behaviors
- ☐ Inappropriate defiance
- ☐ Eager to please
- ☐ Eloping behaviors
- ☐ Excessive sensory seeking behaviors
- ☐ Fatigue
- ☐ Fire setting
- ☐ Gastrointestinal concerns
- ☐ Hyperactivity
- ☐ Hypertonia
- ☐ Hypervigilance
- ☐ Hypotonia
- ☐ Irritability
- ☐ Lonely
- ☐ Lying
- ☐ Nightmares
- ☐ Screaming
- ☐ Self-esteem problems
- ☐ Separation anxiety
- ☐ Shyness
- ☐ Sleep problems
- ☐ Somatic complaints
- ☐ Stealing
- ☐ Stimming behaviors
- ☐ Stubborn
- ☐ Temper tantrums
- ☐ Unexplained fear
- ☐ Withdrawn
- ☐ Worry
- ☐ Social isolation
- ☒ Other: Hx of domestic violence, disruption of placement and substance misuse.

Client Name: Conjoint Sample - Child's Name Client DOB: XX/XX/XXX Date: 3/15/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

TREATMENT PROGRESS

INSTRUCTIONS: Identify the applicable focus of treatment area from the drop-down menu. Document progress since last treatment report. Progress should include information pertaining to evidence-informed interventions utilized and client's response to the clinical interventions (i.e., changes in the client's attitudes, beliefs, and behaviors as reported by caregiver, SW, collateral contacts and behavior observations of client in sessions). Documentation of progress reflects therapist's clinical assessment of progress rather than client's direct statements or quotes. For each update, please include new progress in applicable section and do not delete previous entries. Please note when a treatment area is no longer an active focus of clinical attention.

Add/delete rows as needed.

FOCUS OF TREATMENT: Exposure to domestic violence and there are behavioral and/or emotional issues

Initial Assessment:	9/29/2024 The family became involved with CFWB in August, 2024 after child alerted police of a domestic violence dispute that involved strangulation. The family followed the safety plan from the start of their case. The parents acknowledged learning about potential impacts of DV and how trauma can impact a child's perception of themselves and others. The therapist provided age-appropriate psychoeducation on trauma, its impact on the brain, and the importance of safety in healing from traumatic events. In response, the parents and child identified external triggers that contribute to becoming emotionally dysregulated and identified bodily cues related to emotional dysregulation. Interventions will include psychoeducation, and Attachment, Regulation, and Competency (ARC).
First Update:	12/15/2024 Therapist and clients reviewed what they learned in their individual and group therapy. Therapist facilitated the parents' understanding and concern for the impact previous DV had on their child. The parents were able to apologize to their child and communicated they did not expect the child to manage the safety of the home. The family is using the therapy-led establishment of rituals and routines to support the child's sense of safety. Using ARC, the parents reinforced the child's statements with specific praise and expressed gratitude for the child sharing about his feelings upon accurate affect identification and the child's affect expression. The therapist assisted the family with holding appreciation and understanding of the shared traumatic experiences for the family as a whole and as individuals.
Second Update:	3/15/2025 Parents shared that they will each continue individual therapy after their CFWB case closes to ensure that they have access to support and resources that will support maintenance of their progress. The last quarter focused on the child's return to a more developmentally appropriate trajectory, including enrollment in sports and a more positive self-identity. Parents have consistently attuned to the child and responded consistently to his needs in therapy. The parents shared that they will also be participating in the child's outpatient, individual TF-CBT for trauma processing.
Third Update:	
Fourth Update:	

Client Name: Conjoint Sample - Child's Name Client DOB: XX/XX/XXX Date: 3/15/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

FOCUS OF TREATMENT: Conjoint therapy (please document specific focus) Improve Communication Skills.

Initial Assessment: 9/29/2024 Parents described how their substance abuse histories, peers, and relationship conflict impacted their communication with their child. Therapist provided psychoeducation related to communication styles and elicited feedback from the family regarding their own assessment of communication style. Using ARC, therapist supported the mother in managing her reactive affect as she moved from defensiveness to acceptance of child's communication around how often he was yelled at or ignored. Interventions to include psychoeducation and ARC.

First Update: 12/15/2024 Therapist used My Emotional Cup to support the parents' understanding of the child's needs. The family was led in identifying their own internal bodily cues in effort to effectively respond when regulation/co-regulation is needed. Therapist will continue to coordinate care with the child's individual therapist (ROI on file), emphasizing the developmental expectation that he be supported by parents in his use of coping strategies when feeling sad/angry.

Parents verbalized a commitment to remain non-violent and agreed to remind each other that they are on the same parenting team when addressing the child's needs.

Second Update: 3/15/2025 The family reunified this quarter. Therapy sessions leading up to the reunification focused on review and rehearsal of effective communication and emotion regulation skills. Parents demonstrated effective use of skills in sessions and described how they've been successful at home as well. Child's individual therapist shared that he's been able to utilize the tools he's learned with his family, in individual therapy (parents started joining in preparation for trauma processing). Therapist used Safe House intervention to highlight the family's progress in this goal. The family's Safe House is founded on calm communication and prevention vs reaction.

Third Update:

Fourth Update:

FOCUS OF TREATMENT: Resiliency enhancement The parents will increase safety skills for themselves and their child.

Initial Assessment: 9/29/2024 Therapist coordinated with the parents' group and individual therapists, and child's individual therapist, in preparation for conjoint therapy (ROIs of file). Therapist assessed the child's readiness for conjoint therapy via own clinical assessment and coordination of care with child's individual therapist. Interventions will include psychoeducation, ARC

Therapist supported the family in developing a safety plan that included the identification of shared red flags, the need for time-outs, and appropriate use of assertive communication. The parents agreed to modeling resolution of age-appropriate disagreements in the presence of the child to mitigate any anxiety about his safety. Due to substance abuse history, parents identified maternal grandmother as a safe caregiver to child in the event of a relapse. Child shared that he feels safe in his current placement and identified his teacher and therapist as safe adults that he can trust with any decompensation in safety.

Client Name: Conjoint Sample - Child's Name Client DOB: XX/XX/XXX Date: 3/15/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

	Therapist provided age-appropriate psychoeducation related to trauma, its impact on the brain, and the importance the safety be a goal for each member of the family.
First Update:	12/15/2024 During Safe House intervention, each member shared individual skills learned in therapy to support the family's shared thoughts on what a safe home is like. Parents were led in interventions to support their identification of the child's affect. Therapist supported the family in further identifying steps to take to enhance the psychological safety in the home in preparation for reunification.
Second Update:	3/15/2025 The family reunified during this quarter. Sessions leading up to reunification focused on creating a welcoming, safe environment for the child such as replacing broken doors (reminder of DV), covering electrical outlets. During the final session, the family reviewed their safety plan, updated it to reflect the current living situation, and discussed how each family member contributes to the overall sense of safety.
Third Update:	
Fourth Update:	

DISCHARGE SUMMARY

Date of Discharge: 3/15/2025	Date SW Notified: 3/7/2025

Reason for Discharge: Family successfully met treatment goals and reunified as of 3/8/2025.

☒ Successful completion/met goals* ☐ Poor attendance ☐ Office of Child Safety Case Closed
☐ Other (specify):

TREATMENT PLAN REVIEW

☒ I have reviewed this plan with the youth in an age/developmentally appropriate manner. Date of review: 3/15/2025

DIAGNOSIS

List your diagnostic impressions of the child/youth. Record as many coexisting mental disorders, general medical conditions, and other factors as are relevant to the care and treatment of the individual. All diagnoses identified on the CFWB referral should be included as endorsed, rule out, or criteria not met. If diagnosis was made by previous provider and is being maintained by history, state so.

Child and Family Well-Being
Initial Treatment Plan/Treatment Plan Update: CHILD/YOUTH

Client Name: Conjoint Sample - Child's Name Client DOB: XX/XX/XXX Date: 3/15/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

The Primary Diagnosis should be listed first

ICD-10 Code	DSM-5-TR Diagnosis
Z69.011	Other circumstances related to child neglect, encounter for mental health services for perpetrator of parental child neglect
Z63.0	Relationship distress with spouse or intimate partner
Z65.3	Problems related to other legal circumstances

ADDITIONAL COMMENTS

Any recommendations offered are within the scope of provider's role as a TERM provider and the clinical rationale is clearly stated.

Clients became involved with CFWB because of child exposure to intimate partner violence. The father has a DUI on record, creating issues with gainful employment. Coordination of care with PSW and other providers revealed that clients both developed their individual safety plans and demonstrated an understanding of the cycle of violence and a commitment to remain non-violent. Provider completed safety/IPV risk assessment of both parents separate from session with child. During intake, it was confirmed that group therapy had been successfully completed prior to conjoint therapy. All clients denied any SI/HI and substance abuse. Therapist secured ROIs to support coordination of care with the parents' group and individual therapists and the child's individual TERM therapist.

PROVIDER SIGNATURE

Provider Printed Name: XYZ Therapist	License/Registration type and #: LPCC 7777
Signature: *XYZ Therapist*	Signature Date: 3/15/2025
Provider Phone Number: 619-000-0000	Provider Fax Number: 619-111-1111

REQUIRED FOR INTERNS ONLY

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

Submit Initial Treatment Plan/Update as per the authorized reporting schedule to Optum TERM at Fax: 1(877) 624-8376. Optum TERM will conduct a quality review and will be responsible for forwarding approved Quarterly Progress Reports to the Protective Services Worker.

Client Name: Conjoint Sample - Child's Name Client DOB: XX/XX/XXX Date: 3/15/2025

Provider Name: XYZ Therapist PSW Name: ABC PSW

For Medi-Cal funding: Authorization for continued services is dependent on Medical Necessity review of the treatment plan. Providers will be notified of determination within fourteen (14) business days of treatment plan submission.

Clinical Risk Documentation and Safety Plan Guidelines

- Risk assessments play a vital role in the treatment of all clients and allow you to intervene and address any issues which could lead to decompensation or harm. The following section outlines guidelines for completion of clinical risk assessment and safety.

Clinical Risk Documentation

General Considerations for Clinical Risk Documentation
• Providers should be familiar with the current empirical literature on risk factors that best predict the abuse and re-abuse of children when conducting clinical risk assessments and developing treatment plans for children and their families.
• Treatment plan documentation should reflect comprehensive clinical assessment and reassessment of special status situations, including but not limited to risk of harm and abuse, suicidal or homicidal ideation, self-injurious behaviors, and substance use. It is also important to document the absence of such conditions.
• A thorough risk assessment also reviews any risky behaviors (e.g., non-compliance with medications, presence of psychosis), any plans related to suicidal or homicidal ideation, lethality of the plans and availability of means to execute the plans, and consideration of current psychosocial stressors that may have an impact on the overall risk assessment.
• The risk assessment should include a balanced assessment of client strengths and protective factors.
• Risk assessments should be conducted at the initiation of treatment, throughout the treatment process, and prior to discharge.
• Clients should be involved in the process of addressing risk issues, including the development of crisis and safety plans, removal of means to harm, and other safety measures appropriate to the individual and the situation.
• Although identified risk factors may not necessarily constitute a primary protective issue, good clinical care indicates that all providers assess, intervene, and clearly document client risk factors. It is crucial that your ongoing risk assessments are documented in the client's medical record and treatment plans.
• Treatment plan updates should reflect documentation of any changes in the identified risk factors during the reporting period.
Documentation of Risk Factor
• Documentation regarding the risk factor should be included in the following areas of the treatment plan: A. A formal Focus of Treatment for Safety Planning for Risk Factors should be included in the treatment plan for all active risk factors along with documentation of provider efforts to reduce the risk. B. In the progress section, describe how client is responding to the interventions and any changes in the degree of risk.

Safety Plan Guidelines

General considerations for the development of a safety plan

- The safety plan is a written document created by the client with the assistance of the therapist.
- The safety plan documents how threats to safety of the child(ren) and/or non-protecting parent will be managed.
- Safety planning should be individualized for each client with the goal of reducing immediate and long-term risks.
- The safety plan must specify, in behavioral terms, how the case-specific risk factors will be addressed.
- Safety plans developed for clients receiving therapy via telehealth should include emergency contacts and review of crisis response and other relevant resources nearby the client's geographic location.
- The safety plan should be regularly reviewed and refined over the course of therapy as new risks, safety goals, or risk management strategies are identified.

Child Protection Safety Plan

A. The safety plan must address what needs to happen so that the child(ren) will be safe in their family or home environment, including emotional as well as physical safety and well-being. It must address specific behaviors and steps the parent/caregiver will take to prevent future abuse or neglect. These action steps must be very specific and incorporate the case-specific risks identified in the Therapy Referral Form.

B. This includes specific external or internal triggers or conditions under which the child may be put at risk (e.g., poor attachment to child because child is not biologically related; low frustration tolerance; work-related stressors; emotional changes; fatigue; negative self-talk; red flag words or behaviors used by self or others; high risk situations; thoughts of violent or abusive acts; physical changes signaling increased stress).

C. The plan should identify what the parent/caregiver will do if the identified triggers or "red flags" occur and should consider and address specific steps to prevent abuse, such as:

a. Time out steps to control violent or abusive acts
b. Steps to ensure the child(ren)'s safety
c. Positive activities for stress management
d. Commitment to remain non-violent and non-abusive
e. Rehearsal of safety plan steps when appropriate

D. The plan should include development of an extensive safety network of support adults. **For client protection, please do not release information pertaining to the client's safety plan (i.e., emergency contacts, shelters, etc.).**

E. A sample Child Protection Safety Plan template is available as a resource to assist with safety planning, but use of the template is *not* required. The template is a therapeutic tool which contains suggestions for the therapist to review with the client when they discuss prevention; however, is not intended as treatment advice or a boiler plate plan for what the client will do.

Intimate Partner Violence Safety Plan

A. The following guidelines are intended to provide assistance with safety planning in Child and Family Wellbeing (CFWB) cases involving intimate partner violence.

B. **Submission of written intimate partner violence safety plans to CFWB is not required. For client protection, please do not release this information.**

C. The intimate partner violence safety plan is intended to facilitate empowerment of the victim/ survivor by providing concrete steps for preventing exposure to future acts of physical or emotional abuse through proactive behaviors.

D. The intimate partner violence safety plan should address the emotional as well as physical and technological safety and well-being of the child(ren) and identified victim(s). The identified action steps and behaviors must be very specific and must incorporate the case-specific risks identified in the Therapy Referral Form that the client and therapist are addressing.

E. Protective actions include identification of specific triggers or conditions under which the adult victims and child(ren) may be put at risk. These triggers may be external or internal to the adult victim AND /OR to the offending parent that signal danger. These are best organized on a continuum from earliest warning signs to signs of imminent danger.

F. The safety plan should identify what the victim parent will do if the identified triggers or "red flags" occur.

G. The plan should consider and address client logistics, support system, and access to specific resources such as:

a. Emergency phone numbers (police, crisis lines, battered women's hotlines, safe individuals in their support system)
b. List of available resources (legal guidance, medical, advocacy)
c. List of phone numbers to shelters, safe houses, or other safe places where the client can go
d. Temporary Restraining Order information
e. Concrete behavioral steps to take in an emergency
f. Rehearsal of safety plan steps when appropriate
g. Consideration of safety in the workplace
h. Consideration of technological safety

H. A sample personalized safety plan for domestic violence survivors can be found online at https://www.ncbi.nlm.nih.gov/books/NBK64443/ (Accessed May 2024)

Child Protection Safety Plan

It is necessary to learn new ways to prevent risk of harm to your child. With the assistance of your therapist, you will develop a safety plan that includes the development of a safety network and specifically addresses every 'red flag' or warning sign for harm that you have identified in therapy so that you can provide safety to your child.

Internal Red Flags	
Physical Signs	**What I Will Do In Response To Each Red Flag**
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
Emotional Signs/Self Talk	**What I Will Do In Response To Each Red Flag**
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
External Red Flags	
Environmental Stress	**What I Will Do In Response To Each Red Flag**
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Partner/Caregiver/Childs Words or Actions	What I Will Do In Response To Each Red Flag
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Physical Signs/Signs Pointed Out By Others	What I Will Do In Response To Each Red Flag
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

High Risk Situations	What I Will Do To Avoid or Prevent These Situations
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Time-Out Steps
1. Be aware of your level of stress.
2. Take a cool-down right away. Let partner know that you need to take a time-out or cool-down to prevent increased feelings of frustration, anger, or possible harm to your child.
3. Take a time-out or cool-down every time you think your anger is starting to climb by recognizing your physical and emotional cues and leave the situation (place or person). Identify primary feelings and interrupt negative self-talk.
4. Do not swear, raise your voice, threaten, or use any intimidating behavior.
5. Go somewhere and try to relax and think positively about yourself. It may help to walk, jog, or do deep breathing to get some tension out. **Do not drive, drink alcohol, or take drugs.**
6. Do not use "time out" as a punishment for your partner or to avoid responsibilities when you can appropriately handle them.
My personal time out strategy is:

Be Proactive	
It is important to take positive steps to reduce stress such as exercise programs, 12 step programs, or other positive activities. Some proactive things I can do to reduce stress are:	
Activity	**Who To Contact/What To Do**
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

For client confidentiality, please DO NOT RELEASE this information

Safety Network/Emergency Contact(s)

Contact	Phone Number
In case of an Emergency	9-1-1
Access and Crisis Line	1-888-724-7240
Child and Family Wellbeing Hotline	1-800-344-6000
Friend _____	_____
Friend _____	_____
Family Member _____	_____
Family Member _____	_____
Clergy _____	_____
Sponsor _____	_____
Case Worker _____	_____
Probation Officer _____	_____
Legal _____	_____
Medical _____	_____
Other _____	_____
Other _____	_____