(Due to CWS 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: | | Last Date Attended: | Number of  Sessions Attended: |
| Date of Absences: | | Reasons for Absences: | |

**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: | Date SW Notified: |
| Reason for Discharge:  Successful completion/met goals\*  Poor attendance  CWS 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.

|  |  |  |  |
| --- | --- | --- | --- |
| **ID (ICD-10)** | **Description** | **Corresponding DSM-5-TR Diagnostic Code or V Code** | **Corresponding DSM-5-TR Diagnostic Description or V Code Description** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

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

|  |  |
| --- | --- |
| **SIGNATURE:** | |
| Provider Printed Name: | License/Registration #: |
| Signature: | Signature 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: |

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 CWS SW.

Date faxed to **Optum TERM at: 1-877-624-8376**: