(Due to CFWB SW within 12 weeks from Intake Assessment and every 12 weeks until discharge)

**Check one:** [ ]  **Update** [ ]  **Discharge Summary**

|  |  |  |  |
| --- | --- | --- | --- |
| Facilitator: |       | Phone:       | Agency:       |
| SW Name: |       | SW Phone:       | SW Fax:       |
| **ATTENDANCE** |
| Date of Initial Group Session: Click or tap to enter a date. | Last Date Attended: Click or tap to enter a date. | Number of Sessions Attended:       |
| Date of Absences:       | Reasons for Absences:       |
| Service Delivery Type: Telehealth [ ]  In-Person [ ]  | Service delivery type has been assessed and continues to be clinically appropriate: Yes [ ]  No [ ]   |

**Rating Scale for Documenting Group Participation, Homework, and Treatment Progress**:

 N/A: not addressed yet or not applicable to parent's case

**1** = Rarely **2** = Not often **3** = Sometimes **4** = Often **5** = Very often; routinely

**PARTICIPATION -** *Ratings based on progress-to-date and are reflective of changes in the client’s attitudes, beliefs, and behaviors as expressed in group and in homework assignments:*

|  |  |
| --- | --- |
| Choose an item. | **Engagement:** Shares specifics from own case as they relate to group topic |
| Choose an item. | **Communication:** Accepts feedback from peers without argument |
| Choose an item. | **Communication:** Maintains respectful and considerate interactive style with peers |
| Choose an item. | **Communication:** Provides appropriate, constructive feedback to peers |

**HOMEWORK -** *During this reporting period, client has completed homework:*

|  |  |
| --- | --- |
| Choose an item. | On time, as assigned |
| Choose an item. | Completely and thoroughly |
| Choose an item. | Applied homework topic to own case, as appropriate. Examples:       |

**TREATMENT GOALS\*-** *During this reporting period, parent has been able to:*

|  |  |
| --- | --- |
| Choose an item. | Name or describe at least 5 feelings parents have when their child has been sexually abused |
| Choose an item. | Describe and discuss parent’s own feelings since finding out about the sexual abuse |
| Choose an item. | Described strategies the parent has used for expressing or managing these feelings in appropriate, adaptive ways |
| Choose an item. | Describe the five types of denial of sexual abuse:       |
| Choose an item. | Discuss own denial in group, reasons for the denial, and triggers for denial.  |
| Choose an item. | Discuss understanding of effects of parent denial on child’s mental health |
| Choose an item. | Spontaneously place responsibility for the abuse on the offender |
| Choose an item. | Describe ways in which sexual abuse affects children:       |
| Choose an item. | Spontaneously express empathy in group for the child and what the child has experienced. Examples:       |
| Choose an item. | Share in group the specific statements and behaviors parent has provided to the child that reflect support, acceptance, and validation:       |
| Choose an item. | Identify the emotional and/or behavioral effects of child sexual abuse and how to effectively and appropriately manage them if they appear. |
| Choose an item. | If sexually abused as a child, can spontaneously describe how own abuse affected parent’s ability to recognize or intervene in her/his child’s sexual abuse:       |
| Choose an item. | Describe offender patterns of grooming, triggers, and/or opportunities/high risk situation:       |
| Choose an item. | Describe offender’s relapse prevention plan and how parent will support partner’s relapse prevention plan:       |
| Choose an item. | Describe components of safety planning: prevention and intervention:       |
| Choose an item. | Describe own prevention plan to keep child safe:       |
| Choose an item. | Describe own intervention plan that parent will use if needed to keep child safe:       |
| Choose an item. | Spontaneously describe how these prevention and intervention strategies have been implemented or are in process of being implemented:       |
| **ADDITIONAL TREATMENT GOALS (If indicated for this client):**1. Other:

Comments Regarding Progress:      Other:      Comments Regarding Progress:       |

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

|  |
| --- |
| **Additional Information** (include any relevant information pertaining to readiness to change, curriculum topics that have been covered, current risk factors/how risk has been reduced, updated treatment outcome measure scores, strengths, any barriers to change, and other services recommended at this time and why):       |

**DISCHARGE SUMMARY:**

|  |  |
| --- | --- |
| Date of Discharge: Click or tap to enter a date. | Date SW Notified: Click or tap to enter a date. |
| Reason for Discharge:  [ ]  Successful completion/met goals\* [ ]  Poor attendance [ ]  Office of Child Safety Case Closed  [ ]  Other (specify):      \*Successful completion of treatment means that the client has achieved ratings of 4 or 5 for all components listed under Participation; Homework and Treatment Goals |

**DIAGNOSIS:**

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Mental Status/Psychiatric Symptom Checklist:**The following *current* symptoms were reported and observed:

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Anhedonia | [ ]  Dissociative reactions | [ ]  Flashbacks | [ ]  Isolation |
| [ ]  Anxious mood | [ ]  Distorted blame | [ ]  Homicidality | [ ]  Psychomotor agitation |
| [ ]  Appetite disturbance | [ ]  Distressing dreams | [ ]  Hopelessness | [ ]  Sleep disturbance |
| [ ]  Avoidance | [ ]  Euphoric mood | [ ]  Intrusive memories | [ ]  Somatic complaints |
| [ ]  Concentration challenges | [ ]  Euthymic mood | [ ]  Irritable mood | [ ]  Suicidality |
| [ ]  Denial | [ ]  Exaggerated startle response |  | [ ]  Other:       |
| [ ]  Depressive mood | [ ]  Fatigue |  |  |
|  |  |  |  |

 |

The Primary Diagnosis should be listed first.

|  |  |
| --- | --- |
| **ICD-10 Code** | **DSM-5-TR Diagnosis** |
|       |       |
|       |       |
|       |       |

**Comments** (Include Rule outs, reason for diagnosis changes and any other significant information):

|  |
| --- |
| **PROVIDER INFORMATION** |
| Provider Printed Name:       | License/Registration #:       |
| Signature:       | Signature Date: Click or tap to enter a date. |
| Provider Phone Number:       | Provider Fax Number:       |
| ***If an intern or practicing at the CASOMB Associate level of certification:*** |
| Supervisor Printed Name:       | License type and #:       |
| Supervisor Signature:       | Date: Click or tap to enter a date. |

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

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