TERM Child Sexual Abuse Protection Treatment Standards for Non-Offending/Non-Protecting Parents

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Optum gratefully acknowledges the collaboration of County of San Diego HHSA Child Welfare Services in the development and writing of these Standards.

Optum TERM: Important Updates to TERM Child Sexual Abuse Protection Treatment Standards for Non-Offending/Non-Protecting Parents

Dear TERM Provider:

The TERM Child Sexual Abuse Protection Treatment Standards for Non-Offending/Non-Protecting Parents have been revised to reflect the following:

- **Role of the Provider (page 11)**
  - Updated to reflect the Current CWS therapy referral process.

Optum TERM staff can be reached at (877) 824-8376, Option 4 for any questions about these updates. Thank you for working with Optum in serving clients of the county of San Diego.

Respectfully,

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TERM Clinical Program Manager

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TERM Child Sexual Abuse Protection Treatment Standards for Non-Offending/Non-Protecting Parents

Introduction

Optum TERM is an acronym for Optum Treatment and Evaluation Resource Management, a mental health oversight unit developed under the direction of the County of San Diego Board of Supervisors and operated by Optum through a contract with the County of San Diego HHSA Behavioral Health Services. Optum TERM's mission is to improve the quality and appropriateness of mental health services provided to children and families involved with Child Welfare Services (CWS) and the Juvenile Probation Department.

The current standards were developed for TERM treatment providers for rendering the best possible services to families affected by child sexual abuse and maltreatment, and should be used as the standards for the Child Sexual Abuse Non-Offending/Non-Protecting Parent groups—and/or individual therapy if required—delivered to clients referred by San Diego County Child Welfare Services.

Definitions

Child sexual abuse (CSA) is defined as follows by the California Welfare and Institutions Code 300 (d): The child has been sexually abused, or there is a substantial risk that the child will be sexually abused, as defined in Section 11165.1 of the Penal Code, by his or her parent or guardian or a member of his or her household, or the parent or guardian has failed to adequately protect the child from sexual abuse when the parent or guardian knew or reasonably should have known that the child was in danger of sexual abuse.

California Penal Code 11165.1 states: As used in this article, "sexual abuse" means sexual assault or sexual exploitation as defined by the following:

(a) "Sexual assault" means conduct in violation of one or more of the following sections: Section 261 (rape), subdivision (d) of Section 261.5 (statutory rape), 264.1 (rape in concert), 285 (incest), 286 (sodomy), subdivision (a) or (b), or paragraph (1) of subdivision (c) of Section 288 (lewd or lascivious acts upon a child), 288a (oral copulation), 289 (sexual penetration), or 647.6 (child molestation).

(b) Conduct described as "sexual assault" includes, but is not limited to, all of the following:

(1) Penetration, however slight, of the vagina or anal opening of one person by the penis of another person, whether or not there is the emission of semen.

(2) Sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person.

(3) Intrusion by one person into the genitals or anal opening of another person, including the use of an object for this purpose, except that, it does not include acts performed for a valid medical purpose.

(4) The intentional touching of the genitals or intimate parts, including the breasts, genital area, groin, inner thighs, and buttocks, or the clothing covering them, of a child, or of the perpetrator by a child, for purposes of sexual arousal or gratification, except that it does not include acts which may reasonably be construed to be normal caretaker responsibilities; interactions with, or demonstrations of affection for, the child; or acts performed for a valid medical purpose.

(5) The intentional masturbation of the perpetrator's genitals in the presence of a child.

(c) "Sexual exploitation" refers to any of the following:

(1) Conduct involving matter depicting a minor engaged in obscene acts in violation of Section 311.2 (preparing, selling, or distributing obscene matter) or subdivision (a) of Section 311.4 (employment of minor to perform obscene acts).

(2) A person who knowingly promotes, aids, or assists, employs, uses, persuades, induces, or coerces a child, or a person responsible for a child's welfare, who knowingly permits or encourages a child to engage in, or assist others to engage in, prostitution or a live performance involving obscene sexual conduct, or to either pose or model alone or with others for purposes of preparing a film, photograph, negative, slide, drawing, painting, or other pictorial depiction, involving obscene sexual conduct. For the purpose of this section, "person responsible for a child's welfare" means a parent, guardian, foster parent, or a licensed administrator or employee of a public or private residential home, residential school, or other residential institution.

(3) A person who depicts a child in, or who knowingly develops, duplicates, prints, downloads, streams, accesses through any electronic or digital media, or exchanges, a film, photograph, videotape, video recording, negative, or slide in which a child is engaged in an act of obscene sexual conduct, except for those activities by law enforcement and prosecution agencies and other persons described in subdivisions (c) and (e) of Section 311.3.

(Amended by Stats. 2014, Ch. 264, Sec. 1. Effective January 1, 2015.)

According to County of San Diego HHSA Child Welfare Services, a *Non-Offending Parent* is a parent who did not commit acts of sexual abuse against the child victim. Non-Offending Parents include both the *Non-Protecting Parent* and the *Protecting/Protective Parent*. A *Non-Protecting Parent(s)* allowed the abuse to occur or continue because they failed to engage in acts of protection. The non-protective parent may be custodial or non-custodial.

Non-protective acts include, but are not limited to:

- Leaving victim alone with offender after disclosure was made
- Failing to report victim's disclosure to appropriate authorities
- Failure to believe the victim's disclosure

- Blaming the victim for the abuse
- Not consistently supporting the victim emotionally
- Supporting/believing perpetrator denials

Protecting/Protective Parents **consistently** engage in acts of protection and support the victim and siblings.

Acts of protection include, but are not limited to:

- Believing the victim's disclosure
- Ensuring that the offender does not have access to the victim and other potential victims
- Making supportive statements to the victim and siblings
- Participating in appropriate therapy that supports the victim's healing
- Testifying in support of the victim in Court

The goal of treatment is to address the issues presented by the Non-Offending/Non-Protecting Parent and to provide psycho-educational treatment, specific to the client's case and individual circumstances, that facilitate achievement of consistent engagement in acts of protection and victim/sibling support (i.e., promoting the client's movement from a non-protecting to a protecting parent).

Prevalence

According to a national study by the U.S. Department of Health and Human Services (2012), it was estimated that annually just over 70,000 children under the age of 18 are sexually abused; however, this figure is believed to be grossly underestimated due to high rates of non-disclosure by sexual abuse survivors. Based on a meta-analysis of research findings, an estimated 25-30% of females and 13% of males experience sexual abuse during childhood in the United States (Bolen, 2002). The National Center for Posttraumatic Stress Disorder (NCPTSD) estimates that as many as 10% of boys and 25% of girls are victims of some form of sexual abuse in the United States (Whealin & Barnett, 2009). Levenson & Morin (2001) estimate that less than half of all sexual abuse is ever reported. Of the cases investigated by police, only about 20% result in arrest. Out of the arrests, only 1 in 3 results in an adjudication.

Cultural Factors

Optum TERM requires approved providers to deliver services that are culturally responsive. Such services meet the needs of a community with diverse cultures and linguistic needs. For this reason, Optum TERM's operational definition of "diversity" includes a broad range of dimensions including race, ethnicity, language, national origins, sexual orientation, sexual identity, age, disabilities, religion/spirituality, and groups from a diversity of backgrounds, situations, and environments. Providers are required to complete a minimum of four hours of continuing education each year in the area of cultural competency. The four hours of cultural competency training required by Fee For Service Medi-Cal network will also satisfy the TERM network cultural

competency requirement.

In providing culturally responsive treatment of non-protecting parents in child sexual abuse cases, it is important to be aware that for many ethnic groups, there is a stronger emphasis on preserving family unity than in Anglo cultures. For example, mothers from cultural backgrounds that adhere to rigid patriarchal norms identified themes such as value conflicts regarding family preservation, torn loyalty between the offending partner and child victim, and anxieties around being alienated from their extended family and ethnic community as a result of the disclosure of the sexual abuse (Alaggia, 2002). Due to the discrimination and marginalization associated with race and gender, many women of ethnic minorities may experience complex reactions to child sexual abuse (Miller-Clayton, 2010).

In recent-immigrant communities where some residents may not be legal citizens, disclosing sexual abuse to child protection or law enforcement authorities can be especially risky for youth as well as adults who suspect child sexual abuse, since removal of an offender may jeopardize other family relations through citizenship status checks and the threat of deportation (Aronson Fontes & Plummer, 2010). In communities of color in the U.S., long histories of distrust toward social welfare and law enforcement agencies may hinder the willingness of youth or adults to disclose child sexual abuse or to report suspected sexual abuse to authorities. Racial and ethnic communities with historical experiences of discrimination stigma may be concerned that “airing dirty laundry” around the prevalence of child sexual abuse in their community could result in outsiders invoking such information to justify further discriminatory treatment (Aronson Fontes & Plummer, 2010). For additional cultural considerations, Saunders, Berliner, & Hanson (2003) provide an overview of subgroups impacted by child sexual abuse.

Standards of Practice

Provider Credentialing

For information on ***Credentialing Standards, the Optum Credentialing Committee, Re-credentialing, Provisional Providers, and Interns*** please refer to the Optum TERM Provider Handbook (Optum website under the TERM Manuals tab) pages 3-7, along with Optum TERM standards for interns and provisional providers.

Provider Privileging Criteria

Provider Training and Experience Requirements

Because of the high risk nature of child sexual abuse, unique risk factors, typical lack of physical findings, likelihood of multiple victims/serial victimization, and potential severity of its impact, it is imperative that mental health providers be trained in appropriate assessment and treatment techniques. For privileging in non-protecting parent child sexual abuse treatment, Optum TERM requires the following:

1. For initial privileging, the provider must be approved by the California Sex Offender Management Board (CASOMB) at the Independent or Associate Level or have been approved by the County of San Diego Probation Department and "grandfathered in" by CASOMB to treat sex offenders at the Independent or Associate level. If the provider's practice includes Non-Protecting Parent clients and does not include sex offenders, then the provider is not obligated to retain CASOMB approval at the required re-certification interval because of the requirement for direct service with sex offenders. If the provider is CASOMB approved at the Associate level and chooses to provide services to Non-Protecting Parent clients, the provider must be supervised by a CASOMB approved provider at the Independent level who also is providing the group. For continued privileging exclusively as an NPP treatment provider, the provider is required to minimally obtain fifteen (15) continuing education credits per licensure cycle in the following areas:
    a. Minimally nine (9) credits per licensure cycle (every 2 years) specifically in core sex offender-related topics, as described on the CASOMB website regarding *Certification and Re-Certification Requirements for Sex Offender Treatment Providers.*
    b. Minimally an additional six (6) credits per licensure cycle (every 2 years) in adjunct sexual abuse-related topics as described on the CASOMB website regarding adjunct training topics in *Certification and Re-Certification Requirements for Sex Offender Treatment Providers*.
2. These continuing education requirements must be BBS/BOP approved continuing education units (CEU).

Recommended training topics include:

1) Trainings in cultural competency: understanding issues of culture, ethnicity, inter-racial relationships, acculturation, immigrant status, citizenship, SES, geographic origin such as rural or urban and the intersection of these factors.

2) Professional standards, guidelines and ethics codes pertaining to the provider's licensure, the provision of forensic mental health services, and the provision of treatment services to sex offenders and non-protecting parents.
3) Legal issues as they relate to child sexual abuse, including mandated reporting requirements.
4) Offender characteristics, risk factors, and risk assessment instruments.
5) Sex Offender treatment models and outcomes published in reputable, appropriate peer-reviewed journals.
6) Characteristics of child sexual abuse in CWS-involved families.
7) Victim memory, disclosure, and issues associated with recantation.
8) Factors and risks associated with crossover offenses (gender and age-related crossover offenses in child sexual abuse; child-adult crossover sexual offending).
9) Crisis Intervention, including suicidality and danger to others.

Providers also are encouraged to read the publications listed in the **Addendum** *Selected Readings* on page 22 and to follow the ongoing research published by these authors and their colleagues.

The following organizations have trainings/conferences as a resource for providers:

1) Association for the Treatment of Sexual Abusers (ATSA)
2) California Coalition on Sexual Offending (CCOSO)

Ethical and Legal Standards

Treatment providers and agencies working with non-protecting parents in child sexual abuse cases must meet the ethics code and professional standards developed by the professional associations with which they are affiliated (e.g., the American Psychological Association, National Association of Social Workers, and the California Association of Marriage and Family Therapists). Treatment providers shall also adhere to the Code of Ethics published by the Association for the Treatment of Sexual Abusers (ATSA) and additional relevant standards and guidelines, such as the *Specialty Guidelines for Forensic Psychology* (2013) published by the American Psychological Association. Much of the content of these *Guidelines* is relevant to all providers, regardless of licensure.

Confidentiality and Consent for Treatment

Optum TERM providers do not have a "typical" provider-client relationship with Child Welfare Services (CWS) clients. The limits of confidentiality are substantially different when performing Court-ordered therapy. In Voluntary Services cases, and when clients participate in services voluntarily in cases that are pre-jurisdiction, the provider also closely collaborates with the Protective Service Worker (PSW). In all circumstances, the provider accepts the documentation provided by CWS as the facts of the case. It is required that all TERM therapists discuss the limitations of confidentiality with all clients (e.g., that information gathered during the treatment process may appear in a treatment plan or progress report reviewed by the PSW and ultimately by the Court; delineating exceptions such as reasonable

suspicion of child abuse, suicidal, or homicidal threats). As part of the informed consent process, providers should also obtain the client's agreement to maintain confidentiality of the other members of the group. The general guideline for ensuring informed consent is that the client must be advised in a language reasonably understandable to him/her and that the client be provided specific information regarding the nature of services, the role of the provider, and confidentiality limitations. Providers are required to appropriately document the consent process in the client's record. For additional guidelines, please refer to Confidentiality and Privilege and Informed Consent sections in Optum TERM Provider Handbook (Optum website under the TERM Manuals tab) page 11.

Role of the Provider

For general information on the role of a TERM provider, please see the Optum TERM Provider Handbook (Optum website under the TERM Manuals tab) pages 25-27.

Consistent with the Levenson & Morin (2001) *Connections for Family Safety* curriculum, non-offending/non-protecting parent treatment is designed to be delivered via group modality. This is considered best practice and is consistent with treatment/management standards and guidelines for adult male sex offenders (cf. the Containment and Comprehensive Models, the San Diego County [undated] *Sex Offender Adult Treatment Standards* v. 2), and the Center for Sex Offender Management treatment and program evaluation documents. Individual treatment is included only under very specific circumstances. If individual treatment is determined to be a required modality, as assessed by the TERM-approved Child Sexual Abuse Non-Offending/Non-Protecting Parent group provider, the individual treatment may only be provided by that same treatment provider or, if necessary, by another provider paneled to provide Child Sexual Abuse Non-Offending/Non-Protecting Parent treatment. Treatment by a provider who is not paneled for this specialty is prohibited due to the lack of requisite education, training, and competence.

- Services should be provided in the most appropriate language as determined by the client, or with the aid of an interpreter; providers should be mindful of the client's level of literacy.
- Providers will make a Child Welfare Services Hotline Report if any new episodes of abuse are disclosed during treatment. The provider also will contact the referring PSW to report this information. Therefore, statements made during the course of treatment may trigger mandated child abuse reporting and providers will immediately report child abuse or neglect pursuant to PC Article 2.5 Child Abuse and Neglect Reporting Act, Section 11166.
- Consistent with the Containment Model, San Diego County *Sex Offender Adult Treatment Standards* v. 2; the 2014 ATSA Practice Guidelines for the Assessment, Treatment, and Management of Male Adult Sexual Abusers; and the 2007 Center for Sex Offender Management Comprehensive Assessment Protocol, it is expected that providers will coordinate care with the referring agency, as well as with all professionals involved in a client's case. To *facilitate effective coordination and communication*, the client's written consent for the provider to exchange information with other appropriate professionals

outside of CWS who are involved in the case should be obtained during the initial intake assessment.

Scope of Treatment

The focus of Child Sexual Abuse Non-Offending/Non-Protecting Parent treatment is on minimizing the risk of future sexual abuse to the victim and/or siblings by increasing the non-protecting parent's ability to protect. This can take many forms and include, but are not limited to: supporting the victim emotionally and ensuring that court orders prohibiting offender contact with the victim and/or siblings are maintained. Specific case-related issues may be included in the Therapy Referral Form provided by the CWS PSW. Minimum scope of treatment and topics to be covered are described in Levenson & Morin (2001) *Treating Non-Offending Parents in Child Sexual Abuse Cases: Connections for Family Safety*.

For all non-offending/non-protecting parent treatment (which is assumed to be group modality unless otherwise determined by the group facilitator), the core curriculum is the Levenson and Morin (2001) *Connections Workbook* and accompanying manual for providers: *Treating Non-offending Parents in Child Sexual Abuse Cases: Connections for Family Safety*. The Manual's Table 1.2: *Criteria for Determining Non-offending Parent's Competency for Reducing the Risk of Child Sexual Abuse (CSA)* (page 24) serves as the outcome criteria by which each parent's progress should be evaluated. Providers are expected to include additional training materials, as indicated, and to utilize the manual in a flexible manner that ensures group treatment optimally addresses members' presenting needs.

Providers also are expected to read, and be familiar with, the Center for Sex Offender Management (CSOM) *Key Considerations for Reunifying Adult Sex Offenders and their Families* (2005). CSOM is funded by the Department of Justice Office on Violence Against Women. This document addresses coordination of care among treatment providers and sex offender treatment considerations in child sexual abuse cases.

Treatment Structure

Groups may be open (accepting new members on an ongoing basis) or closed in structure. The groups may range from a minimum of three (3) to a maximum of twelve (12) clients in any particular treatment group.

Group sessions will be a minimum of one and one half (1.5) hours per session. Initial authorization is for six (6) months. Requests for additional sessions must be communicated proactively to the PSW in writing prior to exhausting the authorization on file and will be considered by CWS on the basis of clinical necessity for addressing the protective issues.

Intake & Assessment

Each client will be evaluated individually at intake. The intake process shall be conducted or supervised by an Independent Practitioner, per California Sex Offender Management Board, as described above. Clients whom treatment providers determine to be inappropriate for group treatment, such as clients with significant mental health concerns or developmental delays,

should be discussed with the referring PSW to determine whether individual treatment, or in-home services, would be indicated instead. Additional client care must be coordinated through the PSW. Providers are required to read the Therapy Referral Form and case background materials, and to use the information contained in these documents and gathered from the initial clinical interview to understand the family dynamics and facts in that particular case. In addition, an assessment of the non-protecting parent's perceptions of the abuse and readiness for change should be conducted in order to inform treatment planning (Saunders et al., 2003).

Intake

The intake process should include a clinical interview, review of collateral records, and formal assessment that covers the following:

- Basic identifying and demographic information (including gender, ethnicity, race, and cultural considerations), educational, military, and occupational history.
- A mental status examination and clinical observations, including potential for harm to self or others (see **Appendix I** *Sexual Abuse Protection: Parent Treatment for Non-Offending/Non-Protecting Parents Mental Status/Psychiatric Symptoms*).
- Assessment of risk of further exposure to victimization (including risk that the victim and/or siblings will be exposed to potential abuse and risk that restraining orders will be violated).
- Assessment of parenting, including names and ages of client's children, client's perception of the impact of her child's CSA on herself and her child(ren), attitude toward parenting, parenting related stress, parenting skills/discipline strategies used by client, ability to manage children's behavior and respond empathically to their needs, and any special needs of the children that require specialized parenting.
- A psychosocial assessment including mental health history, medical history, substance abuse history, cultural history, family of origin, developmental history, relationship history, legal history, religious beliefs, and attitudes related to family cohesion and marriage.
- Assessment of strengths, protective factors, and social support system.
- Psychosocial stressors and barriers to participating in and adhering to treatment.
- History of child welfare involvement.
- Trauma history, including a detailing of the client's abuse and intimate partner violence history, including assessment of each type of abuse, physical, emotional, sexual, and whether or not the child(ren) were present. Independent descriptions should be included from the referring agency and from criminal justice/law enforcement agencies, victims, and other treatment providers as applicable. A history of any other types of trauma (including client's own abuse history as a child, conditions in country of origin, and/or immigration experience, as applicable) and the client's role in the violence should be assessed as well.
- Understanding of the offenses, feelings about the perpetrator, degree of client denial or minimization of the allegations/abuse, client's ability to emotionally support child victim in recovery from abuse, and to financially/physically support self and child(ren) without the

offender in the home.

Formal assessment measures should be used as clinically indicated. Minimum requirements include drug and alcohol screens (DAST and MAST) as a part of the intake and initial assessment process. Providers are encouraged to use other assessment measures to capture an adequate picture of the client's needs and functioning. Gathering as much information as possible is recommended to give providers information about whether or not the client will be able to participate in and benefit from treatment and to guide case-specific treatment planning efforts. For example, if substance abuse or mental health symptoms are too pronounced, further assessment/coordination with the PSW may need to occur. Interventions aimed at addressing identified risk factors should be documented in the clinical record.

Substance Abuse (required)

The client should be screened utilizing the DAST and MAST as outlined in **Appendix II**. A scoring sheet for these required screening measures is included in **Appendix III**. If the initial intake evaluation indicates drug and/or alcohol abuse or dependence, this should be addressed at the onset and within the context of the overall treatment. Providers will notify the PSW if client's substance abuse is so severe that it would impact the client's ability to benefit from Child Sexual Abuse Non-Offending/Non-Protecting Parent treatment.

Mental Health

Since parental mental health is a factor that impacts the child victim's level of distress, assessing and treating mental health concerns of the non-protecting parent is a critical factor (Yancey et al., 2013). Providers may complete a mental health screening tool in order to identify whether there are any mental health issues that need treatment. The results from the mental health screening can help determine whether the client is appropriate for group treatment and to target specific treatment needs. Clients whose mental health symptoms are severe enough to impact their ability to benefit from group treatment should have their symptoms addressed in individual modality with the TERM-approved Child Sexual Abuse Non-Offending/Non-Protecting Parent treatment provider either concomitantly or, if deemed too severe, prior to beginning Child Sexual Abuse Non-Offending/Non-Protecting Parent treatment.

Outcome Measures

The Levenson & Morin (2001) criteria (described above) serve as treatment outcome measures and are referenced in the Quarterly Progress Report.

Treatment Approach

Therapists are required to provide services in a manner that is consistent with professional and legal standards of practice, including the 2014 ATSA Practice Guidelines and Department of Justice CSOM treatment guidelines. The treatment goal is to protect the victim and other potential victims by facilitating the parent's growth from being non-protecting to protecting. The containment model (and its contemporary evolution as the Comprehensive Model) is an

evidence-based approach to sex offender treatment that emphasizes coordination and collaboration with all professionals involved in client care. Treatment providers of non-protecting parents should be familiar with this model in order to ensure varying systems of care are working together to place the victim's needs first. For more information, please see the summary of The Containment Model posted on the California Coalition on Sexual Offending (CCOSO) website.

Group modality is specifically used in treatment of non-protecting parents affected by child sexual abuse because of its therapeutic impact on the negative effects of isolation, stigma, and self-esteem (Hernandez, Ruble, Rockmore, McKay, Messam, Harris, & Hope, 2009). Group treatment provides parents with emotional support, increased parenting skills, and motivational enhancement to improve self-functioning and in turn, the functioning of their children (Lomonaco, Scheidlinger, & Aronson, 2000). Providers should use a strengths-based approach in treatment, including reinforcing parenting skills that are being utilized effectively, while at the same time encouraging development of additional supports and resources (i.e., housing, transportation, childcare; McCurley & Levy-Peck, 2009). It is important in the group setting to use unbiased and non-judgmental wording and refrain from assigning blame. Treatment's ultimate goal is to assist the parent in reducing denial and enhancing the ability to support and protect the victim and siblings. Any approach or practice that blames or intimidates the individual or places the individual in a position of danger is not appropriate. Techniques that increase the level of risk, such as ventilation techniques which encourage or include aggression, are not appropriate.

Within the child sexual abuse non-protecting parent literature, the following approaches have been found to have support for their effectiveness:

Cognitive-Behavioral Therapy (CBT)

CBT is the most commonly used approach in non-protecting parent groups (Hernandez et al., 2009). CBT interventions have been shown to better prepare parents for the child's treatment, to decrease parental feelings of post-traumatic distress, to increase parenting skills, to lower levels of avoidance of abuse-related cognitions and feelings, and have been shown to be associated with reduced parental reports of child sexual behavioral problems (Cohen, Deblinger, Mannarino, & Steer, 2004; Hsu, 2003; Stauffer & Deblinger, 1996). More importantly, these interventions serve to improve overall family functioning.

The primary interventions in CBT group curricula (Corcoran & Pillai, 2008; Deblinger, Stauffer, & Steer, 2001; Hernandez et al., 2009; Stauffer & Deblinger, 1996) include:

- Helping the non-protecting parent cope with their own emotional reactions so they can be more supportive of their children and dispute dysfunctional thoughts with more accurate information about child sexual abuse.
- Educating the non-protecting parent about ways to initiate and maintain open parent-child communication regarding their children's sexually abusive experiences and other sexual concerns.

- Providing non-protecting parent with behavioral management skills to assist them in handling their children's behavioral difficulties and manage sexualized behavior.
- Psycho-education about sexual abuse, the child welfare/legal system, normal/maladaptive childhood sexuality, techniques of offenders, strategies to prevent re-victimization and maintain children's safety.

The above principles are incorporated into the Levenson and Morin (2001) curriculum which serves as the core curriculum of Child Sexual Abuse Non-Offending/Non-Protecting Parent treatment.

Safety Planning and Risk Assessment

According to Levenson and Morin (2001), the Non-Offending/Non-Protecting Parent should have a clear understanding of the effects of sexual abuse on children. The parent must be able to support the child in recovery and must develop a family safety plan including both prevention and intervention strategies. Group treatment should address (Levenson & Morin, 2001): understanding denial; victim and family impact; behavioral, physical, and emotional indicators of sexual abuse in children; implications of own childhood abuse (if applicable); understanding offense patterns and grooming behavior; safety planning (including both prevention and intervention strategies); parenting issues; risk of physical abuse; sensitive management of sexualized behaviors; substance abuse; marital issues (dependency issues, domestic violence); additional considerations regarding the children or victims (including special needs and any problem behaviors and parent's ability to address those); being responsive and empathic to child to reduce impact of trauma, guilt, and shame on child.

Curriculum

Treatment goals should be case specific, based on structured clinical assessment and review of collateral materials supplied by the PSW. Outcomes should be measured by increased safety and capacity for protection of the child(ren). The suggested core topics below should be incorporated into the Child Sexual Abuse Non-Offending/ Non-Protecting Parent curriculum, with additional topics to be added as clinically appropriate at the provider's discretion. The curriculum topics were derived from a variety of approaches described in the literature; for example, *An Integrated Approach to Treating Non-offending Parents Affected by Abuse* (Hernandez et. al, 2009); *Project SAFE* (Hansen et al., 1998; Hsu, 2003; Sawyer et al., 2005); *Treating Non-offending Parents in Child Sexual Abuse Cases* (Levenson & Morin, 2001):

What is Child Sexual Abuse?

- Definitions
- Types of abuse
- Patterns and cycle of child sexual abuse
- Interrelation between child sexual abuse and other types of abuse (i.e., domestic violence, neglect, child physical abuse)

Denial

- How denial manifests in the offender, victim, and non-protecting parent
- Identification of client's feelings about the abuse, including feelings related to all family members (victim, offender, other children, herself)
- Challenges the client might face related to torn loyalties between different parties
- Financial, cultural, and societal pressures

Safety Planning

- Development of a safety plan for parents and child(ren) victims that include:
  - Identification of immediate and long term safety needs of both parent and child(ren)
  - Prevention and intervention strategies, supervision, boundaries, and house rules
  - Building a support system

Profile of a Perpetrator

- Tactics of grooming behavior (if present in their case)
- Recognizing risk of abuse and red flags
- Typology of perpetrators, patterns of perpetration, and cycle of abuse
- Deviant fantasies and perpetrators' cognitive distortions to justify the abuse
- Understanding sex offender treatment
- Containment Model

Legal Aspects

- Effects on immigration status
- Custody and Family Court
- Protective Orders, TROs

Understanding Trauma Responses

- Identifying and addressing grief, loss, guilt, shame, and blame
- Understanding impact of trauma on the individual and family
- Non-protecting parent's own abuse history (if relevant), how it impacts parental role, and response to child(ren)'s abuse

Common Co-occuring Disorders

- Mental health conditions (PTSD, depression, anxiety, and other mental health-related symptoms) and how to address them
- Substance abuse and its impact on the individual and the family system
- Relapse prevention plan for mental health and/or substance abuse

Understanding the Effects of Child Sexual Abuse on Children

- Demonstrates the Skills, Knowledge, Comprehension, Application, and Problem-Solving associated with the impact of child sexual abuse on children (Levenson & Morin, 2001)
- Child's role in parent-child relationships
- Effects of sexual abuse on child's trust development

- Physical and emotional boundaries after sexual abuse

Parenting and Developing the Protective Role

- Demonstrates Skills and Problem-Solving related to protecting children from child sexual abuse and implementing a family safety plan
- Understanding continuum of sex offender typology
- Parenting after sexual abuse
- Improving trust and safety in child's family environment
- Accountability of protective role

Understanding Healthy Relationships

- Assertiveness skills
- If reunification is being considered, has developed and implemented prevention strategies with her own children
- Demonstrates behaviors that support the offender in their relapse prevention plan
- Identifying what factors indicate successful offender treatment
- Cultural and societal influences
- Healthy boundaries in healthy relationships
- Power dynamics in sexual abuse vs. healthy relationships

By the end of treatment, the client should demonstrate the problem-solving skills outlined for the eight (8) competency areas outlined in Table 1.2 (Levenson & Morin, 2001, p. 24).

Documentation Requirements

All providers are expected to keep a clinical record to document service provision, including a progress note of each service provided, intake assessment, documentation of informed consent and coordination of care, Intake Assessment form, Quarterly Progress Reports, and Discharge Summary. For additional documentation requirements refer to **Appendix VIII**.

Treatment Progress Reporting

Intake Assessment forms, Quarterly Progress Reports, and Discharge Summaries are required to be submitted to Optum TERM at 877-624-8376 on the most current version of the required reporting forms (located in **Appendix V** and **VI**). Please note that the most up to date versions of the forms can be located on the Optum website under the TERM Group Standards tab. Once the Intake Assessment form, Quarterly Progress Report, and Discharge Summary have passed clinical review, they will be forwarded by Optum TERM to the client's assigned PSW.

Consistent with emergent values in mental health, transparency and collaboration in the treatment planning process is encouraged, including sharing perceptions of progress with the client. Documentation included in the progress section should be specific to the identified over-arching treatment goals.

Intake Assessment Form

The Intake Assessment form (located in **Appendix V**) shall be completed during the intake process and submitted to Optum TERM **within fourteen (14) days from the date the initial authorization** for treatment is issued. A copy should be maintained in the client's case file.

The Intake Assessment form must include a complete diagnosis, including diagnostic code from the ICD-10 and the corresponding DSM-IV diagnosis or applicable V code. The Intake Assessment should include results of formal assessment measures and case-specific treatment goals that address the identified client risk factors and curricula elements specified above.

Quarterly Progress Reports

A progress report indicating client's individual progress in group treatment should be submitted to Optum TERM **every twelve (12) weeks after the initial plan is submitted**. Quarterly Progress Report forms are located in **Appendix VI**. A copy should be maintained in the client's case file.

Discharge Summary

A Discharge Summary should be submitted to Optum TERM **on completion or termination of services** using the Quarterly Progress Report form (**Appendix VI**). A copy should be maintained in the client's case file. Progress toward treatment goals will be used to determine whether a client will be given a certificate of completion.

A certificate of completion will be given under the following conditions:

- Successful completion of the program with fulfillment of established treatment goals, consistent with Levenson & Morin (2001) Criteria and in consideration of the CSOM (2005) Family Reunification criteria.
- Re-admission following a termination may be permitted based on re-evaluation by the referring agency (CWS) and the treatment provider. If the program is then successfully completed, a certificate should be given.

A certificate of completion will be withheld if:

- Client fails to demonstrate consistent protective behaviors toward the victim and siblings, as described above under definition of Protecting/Protective Parent and as operationalized by the Levenson & Morin (2001) criteria.
- An administrative discharge is given (e.g., Child Welfare Services case is closed).
- An inability to continue in the program (e.g., a move out of state or a referral to another treatment program).
- Violation of the conditions of the client agreement for services (any additional treatment needs must be communicated proactively to the PSW for continuity of care).

Quality Review Process

All Intake Assessment forms, Quarterly Group Progress Reports, and Discharge Summaries are subject to review by an Optum TERM clinician. The goal of the review process is the provision of reports to the Court that meet professional standards of practice and that assists Child Welfare Services with formulating recommendations and the Court with decision-making.

During the quality review process, Intake Assessment forms, Quarterly Group Progress Reports, and Discharge Summaries are reviewed against quality standards as outlined above. The reviewer ensures the guidelines for treatment and client plan requirements are followed. In addition, the following elements are also reviewed:

- Has appropriate assessment and safety planning been completed?
- Are client's current functioning and strengths included, with supportive behavioral examples?
- Are the obstacles to treatment and progress addressed?
- Are the therapeutic interventions cited appropriate to clinical circumstances and consistent with professional standards of care?
- Is progress related to the treatment goals, and is the reader provided with sufficient documentation regarding how the case is progressing?
- Are protective and risk issues listed on the Therapy Referral Form being addressed? Are treatment goals case-specific?
- Is the report objective?

When an Intake Assessment, Quarterly Progress Report, or Discharge Summary does not meet quality review standards, or the reader of the report (e.g., judge, Child Welfare Services, or attorney) expresses concerns or files a complaint, the Optum TERM reviewer may contact the provider by telephone or written correspondence (sent via mail or fax). The reviewer then discusses the specific concerns that were identified. If the provider concurs with these concerns, the provider updates the intake assessment and/or report and forwards it to Optum TERM. The provider has the right to disagree with the Optum TERM reviewer and to decline to submit updated documentation. This may result in notification to Child Welfare Services, and subsequently the Court, that the report did not pass quality review. If this occurs, the provider faces potential sanctions for failure to adhere to established standards for Child Sexual Abuse Non-Offending/Non-Protecting Parent treatment. These include temporary closure to Child Sexual Abuse Non-Offending/Non-Protecting Parent treatment referrals while the provider obtains additional education and training or removal from the treatment panel. In addition, at any time, Optum TERM may choose to implement the complaint process if there are significant concerns regarding the work product or if there are ongoing issues that cannot be resolved. Per contractual agreement, Optum TERM panel providers are required to comply with quality improvement initiatives, including the quality review and complaint resolution processes.

Actions related to complaints could include, but are not limited to, the following: responding to inquiries by Optum TERM reviewers, meeting with Optum TERM staff, completing requested revisions to the Intake Assessment and/or progress report, fulfilling requirements for additional

education, training, or consultation, adhering to a quality improvement plan, being made temporarily unavailable to new referrals, or removal from the treatment panel. Formal review by an Optum quality committee or referral to the Credentialing Committee may also occur in relation to any significant quality of care issues.

Please respond to staff requests for quality review consultation in a timely fashion so as to avoid missed deadlines or delays to Court proceedings. Updates to Group Intake Assessment forms, Group Progress Reports, and/or Discharge Summaries must be submitted within seven (7) business days of being requested by TERM staff. If there are extenuating circumstances that preclude meeting this expectation, this should be discussed with Optum TERM staff at the time of the consultation.

Site Monitoring

Providers must agree to monitoring, which will include but is not limited to site visits, inspection of required documentation, and visitation of treatment groups during actual group meetings performed by a TERM team clinician. A copy of the On-Site Group Monitoring Tool is located on the Optum website under the TERM Group Standards Tab. Sites that do not meet established clinical standards or expectations may receive increased monitoring and disciplinary action.

Complaint Process

Providers understand that TERM, CWS, and the Probation Department will communicate regularly and specifically when issues arise regarding monitoring and/or certification, quality of care issues, ethical and/or professional concerns, and any other issues relevant to TERM, CWS, or the Probation Department. For general information on the Optum TERM complaint process, please refer to the Optum TERM Provider Handbook (Optum website under the TERM Manuals tab) page 58.

Recommended Resources

Association for the Treatment of Sexual Abusers (ATSA): http://www.atsa.com/

The Center for Sex Offender Management (CSOM; funded by the Dept. of Justice Office on Violence Against Women): http://www.csom.org/

California Sex Offender Management Board: http://www.casomb.org/

San Diego County Sex Offender Management Council: http://www.sdsomc.org/

The Safer Society: Resources for the Prevention and Treatment of Sexual Abuse. Understanding the Non-Offending Parent in Cases of Child Sexual Abuse, Project SAFE. http://psychology.unl.edu/childmaltreatmentlab/documents/NonOffendingParent.pdf

Addendum: Selected Readings

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Appendices

All appendices referenced are listed below and available on the Optum website www.optumsandiego.com under the TERM Group Standards tab:

- Sexual Abuse Protection: Parent Treatment for Non-Offending/Non-Protecting Parents Mental Status/Psychiatric Symptoms
- Assessment Tools
- Scoring Sheet for Required Screening Tools
- Safety Plan Guidelines
- Initial Intake Assessment Form
- Quarterly Progress Report Form
- On-Site Group Monitoring Tool
- Documentation Requirements