(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**:

**0** = 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:*

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

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

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

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

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

The Primary Diagnosis should be listed first.

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