

SEXUAL ABUSE TREATMENT PROGRAM

POLICY AND PROCEDURE HANDBOOK



sexual abuse treatment program
Children's Medical Services



Florida Department of Health
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Sexual Abuse Treatment Program Handbook

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CHAPTER 1: PURPOSE

1.1 Purpose

The Sexual Abuse Treatment Program (SATP) provides specialized, community-based, family-centered treatment to victims of child sexual abuse and their family members. Individual, group and family counseling is available to victims, siblings, non-offending caretakers, and, in certain areas, offending caretakers. A range of counseling services, as clinically indicated, is utilized to assist families in recovering from sexual abuse, to prevent children's developmental impairment because of the abuse, and to promote healthy, non-abusive relationships.

This program is supported through funds provided by the Department of Health, Children's Medical Services (CMS), and in some cases, Victims of Crime Act (VOCA) funds. Programs operate in areas with limited access to services and a high comparative and demonstrable need for child sexual abuse services. They incorporate a comprehensive and culturally sensitive approach to treatment.

1.2 Scope

This handbook establishes general policies, guidelines, and practices for the Sexual Abuse Treatment Program response to reports of child sexual abuse in coordination with Child Protection Teams (CPT), child protective investigative staff of the Department of Children and Families and Sheriff's Offices, law enforcement, and community-based providers. This handbook contains policies, definitions, and procedures that establish consistent standards and expectations that apply to all sexual abuse treatment programs and community providers rendering services purchased by CMS.

1.3 Authority

Section 39.305, Florida Statutes, requires the development of a model plan for community intervention and treatment of sexual abuse in conjunction with the Departments of Health, Children and Families, Law Enforcement, Education and Corrections; the Attorney General, the State Guardian Ad Litem Program, representatives of the judiciary, and professionals and advocates from the mental health and child welfare community. Chapter 64C-9, Florida Administrative Code, establishes specific definitions, program organization, roles, responsibilities, eligibility criteria, and waivers for the operation of the Sexual Abuse Treatment Program.

The Department of Health (DOH) CMS is the administrative agency for the Florida Sexual Abuse Treatment Program (SATP). CMS works in conjunction with local SATPs to establish policies dealing with program operation and direction; provide support, monitor, and evaluate the overall effectiveness of the programs. Acceptance of a program contract allows the CMS contract manager and related staff unrestricted access to all program documents, including clinical files. Program contracts are awarded (in accordance with state procurement laws) to entities that demonstrate the ability to receive and utilize funds from other sources to augment the state funds provided.

CMS legislative budgets are addressed later in the document.

1.4 Mission and Program Organization

The mission of the Department of Health is to promote and protect the health and safety of all Floridians. Children's Medical Services has two divisions. The Division of Network and Related Programs provides a statewide-managed care service system for children with special health care needs. The Division of Prevention and Intervention includes the Bureau of Child Protection and Special Technologies, which is responsible for Sexual Abuse Treatment Program oversight. The mission statement of the SATP:

"To promote the safety and well being of Florida's children and their families by providing multidisciplinary assessment and treatment services for children suspected of being sexually abused."

1.5 Vision and Values

In conjunction with DOH emphasis on quality improvement efforts, the Bureau of Child Protection and Special Technologies established the following core set of values to guide the work of the bureau:

Accountability. We are committed to delivering quality services, producing positive results, and achieving customer satisfaction. We take full responsibility for our behavior and for the performance of our job responsibilities.

Collaboration. We forge partnerships with other community, state, and federal agencies to strengthen and enhance the services we provide.

Community Diversity. We recognize the uniqueness of each community and are committed to providing services that are flexible in design and responsive to the needs of individual communities.

Innovation. We support exploring new, more efficient and effective ways of doing business through advanced technology and improved business practices.

Integrity. We value respect and integrity in our daily work with our fellow employees, the people we serve and our communities. We do not allow our personal biases to influence our professional judgment.

Teamwork. Our most valuable asset is a dedicated, well-trained staff, working together to meet any challenge. We respect differences of opinion and recognize that the best ideas result from open and honest communication.

1.6 Sexual Abuse Treatment Program Objectives

The Sexual Abuse Treatment Program operates on the premise that child sexual abuse is a multifaceted problem requiring a multidisciplinary response. The purpose of the program is to provide sexual abuse treatment services to victims of sexual abuse and their families. Evidence-based therapy is essential to secure successful long-term outcomes for children and their families. Consistent with the Department of Health's mission, the objectives of the Sexual Abuse Treatment Program include:

- Prevention of child sexual abuse through public education and consultation with other agencies
- Specialized therapeutic treatment of child sexual abuse victims and their families to effectuate safe family functioning; and
- Intervention in child sexual abuse through recommendations that support child safety and provide expert court testimony.

The Child Protection Unit will procure services from providers who can demonstrate the ability to provide specialized sexual abuse treatment services according to the standards set forth in this handbook. Determination of the need to establish a sexual abuse treatment program within a specified geographic area is based upon the following:

- A. The number of child sexual abuse victims for whom there is no specialized sexual abuse treatment available
- B. The demonstrated ability of community agencies and professionals to work cooperatively to effectuate intervention and treatment in child sexual abuse cases.

1.7 History

In 1971, s. 827.07, F.S., mandated reporting of suspected child abuse and neglect. This resulted in a large increase in abuse reports investigated by the state. The statute required that child abuse investigators "include a determination of harm or threatened harm to each child, the nature, and extent of present or prior injuries, abuse, or neglect, and evidence thereof".

The Department of Health and Rehabilitative Services (HRS) recognized the need for a specialized medical resource and made a commitment to provide this under the auspices of the Children's Medical Services Program. This plan culminated in a legislative appropriation in 1978 to fund a pilot project for Child Protection Teams, using a medically directed, multidisciplinary team approach.

In 1981, the child welfare system in Florida was reorganized and a separate division called the Children, Youth and Families (CYF) Program was established within the Department of Health and Rehabilitative Services. At the same time, child welfare professionals were beginning to recognize the special needs of victims and families involved in intrafamilial sexual abuse. The CYF Program was charged with the responsibility for the investigation and treatment of intrafamilial sexual abuse, but few of the staff had the necessary training and skills to perform these functions adequately. Child Protection Teams, which were administered by the Children's Medical Services Program, became the focal point for expertise in the medical examination of sexually abused children and the evaluation of sexual abuse allegations.

In response to the need for the development of training and consultation in sexual abuse cases, the CYF Program contracted with two universities to develop training programs to assist CYF staff that was dealing with incest cases. In addition, the CYF program office wrote a federal Child Abuse and Neglect grant to hire a sexual abuse consultant. The Sexual Abuse Consultant was hired under a joint contract with the CYF Program Office and the Children's Medical Services Program Office to work with both the Child Protection Team staff and CYF staff.

During this period, concern had been growing that a large number of sexually abused children were being placed in foster care because of the lack of sexual abuse treatment services that could benefit the entire family. In order to protect children while allowing them to remain in their homes, treatment services needed to be available for the offending parent as well as the child. A budget issue for intrafamilial sexual abuse treatment services was written and introduced to the Legislature as part of the Governor's budget request in fiscal year 1984-1985. Funding was requested for five sexual abuse treatment programs at a cost of \$150,000 per program. The 1985 Legislature funded the request, and appropriated \$300,000 for the development of six programs.

In authorizing the appropriation, the Legislature created section 415.5095, Florida Statutes. This newly created section required the Department of Health and Rehabilitative Services to develop a model intervention and treatment plan for child sexual abuse victims and their family members. The model plan was to be developed in conjunction with the Department of Law Enforcement, the Department of Education, the Attorney General, the State Guardian Ad Litem Program, the Department of Corrections, and representatives from the mental health and child welfare communities. Utilizing input from the aforementioned agencies and departments, the model plan was written by the Sexual Abuse Consultant, Michael Lanier. It was patterned after the recommendations for community intrafamilial sexual abuse treatment contained in the Handbook of Clinical Intervention in Child Sexual Abuse (Sgroi, 1983). The plan described the essential investigation and intervention elements to be provided by communities funded for intrafamilial sexual abuse treatment programs. It was submitted to the Office of the Governor on February 27, 1986.

Section 415.5095, F.S., also required that Health and Rehabilitative Services (HRS), now the Department of Children and Families (DCF), and DOH develop an interagency agreement specifying the roles of each department for child protection and sexual abuse treatment. In 1998, it was further amended to provide that the continuing interagency agreement specify how coordination of services was to occur and how joint oversight was to be implemented. In 1998, Section 415.095 was changed to Chapter 39.305.

Following the development of the model plan, there was a request for proposals to implement programs based upon the plan. Twenty-seven proposals were submitted in response to the request. One or more proposals were received from every HRS district. Six programs were recommended for funding by a review committee composed of representatives from the agencies involved in developing the model program. Prior to actual funding, a pre-site visit was made to each of the selected agencies to meet with representatives from the community to ensure their active involvement in the program.

A shift in philosophy occurred during the process of selecting providers from fully funding two programs at \$150,000 each to partially funding six programs at \$50,000 each. The Legislature

envisioned that having programs collect first and third party payments and solicit local funding from community resources could maximize state or program funds.

In fiscal year 1985-1986, sexual abuse treatment programs were established in Lakeland, Ft. Myers, Panama City, Sarasota, Pensacola, and Brooksville. These were areas where no sexual abuse treatment services had previously been available and where community agencies had collaborated to develop coordinated plans of evaluation and intervention that best met the requirements of the model plan. Since that time, additional programs have been added resulting in a statewide network of 13 contract providers. The additional programs are located in Jacksonville, Tallahassee, Daytona Beach, Winter Haven, Melbourne, Gainesville, and West Palm Beach. A current listing of programs can be found on the internet at:

<http://www.cms-kids.com/ContactUs/satpdir.pdf>

1.8 Definitions

Definitions of terms used in this handbook can be found in the Glossary.

CHAPTER 2: PROGRAM ORGANIZATION

2.1 Child Protection Unit

The Department of Health, Child Protection Unit has program management responsibility for the Sexual Abuse Treatment Program. Specific responsibilities of this unit include:

- Ensuring that the Sexual Abuse Treatment Program is implemented according to legislative intent and as provided in state law, rules and regulations
- Establishing program standards and performance objectives
- Managing contracts for the individual sexual abuse treatment programs
- Reviewing, monitoring, and ensuring compliance with statewide standards and performance measures
- Statewide supervision of the administration of the SATP, including but not limited to:
 - Identifying statewide program needs and recommending solutions and priorities
 - Technical assistance for the program coordinators and staff of the sexual abuse treatment programs
 - Monitoring individual programs to ensure uniform quality among the programs
 - Developing workload and productivity standards
 - Developing resource allocation methodologies
 - Compiling reports, analyses, and assessments of individual and statewide program data.

2.2 Program Composition

A. Composition

As outlined in Florida Administrative Code, 64C-9.002, each Sexual Abuse Treatment Program functions under the direction and supervision of a program coordinator who has the responsibility of the daily coordination of SATP activities. The qualifications for the coordinator and the SATP counseling staff are listed below.

B. Staffing Changes

The SATPs are required to notify the Child Protection Unit of any terminations or new hires. Specifically, the programs must immediately notify their contract manager in writing if any position funded by the DOH contract remains vacant for 60 days. Program coordinators who have questions regarding hiring procedures should contact their contract manager(s) for guidance and assistance.

2.3 Personnel Qualifications and Responsibilities

Chapter 64C-9, Florida Administrative Code, addresses the professional staffing requirements for sexual abuse treatment programs. Beyond those professionals required by rule, the programs determine the number and types of positions necessary for the performance of the annual contract. Prior to employment, all new applicants must be screened in accordance with s. 39.001 (2) (b), F.S.

The following are required qualifications, duties, and responsibilities associated with each position employed or contracted for the sexual abuse treatment program. Depending on specialized needs in its area, additional duties or responsibilities may be identified by each program.

A. Program Coordinator

Qualifications:

- Licensed as a clinical social worker, mental health counselor, marriage and family therapist, or psychologist by the State of Florida.
- At least one year of clinical experience in the field of child sexual abuse.
- Continuing education standards that include a minimum of eight hours of training per year in child abuse, abandonment and neglect with at least two hours of training specific to child sexual abuse.
- Availability to provide oversight of program, client assessment and treatment

Responsibilities and Duties:

- Provide overall program direction and supervision for service delivery and administration.
- Provide consultations and evaluations of children and supervise and review the work of the agency's practitioners, including contracted and fee for service personnel for the provision of evaluations of children suspected to be sexually abused or neglected.
- Attend case staffings or designate a clinician to attend in his/her place.
- Attend statewide sexual abuse treatment program meetings, and other meetings and training sessions to maintain the knowledge and skills required for the position.
- Provide depositions and expert court testimony, when appropriate. Reimbursement for expert testimony is not provided by CMS and must be sought by the program coordinator through the usual court procedures.
- Act as a liaison with Children's Medical Services, Department of Children and Families, law enforcement, the judiciary, and community agencies.
- Coordinate services with the Child Protection Teams, child protection staff from DCF and designated sheriff's offices, other agencies and local community resources.
- Serve as a liaison with CMS Central Office to ensure compliance with standards, policies, and performance criteria.
- Prepare the annual program budget and complete required reports.
- Provide or arrange for training in the community for professional staff and others and educate the community by conducting community outreach trainings on the services available from the agency

B. Counselor

Qualifications:

- A Masters degree in Psychology, Social Work or other behavioral science (licensure preferred).

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- At least one year of clinical counseling experience, six months of which must have been in providing treatment to sexually abused children and their families.
 - Continuing education standards that include a minimum of eight hours of training per year in child abuse, abandonment and neglect with at least two hours of training specific to child sexual abuse.
 - Supervision by a licensed clinical social worker, psychologist or mental health professional

Responsibilities and Duties:

- Interview children, family members and significant others as needed to obtain psychosocial information for clinical evaluations.
- Develop behaviorally specific treatment plans for all family members involved in the program.
- Provide counseling to child victims, siblings of victims, non-offending caregivers and offenders
- Monitor attendance, participation and progress of family members in treatment
- Coordinate client services and referral to community agencies
- Attend case staffings and share information with other team members
- Maintain client records, including the tracking of treatment goals and objectives
- Complete closing summaries on all clients terminated from the program
- Provide court testimony
- All counselors must carry professional liability insurance
- Ensure client's right to privacy and ensure appropriate confidentiality when information about the client is released to others.

2.4 Abuse Reporting Responsibilities

Mandatory Reporting Requirements

Section 39.201, Florida Statutes, requires that any person who knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare shall report such knowledge or suspicion to the Florida Abuse Hotline. Reports may be made by calling the toll free number (1-800-96-ABUSE) or by faxing a written report to 1-800-914-0004 with all necessary information, including reporter's name, contact telephone number or fax number.

The Hotline determines if the report requires an immediate initial response, or whether the protective investigator is given 24 hours to respond. Cases of suspected child abuse, abandonment, or neglect by an adult caretaker accepted as reports for investigation by the Hotline are electronically transmitted to the appropriate DCF district or designated sheriff's office responsible for the child protection investigation.

CHAPTER 3: SEXUAL ABUSE TREATMENT PROGRAM REFERRAL

3.1 Program Availability, Eligibility and Access

A. Availability of Services.

Sexual Abuse Treatment Programs provide assessment and treatment services to supplement the Department of Health, Child Protection Teams and the child protective investigation activities of DCF and designated sheriff's offices. A listing of the SATP offices, the names of the program coordinators, and locations can be found on the Internet at:

<http://www.cms-kids.com/ContactUs/satpdir.pdf>

B. Eligibility for Services

- **Each SATP provider will determine eligibility for SATP services according to the following criteria:**
 - The child is an alleged victim of intrafamilial sexual abuse.
 - The child is an alleged victim of intrafamilial child on child sexual abuse.
 - The adult caregiver is a non-offender.
 - Child is a sibling to sexually abused child.
 - Offenders eligible for treatment are those whose victims are or had been in treatment with the program.
 - An evaluation of the offending caretaker has recommended community based treatment. Those offenders without numerous prior incidents of molesting children, previous unsuccessful therapy, prior felony criminal convictions, or severe mental illness shall be eligible for the program.
 - Offender non-acceptance for treatment does not prohibit the child victim and the victim's non-offending caretaker from receiving services from the program.
 - Offenders are expected to pay for their own therapy and, when feasible, to pay for the treatment of the victim.
 - There must be an abuse report alleging sexual abuse or threat of sexual abuse, but the case does not have to be active.
 - The child must be named as a victim in the abuse report.

NOTE: For, contracts that contain VOCA funding, other eligibility requirements are spelled out in the contract.

- No child alleged to be a victim of sexual abuse, his/her siblings, or non-offending caretakers will be excluded from the program solely because of inability to pay for treatment.

3.2 Sexual Abuse Treatment Program Referrals

A. Referral Requirements

To be accepted as an SATP case, all referrals of intrafamilial child sexual abuse must have been reported to the Hotline. If a report has not been made in a case in which there is

reasonable cause to suspect that the child has been abused or neglected, the SATP must notify the referring person of his legal responsibilities to make a report to the Hotline and follow-up to ensure that a report is made. If no report is called to the Hotline, the SATP staff person must report it. (See paragraph 2.6A for an explanation of mandatory abuse reporting requirements).

B. Referral Information

Information regarding referrals accepted by the programs must be documented in the case record utilizing an intake or case information form. The provider must attempt to contact new referrals within 2 working days of receipt of the referral. As applicable, information gathered during the intake process should include:

- Abuse report, if available
- Alleged victim's name
- Victim's date of birth, race, gender and ethnicity
- Victim's social security number
- Family demographics
- Identification and relationship of each household member and others involved to the abuser and to each other
- Known risk factors – including, but not limited to - domestic violence, substance abuse, criminal history and/or mental health concerns
- Information regarding custody orders, living arrangements and/or other court orders
- Summary of the reason for the referral. The reason should be comprehensive and may involve gathering more information than what is provided on the original referral (which is sometimes too succinct for a full understanding of the child and family's situation)
- Specific services requested by CPT, the protective investigator, or other referral source
- Information regarding prior abuse reports
- Information regarding prior involvement with CPT

C. Referral Source

Child Protection Teams (CPT) and the Department of Children and Families (DCF) or designated sheriffs' offices are the primary referral sources for sexual abuse treatment program services. However, the initial referral may also come from other involved professionals (e.g. law enforcement, hospitals, physicians, etc.) or from the families themselves. Necessary services to children and families should not be limited based on source of referral. If the provider has questions, the contract manager should be contacted.

D. Referral Intake Process

An intake interview will be scheduled to explain the program and determine appropriateness for treatment. If accepted, a psychosocial evaluation of the family will be completed by the SATP within 10 working days of initial contact, and prior to entry into the program. If a psychosocial has already been completed by another agency, and it meets the SATP's needs, a new psychosocial need not be done. For each member of the family entering the program, a treatment plan will be developed which will include the type of therapy to be provided and behaviorally specific goals to be achieved. These goals will be monitored at a minimum every

six months to assess progress toward treatment plan goals. Group, individual and family counseling will be offered for child and adolescent victims, siblings, non-offending caregivers and offenders who qualify for treatment.

CHAPTER 4: SEXUAL ABUSE TREATMENT PROGRAMS SERVICES

4.1 Opening a Case

To open a case, an assessment of the child must be completed by the SATP within 10 working days of the initial contact. Attempts made to complete the assessment must be documented in the case record. Opening a case involves creating a physical file.

4.2 Case Record Documentation

Each child and family member referred to the SATP for assessment and treatment must have an individual case record that includes documentation of any CPT involvement with the child, per s. 39.202(7). Each case file containing assessment and treatment plan information, including the rationale for treatment choice, behaviorally specific goals and progress notes that document progress toward treatment goal attainment. Standardized assessments to evaluate trauma and general well being of clients shall be completed initially and at six month intervals.

Clear and accurate documentation of assessment, treatment, and case coordination activities is essential. Such documentation provides a comprehensive record of SATP involvement with the case and is necessary in order to accurately record services. The following information must be in each client's file:

- Referral information
- Demographic information
- Consent to Treatment Form
- Authorization for Release of Information Form
- Third Party Billing Documentation (Medicaid number, Victim Compensation Form, etc.)
- Fee Agreement (when applicable)
- Any applicable court orders (orders to treatment, performance agreements, dependency orders, visitation orders, etc.)
- Child Protection Team reports (interviews, psychosocial assessments, psychological evaluations, medical evaluations, staffing summaries, etc.)
- Intake and Referral activity
- All activities conducted
- If there is no complete Child Protection Team psychosocial in the file, an SATP specialized bio-psychosocial assessment of the family which contains referral information and identifies the strengths, concerns, resources and priorities of the family
- Assessment of the family which contains referral information and standardized tests; and identifies the strengths, concerns, resources and priorities of the family
- A treatment plan for each family member which includes behaviorally specific goals and objectives to assess treatment progress
- Progress notes which detail the date of each treatment session, who was present, and what progress was made toward accomplishment of the treatment goals

- Closing summary which includes the date of termination from treatment, extent of progress in accomplishing treatment goals, reason for closure and disposition

Client records must be kept secure at all times. All child records and any child specific supporting administrative records shall be retained for a period of seven years from the last client entry, or until the child has reached 18 years of age, whichever occurs first.

4.3 Chronological Record

Record entries listed on a separate chronological log are critical in providing documentation of all case contacts and activities completed by the counselor or other program members. Casework documentation must do more than indicate who was seen, when, and where. When viewed, it must present a concise history of all activities related to the case.

Programs should create a legend for standard abbreviations used in the chronological log and their use should be consistent within the program. The legend key must be on the first page of the chronological record. The legend should include abbreviations for frequently referenced local agencies. For other local agencies, the counselor should first write out the name, followed by the abbreviation in parentheses. Thereafter the agency can be referenced with the abbreviations.

Record entries should be made at the time of the event or contact. They should indicate objective observations, record events, and make note of actions. At a minimum, chronological record entries should:

- Be legibly written. If handwriting is not legible, entries should be typed.
- Contain the date the information was documented in the chronological log (MM/DD/YY) and, if different, the date of the event (MM/DD/YY). This may occur when the counselor or other program member had contact regarding the case but was unable to document the contact on the day it occurred.
- Be signed with (at a minimum) the writer's full last name and first initial. Signature stamps should not be used unless also initialed by the writer.
- Identify the mode of contact (e.g., telephone, email, mail, fax, or in person) and the person contacted followed by their roles in the case or their relationship to the child/victim.
- Document all contacts (including attempts to contact) made on behalf of the child.
- Clearly document the information provided or shared and the source of the information.
- Document all assessment activities, including who was present and a brief description of the results/findings.
- Include the dates of transmittal and receipt of reports and other documents.
- Clearly identify errors in writing by crossing through the error, labeling it as an "error" with initials of writer after or above the error. Errors must be dated if made pursuant to original date of entry. Liquid paper or similar products should never be used in the case file.
- Include documentation of supervisory review and consultation, and peer review. The counselor's follow-up to any recommendations resulting from the supervisory review or an explanation as to why the counselor was unable to complete the supervisor's recommendations should also be included. Explanations should be provided for planned activities that did not occur.

4.4 Types of Services Availables

Services available include treatment planning, family bio-psychosocial assessments, group counseling, individual counseling, and family counseling.

A. Treatment Plans

Treatment plans should be developed based on information gathered in the psychosocial assessment, abuse reports, and interviews with other professionals and family. The treatment plans should clearly outline the goals that have been established in conjunction with the child. Progress toward these goals should be documented clearly in the progress notes and should be updated as needed, but no less than once every six months. Treatment Planning is focused on identifying the client's therapeutic needs, identifying risk factors, and safety planning for the child. Appropriate and effective interventions reduce the level of risk and the negative effects of the trauma experienced by the child and family; thereby promoting the provision of a safer and healthier family environment.

B. SATP Specialized Bio-Psychosocial Assessment

An SATP specialized psychosocial assessment is an evaluation of the history of the family system, conducted by a counselor or other trained professional. This involves a systematic process of gathering information to formulate professional conclusions and recommendations.

This psychosocial assessment includes interviews of all members of the immediate family and may include extended family members or others who directly impact family dynamics. Emphasis is placed on the child and family's history as a context for the presenting sexual abuse allegations. The assessment assists in identifying pertinent family dynamics, assessing family strengths and weaknesses, and determining the needs of the child and family. The assessment report is conducted within 10 calendar days of initial contact and will include, at a minimum:

- Name of the interviewer
- Persons interviewed and date of each interview
- Abuse report information
- Summary of background information and abuse allegations
- The influences of family dynamics on the individual
- Issues of childhood development
- Medical and mental health status and behavioral observations
- Family history
- Family functioning, including dynamics of sexual abuse
- Impressions and recommendations, including an evaluation of the level of risk

The family history section includes a brief description of the family of origin and personal history of each parent, including any prior social service agency interventions. The family function section of the psychosocial should include dynamics related to the sexual abuse allegations. This section identifies the principle features of the family, particularly as they pertain to areas of

dysfunction and stressors (e.g. isolation, finances, family violence, substance misuse, criminal history, mental health issues, etc.) related to the presenting allegations.

C. General Guidelines

Sexually abused children often suffer resultant emotional, behavioral, medical, relational, and social problems that can have lifelong effects. Sexually abused children should be carefully assessed, using appropriate assessment instruments. Each assessment should be tailored to the specific child and family. Based upon assessment results, an individually tailored treatment plan should be developed to meet individual child and family needs. The assessment is the foundation of the treatment process.

Documentation of completed assessments should accurately record the nature of the assessment, the date(s) involved, the participants, the outcomes and/or conclusions, and the subsequent recommendations. The assessment should be behavioral and identify the intensity, duration, and frequency of treatment.

D. Time-Frames – Required Reports

- The provider is required to report client data monthly. This data is due in a format prescribed by the department by the fifteenth of each month.
- The provider is required to conduct trainings to the community to promote awareness to the SATP program and its services. The provider shall submit by the fifteenth of each month a report summarizing trainings conducted during the month.
- The provider is required to report performance data quarterly in a format prescribed by the department, by the fifteenth of the month following the quarter.
- Each staff person is required to have a certain number of in-service training hours each year as outlined in paragraph 2.4 A., B. and C. To document this, the provider shall submit a quarterly report outlining the in-service training hours provided for counseling staff during the quarter by the fifteenth of the month following the quarter.
- DOH policies require that financial reports be submitted quarterly to document how funds are being utilized. These reports are due the fifteenth (15th) of the month following the end of the quarter.

E. Use of Standardized Measures

Standardized assessment instruments are very useful tools in the assessment of sexually abused children and their families. They provide a standardized and structured approach to measuring problems commonly experienced by sexually abused children, and assist in providing a more precise assessment of target problems. They also can be administered over time to assess treatment progress and aid in clinical decision-making. Several instruments have been developed specifically for measuring sexual abuse-related problems and have been tested with sexually abused children. They are designed to evaluate problems frequently experienced by these children and to be used specifically in cases of sexual abuse. In addition, many general mental health measures that are used with all sorts of child populations have been used successfully with sexually abused children. All of these instruments can be clinically valuable when assessing sexually abused children and their families. Standardized measures should be considered an integral part of any comprehensive clinical assessment process. Examples of instruments that have been used successfully in child sexual abuse cases include:

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- Child Abuse Potential Inventory (Milner, 1986)
 - Child and Adolescent Functional Assessment Scale (Hodges, 1997)
 - Child Behavior Checklist (Achenbach, 1991)
 - Child Sexual Behavior Inventory (Friedrich, 1998a)
 - Children's Impact of Traumatic Events Scale (Wolfe & Gentile, 1991)
 - Child's Attitude towards Mother Scale (Hudson, 1982)
 - Child's Attitude towards Father Scale (Hudson, 1982)
 - Fear Survey Schedule for Children–Revised (Ollendick, 1978)
 - Index of Self Esteem (Hudson, 1982)
 - Kovacs' Children's Depression Inventory (Kovacs, 1992)
 - Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1985)
 - Symptom Checklist-90-Revised (Derogatis, 1983)
 - Trauma Symptom Checklist for Children (Briere, 1996)
 - Trauma Symptom Inventory (Briere, 1995)
 - Parent Emotional Reaction Questionnaire (1996)
 - Parental Support Questionnaire (1996)

The above list is not an exhaustive or comprehensive list of measures that can be useful in child sexual abuse cases. However, these are examples of measures that have been used successfully with sexually abused children and their families. Appropriate standardized measures should be selected according to the presenting problems.

F. Case Review

Case review is a formalized internal program process for reviewing the content, status, and treatment progress. At least one supervisory review must be completed every three months on every case. However, complex cases, cases remaining open for an extended period of time, and cases being handled by less experienced counselors should be reviewed on a more frequent basis. Documentation of case reviews, usually completed by the program coordinator, must include:

- Date of review
- Name of the program coordinator completing the review
- Concurrence with ongoing case activities and recommendations for additional case activities

G. Case Closure

The case is ready for closure after all treatment has been successfully completed and all documentation in the case file has been reviewed and approved by the program coordinator. The counselor must review the accuracy of the data prior to submission for closure and enter the date of closure (termination) in the case file after the coordinator has approved closure.

Upon discharge of a family from the program, a closing summary must be completed which includes the date of termination from treatment, the extent of progress made toward accomplishing the treatment goals, and the reason for closure and disposition.

Guidelines for closure are as follows:

- Client noncompliance with program policies and procedures
- Services have been provided and no further services are indicated

Referral sources should be notified within 24 hours when a family fails to keep appointments so that the level of needed intervention can be determined. Another situation may be that the family moved out of the service area after the counseling began, and is no longer attending. This should be reported to the Child Protective Investigator within 24 hours of determination if the CPI is still involved in the case. If a Community Based Care Provider has case responsibility, this should be reported to the CBC. In either case, if there is reasonable cause to suspect that the child is being abused or neglected, or at risk of being abused or neglected, the Hotline must be called (1-800-96-ABUSE). All contacts must be documented in the case file.

In instances where no assessments were completed, the program should document the attempted contacts, and the program coordinator must sign off on the referral as closed. This will not be counted as a case, because no services were provided.

4.5 Record and Report Confidentiality

Pursuant to s. 39.202 (6), F.S., all records and reports of the sexual abuse treatment programs are confidential and exempt from the provisions of s. 119.07(1), F.S., the Florida Public Records Law, and s. 456.057, F.S., regarding ownership and control of client records. Program records shall not be disclosed, except, upon request, to the state attorney, law enforcement, Department of Health, Department of Children and Families, and designated sheriff's offices, and other necessary professionals, in furtherance of the treatment or additional evaluative needs of the child, by order of the court, or to health plan payers, (limited to that information used for insurance reimbursement purposes).

4.6 Retention of Records

CMS's contracts with providers require that administrative records pertinent to the contract be retained for a period of six years. If an audit has been initiated and audit findings have not been resolved at the end of five years, the records shall be retained until resolution of the audit findings or any litigation that may be based on the terms of this contract.

Client records should be kept for a minimum of seven years from the date of the last entry or until the child attains the age of 18, whichever occurs first. All records must be maintained in a secure setting, either in locked file cabinets or behind locked doors. Case records should be secured when a counselor leaves the office. At no time should case records be left on a desk in an unlocked office or in a public access area.

CHAPTER 5: PROGRAM STANDARDS AND QUALITY ASSURANCE

5.1 Standards Authority

The sexual abuse treatment program operates in accordance with the standards and program rules established in s. 39.305, F.S., and Chapter 64C-9, Florida Administrative Code. Operational procedures and standards are further clarified in this handbook and in the annual sexual abuse treatment program contracts. Program rules and standards address issues of eligibility for services, provider qualifications, services, and record/data requirements. An annual, formal, on-site monitoring of program services and compliance with program standards and requirements assures quality in sexual abuse treatment programs. The focus of the monitoring is to assess the quality of treatment services provided and to support programs in successfully achieving their goals, objectives, and activities. The monitoring process includes:

- A review of program operation and records
- Interviews with SATP staff
- An exit meeting to review initial findings, and
- Completion of a formal monitoring report summarizing the findings of the visit and needed corrective actions.

5.2 Performance Standards

A. Standards

By executing the contracts, SATP providers agree to comply with the conditions, standards, and indicators of performance set forth in the contracts. These requirements include, but are not limited to:

Required Number of Clients: Programs will be required to provide services to a set number of child victims and non-offending, as well as any siblings needing therapeutic treatment.

Contact with Client/Family: Initial contact must be attempted within **two working days** of referral. Attempts must be ongoing and documented on a chronological log in the case file.

Intake/Assessment Timeliness: The provision of intakes/assessments must be completed or offered within **10 working days** of initial contact. Attempts must be ongoing and documented in the chronological record in the client's file. An Intake assessment also known as a bio-psychosocial assessment of child and their family members must be completed and up-dated every six months. A copy of the assessment must be found in each family member's case file.

The assessment for 100% of treatment plans will be developed in accordance with the criteria set forth in the SATP Handbook

Monthly Data Reports: Programs are required to report statistical data monthly. This data is due by the 15th of each month, and captures the numbers for the previous month.

The purpose of this report is to gather data to support the provider's delivery of contractual services.

Quarterly Performance Reports: Programs are required to participate in monthly data collection and, in addition, must submit quarterly performance reports that are due by the 15 of the month following each quarter. A conference call is scheduled to discuss the quarterly report and to work with the provider to ensure that service provision is meeting contractual guidelines.

The core contract for the programs identifies services that must be provided by each SATP. It is the Program Coordinator's responsibility to ensure clear documentation of service provision. Program compliance will be determined through annual quality assurance reviews and fulfillment of contract standards. The DOH CMS Central Office monitors program progress toward achieving these standards through data extracted from monthly reports.

B. Performance Standards Monitoring

Sexual abuse treatment programs must meet the core standards set forth in the annual contracts. By execution of the contracts, providers acknowledge an understanding that the achievement of these standards will be reviewed, achievement reported, and corrective action taken if performance is below standard. If a provider fails to meet these standards, the department, at its exclusive option, may allow a designated period of time for the provider to achieve compliance with the standards. If the department affords the provider an opportunity to achieve compliance, and the provider fails to achieve compliance within the specified time frame, the department may terminate the contract in the absence of any extenuating or mitigating circumstances. The determination of the extenuating or mitigating circumstances is the exclusive determination of the department.

5.3 Quality Assurance Reviews

A. Scope and Frequency of Review

At a minimum, quality assurance reviews must include an assessment of compliance with the standards and requirements outlined in the annual contract. Reviews also include a review of the quality of work and an assessment of client satisfaction. At a minimum, the provider's program will be reviewed annually.

B. Methodology

Each program will receive an on-site visit at least once each fiscal year. At that time, a sample of case files will be reviewed. In addition, the monthly numbers submitted by the programs will be reviewed in the context of the data collection program utilized.

C. Follow-up

A written report of the monitoring results will be sent to the provider within 30 calendar days of the review date. The report may include recommendations for enhancing the provider's service. The report will identify corrective actions in relation to minimum standards and requirements under the annual contract and any quality issues. The report will specify dates for the development of a corrective action plan and for completion of the corrective action. The

provider will provide the department with a corrective action plan and submit monthly status reports on their progress, if applicable. The department may conduct an on-site follow-up visit to review the corrective actions taken.

D. Waivers

In the event compliance with a standard established in Chapter 64C-9, Florida Administrative Code, is not attained, a team may request a waiver of that standard. A waiver of a specific standard shall be granted only for a specific period of time that shall not exceed the contract period. The Prevention and Interventions Division Director for Children's Medical Services shall make final approval or disapproval of all requests for waiver. The CMS Central Office shall notify the program in writing that the request for waiver of a specific standard has been granted or denied. If a request for a waiver is denied, the denial letter shall include advice of the right to request an administrative hearing under Section 120.57, Florida Statutes. Waiver requests shall contain at least these sections:

- Identification of the personnel standard for which the waiver is requested
- Description of the attempts to meet the standard
- A plan for remediation of the need for the waiver
- Assurance and an explanation in the request that granting of such a waiver will not adversely affect the quality of care rendered by the provider, and
- An assessment of need and lack of existence of alternative solutions.

CHAPTER 6: ADMINISTRATION

5.1 Program Administration

The Children's Medical Services Program of the Department of Health, Office of Prevention and Intervention has general administrative responsibility for the Sexual Abuse Treatment Program.

A. CMS Central Office Responsibilities

Each year, Children's Medical Services (CMS) contracts with local providers to provide sexual abuse treatment. CMS Central Office responsibilities include program planning and development; establishing standards, policies and procedures for the Sexual Abuse Treatment Program (including program evaluation and monitoring procedures); resource development (including legislative budget requests and resource allocation plans); providing technical assistance and training to SATP staff and other agency or program staff regarding the operation of the Sexual Abuse Treatment Program; and providing for the services of a statewide consultant with expertise in sexual abuse treatment.

The Contract Manager is responsible for assisting in the programmatic coordination between the CMS central office and the sexual abuse treatment programs. Specific responsibilities include contract management functions such as approving and processing invoices for payment submitted by the SATPs and negotiating and executing contracts and contract amendments. The CMS Contract Manager monitors the Sexual Abuse Treatment Program contract to ensure compliance with contractual obligations and participates in the onsite monitoring of the SATP with CMS program central staff.

B. Sexual Abuse Treatment Program Organization

Each Sexual Abuse Treatment Program functions under the direction of a Program Coordinator. The Program Coordinator is responsible for administrative oversight of the program and must provide for clinical supervision of the treatment staff. Treatment staff may be salaried employees of the program or be subcontracted employees providing treatment on a fee for service basis. All subcontracts must be submitted to CMS Central Office for approval by the Division Director for Prevention and Intervention prior to implementation.

5.2 Program Funding

The Sexual Abuse Treatment Program (SATP) is funded through a special appropriation category from general revenue funds called Medical Services for Abused/Neglected Children. Many of the contract providers receive additional funding from local community resources, such as United Way or a Children's Services Council, and/or charge fees to those families who have the ability to pay for treatment. Some programs are enhanced with VOCA funding and, in some cases, totally funded by VOCA. Each SATP is also required to bill all known third party resources for treatment services provided to child sexual abuse victims and their families. Offenders should pay for their own treatment and, whenever feasible, for the victim's treatment.

A. Program Contracts

The CMS Central Office, through contracts with local agencies or organizations, funds Sexual Abuse Treatment Programs, in part or in full. A variety of agencies, such as community mental health centers and non-profit organizations, participate in the statewide network. The contracts are for a state fiscal year (July 1 – June 30). Contracts include program standards and provisions.

To ensure community involvement in the program, the provider must maintain liaison with the following: law enforcement, State Attorney's Office, Department of Children and Families, the lead Community Based Care agency, the Child Protection Team, Guardian Ad Litem, Program and Probation and Parole, as well as other groups as necessary.

B. Third Party Funding

Each Sexual Abuse Treatment Program will bill the appropriate third party source (Medicaid, the Crimes Compensation Trust Fund, insurance, etc.) for remuneration for sexual abuse treatment services. The provider will utilize third party collections prior to charging the contract for treatment services. The offender must be responsible for his/her own treatment costs as well as, when feasible, the victim's treatment costs.

5.3 Program Standards

The Sexual Abuse Treatment Program operates in accordance with CMS program rules, Chapter 64C-9, Florida Administrative Code, and in accordance with program standards that are included in the annual SATP contracts. Program rules and standards address issues of eligibility for services, provider qualifications, services, and record/data requirements.

A. Background

The rules for the Sexual Abuse Treatment Program were first promulgated in 1993. The rules were based upon recommendations from SATP providers and the Sexual Abuse Consultant. The original program standards were developed from the Model Plan for Intervention and Treatment as required by statute.

B. Development and Review Process

The process for review and modification of Sexual Abuse Treatment Program rules and standards is as follows:

1. SATP standards will be reviewed at least every two years (in odd numbered years) for potential modification.
2. SATP staff in the CMS Central Office will request all Sexual Abuse Treatment Providers to review and submit suggested modifications to the SATP rules and standards. Information obtained through program monitoring and evaluation activities will also contribute to proposed modifications.
3. SATP staff in the CMS Central Office will compile and review suggested modifications and develop revisions as determined appropriate.

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4. The proposed revised SATP standards, with changes highlighted, will be disseminated for review and comment to all Sexual Abuse Treatment providers and others, as appropriate.
 5. Comments on proposed revised standards will be reviewed and final modifications made, as appropriate. Any changes made at this stage in the revision process will be noted and justification provided for the change.
 6. The final revised standards will be incorporated into the SATP contracts.
 7. Modifications to the SATP standards may be made without regard to this process, if deemed necessary by the Deputy Secretary for Children's Medical Services or Division Director, in the following circumstances: the change is necessary to conform to state or federal law; or the change will not impact on the current contractual obligations of the SATP providers.

Appendix A: ADMINISTRATION

Certain statewide guidelines and protocols have been developed to assist providers in complying with requirements for the delivery of program services under the Sexual Abuse Treatment Programs (SATPs). The SATP contract is a statewide program-specific model contract. The information in this section is specific and supplemental to the contract language. Contract language may be repeated for clarification.

A. Fiscal

1. Method of Payment.

The Sexual Abuse Treatment Program contract method of payment is based on a negotiated fixed rate total annual contract amount disbursed monthly at a fixed rate, paid after the delivery of a month's services. When there is a renegotiation of the total annual contract amount during the contract year, the remaining monthly fixed rates are adjusted accordingly.

2. Program Budget

Once contract amounts are determined, providers shall submit a proposed program budget and supporting narrative to the program office. The proposed budget is the justification for funding service. The contract manager reviews the proposed program budget, resolves any questions/issues with the provider and approves prior to contract execution or approved with written contingencies and due dates that are binding on the provider. Inherent in the approval of a program budget is the provider's acknowledgement of the requirements for on-going management of the program budget throughout the contract period. The proposed program budget shall project revenue and expenditures for the program services and eligible clients defined in the SATP contract.

All program income available (including any received but not expended to date) and expected to be received during the contract period shall be projected, and each type identified by line item with narrative explanation. Certified public expenditures and program in-kind contributions that have current value and cover essential expenditures otherwise (e.g. rent, utilities, etc.) shall be budgeted as both revenue and planned expenditures.

a. Deficit Budgeting

Deficit budgeting is not allowed. However, if revenue projections exceed planned expenditures, initially and temporarily, a "contingency" expense line item may be budgeted to allow time for planning for the use of the unexpected revenue available

b. Format

Providers must complete the Position Detail Sheet provided by the CMS Program Office as part of the justification for the personnel section of the program budget. While the basic presentation of the budget may be consistent with the agency's accounting system, it must contain all required elements of the CMS Program Office

format. Budget line-items should be grouped by general sub-categories with sub-totals.

c. Proposed Expenditures

Proposed expenditures shall be reasonable and necessary in order to provide the program services defined in the contract. An accompanying narrative shall indicate the type of expenditure by line item and clearly explain how the proposed expenditure supports the program.

d. Cost Sharing

When costs are shared with other programs of the provider agency, the provider shall determine the SATP share of cost based on an acceptable methodology (i.e. head count, square footage). The proposed budget narrative shall specify the totals (e.g. head count) and the total cost and show the calculations to arrive at the SATP share of the cost.

e. Percentages of Cost

Any percentage of direct personnel salary and benefit costs for general agency management paid for by SATP funds must include clear documentation of each individual's functional activities supporting the provision of SATP services and related administrative duties. NOTE: The Program Coordinators and/or designees shall spend a minimum total of 75% of their time providing programmatic and administrative oversight of the SATP contract program.

Indirect Cost Rate Percentage shall be negotiated up to the maximum allowable amount established for Children's Medical Services (except for maximum statutory rates for state agencies).

f. Unauthorized Expenditures

Certain types of expenditures will not be approved. These are:

- 1) Depreciation of non-expendable property, which is defined as those items costing \$1000 or more per item (or packaged item). Expenditures to acquire such property are allowed provided they are reasonable and necessary.
- 2) Depreciation of assets other than non-expendable property, including fixtures and buildings. Necessary and reasonable acquisition costs for assets and buildings may be budgeted based on the SATP share of cost. Actual current building expenses presented as rent shall be evaluated as to reasonableness based on local market rates.
- 3) Food

- 4) Purchases that confer or provide ownership by clients (food, clothing, furniture, etc.)
- 5) Fund-raising and lobbying costs
- 6) Miscellaneous line-item costs (or petty cash funds) exceeding \$150.00
- 7) Any other cost that is determined not to be reasonable and necessary to the provisions of services under the contract.

h. Budget Revisions.

Refer to the criteria in Attachment I, Section D. of the contract. Whenever a question arises as to what is a substantive budget revision, discuss with your contract manager prior to submitting a budget revision for review.

i. Program Revenue.

Providers are expected to pursue and bill all third party and other possible revenue sources for the SATP program. Program income is defined in Attachment I, Section D. of the contract.

j. Prior Approval for Purchasing - Information Resource Requests (IRRs).

Prior to purchasing data processing equipment, regardless of the cost of an item, providers are required to submit an IRR to the department for approval. This request and approval process is to ensure that: data processing equipment meets the department's standards, the CMS Program Office is aware of each team's technological capacity and needs, and verification of the provider's contract inventory of technology assets purchased with SATP funds.

Providers are required to submit an IRR and the vendor quote chosen for the item to be purchased for the following data processing equipment and software: Servers, computers, printers, software and upgrades of same; all items to be purchased shall meet the department's current standards. The state standards and approved contract vendors are identified through DOH Intranet. Providers shall follow their agency purchasing policy in determining the vendor to be used. State contract negotiated prices may be available to the provider. Note: The department strongly recommends that minority vendors be used when purchasing. IRRs shall be submitted to the CMS contract manager.

When approved, the IRR will be given an identifying number, and the IRR, with the approval signatures of the CMS contract manager and the CMS Program Office Systems Technology designee, will be returned to the SATP to document the purchase of the data processing equipment. A copy of the approved IRR should be attached to the purchase order and a copy placed in the current fiscal year provider contract file in the CMS Program Office.

k. Quarterly/Final Revenue and Expenditure Report

Quarterly and final revenue and expenditure reports are required to be submitted within 45 days of the end each quarter and 45 days of the contract fiscal year. While final income and expenditures may vary some from the approved budget or the most recent submitted revision, any substantive difference shall be explained prior to the CMS Program Office acceptance of the final report for the contract year. Special projects components shall be separately identified and reported in the same format as in the approved program budget. Non-expendable property items (items costing \$1000 or more per unit) shall be identified by item and unit cost.

B. Independent Audits

Each SATP provider shall provide the department an Independent Audit for each fiscal year. As a result of the Single Audit Act, some Independent Auditors are now completing a compliance audit requiring the auditor's review of a random sampling of SATP client records.

Audit Report and Corrective Action

Audit reports are due 270 days (9 months) after the last day of the provider's fiscal year ending date, except for government agencies, whose audits are due 12 months after their fiscal end date. The contract manager reviews each audit according to the "Checklist for Reviewing Single Audit CPA Reports," and, if there are findings, the provider is required to present a corrective action plan to his contract manager. The corrective action plan is tracked until the corrective action is completed. The contract manager can supply the provider with an "AUDIT Corrective Action Guide for Contract Providers" to assist in tracking compliance.

GLOSSARY

Abuse - Any willful act or threatened act that results in any physical, mental, or sexual injury or harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired.

Assessment – The initial process of determining the child and family members' therapeutic needs.

At Risk - The likelihood that a child will be abused or neglected.

Case - An individual child referred to and accepted by a sexual abuse treatment program for assessment and treatment services, as a result of a report of alleged sexual abuse.

Case Coordination - Those activities that are provided on behalf of clients to complete assessment and treatment [e.g., contacts to arrange specific assessments, case activities and collateral contacts with law enforcement, state's attorney, Department of Children and Families{DCF}, Guardian Ad Litem, schools].

Case Documentation - All material that provides information on case specific activities completed by counseling staff and the case coordinator, (e.g., face-to-face and telephone contacts regarding the case, completion of child and family interviews, etc.).

Case Management – Services to arrange, coordinate, access services for sexually abused children and their families. These services will include but are not limited to personal advocacy, information and referral, assistance with completion of VOCA forms, follow-up contact, and educational and transportation assistance.

Case Review - A formalized internal process for supervisory review of the content, status, and progress of the child and family members' treatment plans. Case reviews must be documented in the child's case file.

Child - Any unmarried person under the age of 18 years who has not been emancipated by order of the court. [s. 39.01 (12), F.S.]

Child-on-Child Sexual Abuse – As stated in Chapter 39, sexual abuse of a child by another child.

Child Sexual Abuse – As identified in Chapter 39, Florida Statutes, child sexual abuse means one or more of the following acts:

- 1) Any 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) Any sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person.
- 3) Any intrusion by one person into the genitals or anal opening of another person, including the use of any object for this purpose, except that this does not include any act intended for a valid medical purpose.

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- 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 either the child or the perpetrator, except that this does not include:
 - (a) Any act which may reasonably be construed to be a normal caretaker responsibility, any interaction with, or affection for a child; or
 - (b) Any act intended for a valid medical purpose.
 - 5) The intentional masturbation of the perpetrator's genitals in the presence of a child.
 - 6) The intentional exposure of the perpetrator's genitals in the presence of a child, or any other sexual act intentionally perpetrated in the presence of a child, if such exposure or sexual act is for the purpose of sexual arousal or gratification, aggression, degradation, or other similar purpose.
 - 7) The sexual exploitation of a child, which includes allowing, encouraging, or forcing a child to solicit for or engage in prostitution; or engage in a sexual performance, as defined by chapter 827.

Child Protection Staff - Department of Children and Families and designated Sheriffs' Offices that provide child protective investigations, and DCF or Community Based Care (CBC) staff that provide protective supervision, foster care and adoptions services.

Child Protection Team (CPT) - A medically directed multidisciplinary team statutorily mandated to supplement the child protection activities of DCF, designated sheriffs' offices or designated community-based providers.

Child Protective Investigator – The individual responsible for investigating allegations of child abuse, neglect and/or abandonment called to and accepted by the statewide Florida Abuse Hotline.

Children's Medical Services (CMS) - The Children's Medical Services Program of the Department of Health. CMS champions excellence in the delivery of health care for children with special needs through a comprehensive system of care.

Client - means any person eligible for therapeutic services as defined in the Florida Administrative Code and the SATP Model Plan.

Community Based Care Provider - A provider contracted with DCF to manage protective supervision, foster care and adoption cases.

Counseling - A therapeutic process that engages individuals or families in the resolution, behavioral, emotional, or cognitive dissonance

Court Activity – Any activity performed by a member of the SATP as a result of a subpoena. This includes court testimony and depositions.

Department of Children and Families (DCF) - The state agency responsible, either directly or through contracted providers, for child abuse investigations, court ordered and voluntary protective services, foster care, licensing and adoption services.

Department of Health (DOH) - The public health agency responsible for the health and safety of all citizens of the state of Florida.

Extra-familial Sexual Abuse- Sexual abuse that has been perpetrated against a child by any one other than a family caretaker

Family Counseling – A therapeutic process that engages family systems

Group Counseling – The provision of counseling within a group setting in which the group is scheduled to have at least 5, but no more than 10, participants, which is optimal to utilize the group dynamic. However, the number of participants is subject to clinical discretion with documented rationale.

HomeSafenet (HSn) - The DCF statewide information system designed for the collection of child abuse, neglect, or abandonment allegations received by the Hotline; investigative information, and case information.

Individual Counseling –A therapeutic process that assists individuals with the resolution of behavioral, emotional, or cognitive dissonance

Intrafamilial Sexual Abuse – Sexual abuse that has been perpetrated against a child by a family member or a person in a care-giving role within the family unit.

Model Plan - The "Model Intervention and Treatment Plan," developed in response to the legislative mandate as stated in Section 39.305, Florida Statutes, describes the treatment methodology to be used by Sexual Abuse Treatment Programs. This includes any subsequent revisions made to the handbook during the contract year

Non-offending Caregiver – The parent or caregiver within the family unit who did not sexually abuse his or her child

Offender – The person who is accused of sexually abusing the victim.

Offender Evaluation – An evaluation for the purpose of determining if the offender is appropriate for the community-based outpatient treatment offered by the SATP

Program Coordinator – The person responsible for the administration of each local sexual abuse treatment program

Referral - Any request for SATP assessment or treatment services. A referral does not always result in the opening of an SATP case.

Risk Factors - Factors present that impact on the child's safety and well-being. Environmental, developmental, behavioral, and medical are some of the factors that would be assessed when determining the dynamics that impact on the overall level of risk to a child.

Sexual Abuse Treatment Program – Program funded in part or in whole through a contract with CMS which conforms to the model plan, the contract, the statute, and administrative rule.

Sexual Abuse Treatment Program Resource Book – A notebook that contains the SATP Handbook, all the current law, rules, operation procedures, contract, and information pertaining to the functioning of the SATP program. Each program is responsible for keeping this notebook up to date.

Threatened Harm – A situation which is likely to result in harm to the child

Victim – For the purposes of SATP program, a victim is a child who has disclosed sexual abuse; or there are indicators of sexual abuse, regardless of DCF findings.

VOCA – Victim's of Crime Act of 1984 – Victim assistance grant program which authorizes federal financial assistance to states for the purpose of compensating and assisting victims of crime and providing funds for training and technical assistance

Waiver – For the purposes of this document, written permission from the Division Director of Prevention and Intervention allowing an applicant to function as a counselor or program coordinator without meeting the minimum requirements for the position. Florida Administrative Code Chapter 64C-9 mandates minimum requirements and provides for waivers of same.

