TERM Intimate Partner Violence Victim Group Psychotherapy Treatment Standards

Prepared by: Optum Public Sector San Diego

Optum TERM
P.O. Box 601340
San Diego, CA 92160-0340
Phone: 877-824-8376 | Fax: 877-624-8376

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

Optum TERM: Important Updates to TERM Intimate Partner Violence Victim Group Psychotherapy Treatment Standards

Dear TERM Provider:

The TERM **Intimate Partner Violence Victim** Group Psychotherapy Treatment Standards have been reviewed and the following items have been updated:

- Updated resource links were included
- Updated Recommended Topics for CE's to include Safety & Technology, Effects of Strangulation, and Stalking
- Updated Safety Planning and Risk Assessment section to include expectations for lethality risk considerations
- Updated Treatment Approach section to include latest evidence-based information on correlation between attachment styles and intimate partner violence.
- Updated Curriculum Topics to include Stalking, Stalking & Technology, and Effects of Strangulation

Optum TERM staff can be reached at (877) 824-8376, Option 1. Thank you for working with Optum in serving clients of the County of San Diego.

Respectfully,

LeAnn Skimming, Ph.D.

TERM Clinical Program Manager

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TERM Intimate Partner Violence Victim Group Treatment Standards

Introduction

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

The current standards were developed to assist TERM group psychotherapy providers in rendering the best possible services to families affected by intimate partner violence and child maltreatment, and should be used as a guide in the operation of Intimate Partner Violence Victim groups delivered to clients referred by San Diego County Child Welfare Services.

Definitions

It should be noted that the literature pertaining to intimate partner violence is predominantly based on a female population. Throughout these Standards, group participants are referred to as "female,'' though the standards of practice for Intimate Partner Violence Victim group treatment described below apply to both female and male victims. Please also note that the terms "victim", "survivor", and "battered woman" are used interchangeably.

Key Principles

Key principles for increasing child safety and better outcomes for victims of intimate partner violence (IPV) and their children identified by the California Leadership Group on Domestic Violence and Child Well-Being (Rosewater & Moore, 2010) include:

- Keeping the parent safe and ensuring that he/she is able to engage in a safe, secure and nurturing relationship with the child.
- Respecting a child's developmental needs and keeping safety paramount to ensure that a child maintains a continuous relationship with his/her non-offending parent and when possible, a safe relationship with his/her offending parent.
- Ensuring a non-offending parent is not held responsible for the offending partner's behavior.
- Recognizing and strengthening the protective behaviors that parents engage in.

Cultural Factors

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

training required by Fee for Service Medi-Cal network will also satisfy the TERM network cultural competency requirement.

Standards of Practice

Provider Credentialing

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

Provider Training and Experience Requirements

Because of the high risk nature of intimate partner abuse and relationship violence, combined with the severity of its impact on children at many levels, it is imperative that mental health providers be trained in appropriate assessment and intervention techniques. To be approved as a TERM intimate partner violence victim group treatment provider, providers are required to demonstrate a minimum **of six (6) months supervised training experience** in working with intimate partner violence adult victims and topics relevant to the Child Welfare population (including child abuse, parenting, denial, violence, neglect, substance abuse, child development, and diagnosis and treatment of emotional and mental disorders) and completion of an approved **forty (40) hour training** program in intimate partner violence that fulfills California State's requirement for intimate partner violence victim counselors. Ongoing advanced training in the area of intimate partner violence and related topics are also required to maintain approval for this specialty and include the following: 1) **Fifteen (15) hours of CEUs** in intimate partner violence training in the last thirty-six (36) months; AND 2) Evidence of **two years of experience** in treatment of intimate partner violence victims within the last five years.

Recommended training topics may include:

1) Information about same gender couple violence and treatment needs of this population.
2) Trainings in cultural competency: Understanding issues of culture, ethnicity, inter-racial relationships, acculturation, immigrant status, citizenship, SES, geographic origin such as rural or urban and the intersection of these factors.
3) Ethical issues, maintaining appropriate boundaries, and vicarious trauma.
4) Legal issues as they relate to intimate partner violence treatment, including mandated reporting requirements, confidentiality, and privilege.
5) A historical context of intimate partner violence, the role of society in perpetuating violence.
6) How to work effectively with victims who remain in contact with their abusers.
7) Co-occurring disorders and intimate partner violence.
8) Substance abuse and intimate partner violence.
9) Personality disorders and intimate partner violence.
10) Effects of intimate partner violence on parenting and children.
11) Trauma informed services.

12) Neurobiology of trauma and PTSD and the effects of intimate partner violence.
13) Attachment theory and child development.
14) Motivational Interviewing.
15) Parenting skills, including how to address reunification and co-parenting issues.
16) Impact of intimate partner violence on children and youth.
17) Dynamics of power and control.
18) Conflict resolution, respectful communication, assertiveness, and boundaries.
19) Assessment of intimate partner violence.
20) Safety planning and relapse prevention planning.
21) Safety and technology
22) Stalking
23) Effects of strangulation
24) Seeking Safety to work with victims with co-occurring PTSD and substance abuse.
25) Crisis Intervention, including suicidality.
26) Cognitive restructuring IPV-related attitudes and beliefs, such as self-defeating thoughts.
27) Resiliency, empowerment, strengths-based treatment, and the recovery model.
28) Dialectical Behavioral Therapy.
29) Safety-Organized Practice/Signs of Safety.
30) Transtheoretical Model of Behavior Change.
31) Solution Focused Therapy.
32) Group facilitation and group dynamics.
33) Community resources.

The following trainings are available as a resource for providers:

1) Local intimate partner violence agencies provide a 40-hour training curriculum which meets CA State requirements for intimate partner violence victim counselors. The San Diego Domestic Violence Hotline, (888) DV-LINKS, have current information on approved 40-hour trainings in the community.
2) DV Essentials: An 8 hour bi-annual training given by the Domestic Violence Council.
3) Institute of Violence, Abuse and Trauma (IVAT).
4) Relationship Training Institute.

Ethical and Legal Standards

Treatment providers and agencies working with victims of intimate partner violence must meet the ethical standards outlined by professional groups with which they are affiliated, e.g., the American Psychological Association, National Association of Social Workers, and the California Association of Marriage and Family Therapists.

Confidentiality and Consent for Treatment

Optum TERM providers do not have a “typical” therapist-client relationship with Child Welfare Services (CWS) clients. The limits of confidentiality are substantially different when performing Court-ordered therapy. In Voluntary Services cases, and when clients participate in services voluntarily in cases that are pre-jurisdiction, the therapist also closely collaborates with the

Protective Service Worker (PSW). It is required that all TERM therapists discuss the limitations of confidentiality with all clients (e.g., that information gathered during the therapy process may appear in a treatment plan or progress report reviewed by the PSW and ultimately by the Court; delineating exceptions such as reasonable suspicion of child abuse, suicidal or homicidal threats; and TERM On-Site Monitoring Visits). As part of the informed consent process, providers should also obtain the client's agreement to maintain confidentiality of the other members of the group. The general guideline for ensuring informed consent is that the client must be advised in a language reasonably understandable to him/her and that the client be provided specific information regarding the nature of services, the role of the therapist, and confidentiality limitations. Providers are required to appropriately document the consent process in the client's record. For additional guidelines, please refer to Confidentiality and Consent for Treatment section in the Optum TERM Provider Handbook (Optum website under the TERM Manuals tab) pages 26-28.

Role of the Therapist

For general information on the role of a TERM provider, please see the Optum TERM Provider Handbook (Optum website under the TERM Manuals tab) pages 25-27. Additional key obligations for group providers include:

- For concerns regarding the appropriateness of a referral, providers should consult with the client's PSW.
- If a referral is generated from the PSW that may pose a potential conflict of interest, it is the responsibility of the provider to evaluate the appropriateness of the referral and decline if necessary.
- Providers should not include perpetrators in the same group as victims.
- In the case in which a client has been both the perpetrator and victim of intimate partner violence, the provider should consult with the PSW if there is any question about which group type is appropriate.
- Services should be provided in the most appropriate language as determined by the client, and providers should be mindful of the client's level of literacy.
- Providers will report any new episodes of violence reported during treatment to Child Welfare Services as soon as possible.
- Statements made during the course of treatment may trigger mandated child abuse reporting. Providers will immediately report child abuse or neglect pursuant to PC Article 2.5 Child Abuse and Neglect Reporting Act, Section 11166.
- It is expected that providers will coordinate care with the referring agency, as well as with all professionals involved in a client's case. To facilitate effective coordination and communication, the client's written consent to exchange information with other appropriate professionals involved in the case should be obtained during the initial intake assessment.

Scope of Group Treatment

The focus of intimate partner violence treatment for parent victims is on increasing the physical and emotional safety of the parent and child(ren) and decreasing risk of violence in the family.

The scope of therapy is determined by the Court's order (in Court ordered cases) and specified by protective issues and treatment goals supplied by the PSW on the Therapy Referral Form. For additional guidelines, please refer to Scope of Treatment section in the Optum TERM Provider Handbook (Optum website under the TERM Manuals tab) pages 27-28.

Treatment Structure

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

Group sessions will be a minimum of one and one half (1.5) hours per session. The length of treatment is based on a 26-week curriculum following a schedule of one (1) session weekly. Request for additional sessions must be communicated proactively to the PSW prior to exhausting the authorization on file and will be considered on the basis of clinical necessity.

Intake & Assessment

Each client will be evaluated individually at intake. The intake process shall be conducted or supervised by a licensed TERM provider. Clients whom treatment providers determine to be inappropriate for group treatment (e.g., due to immaturity, actively psychotic behavior, or borderline intellectual functioning) may be referred to individual treatment or other services for intimate partner violence as appropriate. Additional client care must be coordinated through the PSW. Providers are required to read the Therapy Referral Form and case background materials, and to use the information contained in these documents and gathered from the initial clinical interview to create case specific treatment goals and safety plans.

Intake

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

- Basic identifying and demographic information, including educational, military and occupational history.
- Trauma history, including a detailing of the client's intimate partner violence history, including assessment of each type of abuse, physical, emotional, sexual and whether or not the child(ren) were present. Independent descriptions should be included from the referring agency and from criminal justice agencies, victims, and other treatment providers as applicable. A history of any other types of trauma and the client's role in the violence should be assessed as well.
- A mental status examination and clinical observations, including potential for harm to self or others.
- Risk assessment to identify and manage/reduce risk to clients and their children.
- A psychosocial assessment including mental health history, medical history, substance abuse history, cultural history, family of origin, developmental history, and relationship history.
- Strengths and protective factors.

- Barriers to participating in and adhering to treatment.
- History of child welfare involvement.
- Assessment of parenting, including names and ages of client's children, client's perceived impact of IPV on children, and parenting skills/discipline strategies used by client.
- Use of required formal assessment measures including Drug Abuse Screening Test (DAST), Michigan Alcohol Screening Test (MAST), and Danger Assessment (Campbell, 2003; update 2019) at a minimum and others as clinically indicated. For a list of assessment measures, please review online appendix Assessment Tools (Optum website under the TERM Group Standards Tab).
- Safety Plan

Assessment Measures

Minimum requirements include a substance abuse screening and intimate partner violence risk assessment as a part of the intake and initial assessment process. If assessment indicates that substance abuse or mental health symptoms require treatment before admission into the group or concurrently with the group; this should be documented in the Initial Client Plan and coordinated with the PSW. Providers are encouraged to use other assessment measures in order to capture an adequate picture of the client's needs and functioning. Please see online appendix Assessment Tools (Optum website under the TERM Group Standards Tab) for a list of relevant measures, which are divided into the following assessment categories:

Substance Abuse (required)

The literature indicates a strong bi-directional relationship between trauma and substance abuse, and an intimate partner violence victim cannot be successfully treated without also treating co-occurring substance abuse issues. During the intake and initial assessment process, clients participating in group therapy should be screened for alcohol and drug abuse, utilizing the DAST and MAST from the online appendix Assessment Tools (Optum website under the TERM Group Standards Tab). Therefore, if the initial intake evaluation indicates drug and/or alcohol abuse or dependence, this should be addressed at the onset and within the context of the overall treatment. Providers are required to document in the Initial Client Plan and to coordinate with the PSW if the client's substance abuse is so severe that it would impact the client's ability to benefit from group treatment. Providers will report to Child Welfare Services any client's failure to comply with the substance abuse treatment recommendations utilizing the Intake Assessment or Group Quarterly Progress Report form (found on the Optum website under the DV Victims Group Tab).

Intimate Partner Violence Risk (required)

Intimate Partner Violence Risk assessments were designed to help professionals understand the victim's current risk of being re-assaulted and to provide useful data to consider during the safety planning process. A domestic violence risk measure needs to be used during the intake and initial assessment process. The Campbell Danger Assessment (DA) (2019) is required.

Intimate Partner Violence Assessments – Treatment Needs

Several different tools have been developed to provide insight into the impact of intimate partner violence on the client and his/her readiness for change. Providers can develop interventions specific to the stage of change the client is in and gauge what areas will need to be addressed in treatment. Several of these measures can also be used as outcome measures to track the effectiveness of therapy.

Trauma

Trauma measures can help clarify the nature and severity of trauma symptoms and can be used to inform treatment planning. Clients whose trauma symptoms are severe enough to impact their ability to benefit from group treatment should have their symptoms of trauma addressed before beginning a Intimate Partner Violence group.

Mental Health

Providers should complete a mental health screening tool if mental health concerns are suspected, if risk for suicidal or homicidal intent is present, and/or if the client's PSW indicates concern. The results from the mental health screening can help determine whether the client is a candidate for group treatment and to target specific treatment needs. The mental health screening tools can also be used as outcome measures to track treatment effectiveness.

Outcome Measures

Repeated assessment to measure treatment progress and outcomes is recommended. Many of the assessment tools in Assessment Tools (Optum website under the TERM Group Standards Tab) can be given pre-treatment and post-treatment to track client's progress in group. Self-report measures, such as the Beck Depression Inventory-II, Beck Anxiety Inventory, or Beck Hopelessness Scale can track changes in a client's symptoms over time. The Domestic Violence Survivor Assessment (DVSA) measures the stage of change that the client is in related to her abusive relationship and can be used to demonstrate change over time as clients progress through treatment (Murray & Graves, 2013). One of the most important outcomes for intimate partner violence treatment is the client's ability to demonstrate the use of safety skills for herself and her children.

Treatment Approach

Therapists are required to provide services in a manner that is consistent with professional, ethical, and legal standards of practice. Intimate Partner Violence group treatment approaches should be trauma and evidence-informed and should be selected to maximize the client's ability to address the protective issue(s) and mitigate risk to the child(ren). The over-arching goal for intervention with victims of intimate partner violence is the promotion of safety for the family and ending the abuse. Treatment based upon formal risk and needs assessment is the preferred approach, provided within a context of comprehensive support for the victim and child(ren).

Safety Planning and Risk Assessment

Per San Diego County Probation Domestic Violence Offender Standards *"Couple's or family counseling are currently prohibited by California State Law within the 52 week program pursuant to PC1203.097(c)(1)(G). Any referral to couples counseling shall meet the criteria set by San Diego Domestic Violence Treatment and Intervention Committee of the Treatment, Evaluation and Monitoring Committee.Safety Planning and Risk Assessment".*

Safety planning is the first priority when working with survivors of intimate partner violence. Safety planning should include an assessment of general safety risks that survivors encounter as well as specific risks that are present in various areas of their personal, professional, parenting and virtual lives. The plan should encompass methods which are aimed at resolving immediate threats and other issues impairing welfare and safety of survivors, including identifying community, medical and social resources, facilitating access to resources, minimizing or eliminating risk and the development of a written safety and protection plan (Sudderth, 2017). Battered women seeking help may already have a safety plan in place, but therapists should still review these plans with their clients to get a clearer understanding of their unique needs and to make any updates as clinically indicated. Providers are required to review collateral records and coordinate safety planning with safety goals identified in the client's case plan. When coercive-controlling violence is present it is best practice to approach safety assessment assuming it is intimate terrorism, and tailor safety planning accordingly as risks continue to be assessed. (Logan & Robert, 2018).

TERM providers rendering services to victims of intimate partner violence are expected approach risk assessment and safety planning with consideration of the intimate partner violence victim and the children's safety by including an understanding of the of all lethality risks such as stalking, strangulation, role of weapons, and suicidality. (Elliot & Romero, 2022; Messing, 2019)

Attachment Style

Recent research has identified a strong correlation between attachment style and intimate partner violence for victims and offenders. The strongest correlation was found with anxious attachment style, trailed by avoidant attachment and disorganized attachment styles, with a negative correlation between secure attachment and intimate partner violence. This research suggests that mental health professionals working with families impacted by intimate partner violence must focus some interventions on increasing survivors and offenders understanding of their attachment styles, and the importance of developing secure attachments to prevent further relational violence and intergenerational patterns of IPV from perpetuating (Spencer, Keilholtz, & Stith; 2021)

Evidenced-Informed and/or Promising Practices

Interventions for victims of intimate partner violence are relatively under-developed in the literature (Brosi & Rolling, 2010; Lee, 2007). However, several approaches have gained empirical support or are cited in the literature as promising practices (Murray & Graves, 2013).

Cognitive-Behavioral Therapy (CBT)

CBT is specifically used in treatment of intimate partner violence and helps survivors understand the thoughts and feelings that influence behaviors. CBT helps survivors develop more helpful and healthy thoughts, feelings, and behaviors while highlighting client strengths and resources (Cohen, 2008). CBT is also commonly used to treat a wide range of co-occurring disorders, including phobias, addiction, depression and anxiety. A cognitive-behavioral approach seems to be the favored theoretical intervention with survivors of intimate partner violence and has had the most empirical support for treating trauma survivors in general (Roberts & Burman, 1998). A great percentage of empirical evidence supporting CBT has been gathered from racially homogeneous samples. Due to cultural differences and isolation from mainstream culture, most minority and disadvantaged women have lower success rates with mainstream interventions (Schmidt, 2014).

Dialectical Behavioral Therapy (DBT)

There is growing evidence identifying DBT as a useful component in treatment of intimate partner violence. Although the research is limited to date, several studies show that it is a promising intervention. The Mindfulness, Distress Tolerance, Emotional Regulation, and Interpersonal Effectiveness Skills components of DBT can help survivors of intimate partner violence learn more effective ways to manage their symptoms (Iverson, Fruzzetti & Shenk, 2009).

Solution-Focused Therapy

Solution-Focused Therapy has been used with intimate partner violence offenders and has also been shown to be a promising practice with women who have experienced intimate partner abuse (Lee, 2007). The overall goals of Solution-Focused Therapy are to stop violence, establish safety, empowerment, and healing. This form of therapy utilizes the client's strengths and competencies.

Group Psychoeducation

Survivors often benefit from psychoeducational material given in group settings that help them develop knowledge and skills to manage the effects of their abuse (Murray & Graves, 2013). Psychoeducational activities can include skills training and brainstorming discussions on topics such as self-esteem, trust building, boundaries and conflict management. Research indicates the approach provides a useful forum for clients to develop increased insight while building support and connection with other group participants (Rizo, et.al, 2018).

Transtheoretical Model of Behavior Change (TTM)

Leaving an abusive partner is a complex process that involves multiple stages. The Transtheoretical or Stages of Change Model conceptualizes this process as including five stages based on a woman's readiness to leave or address the intimate partner abuse (Burman, 2003). The Stages of Change include: pre-contemplation (i.e., minimizing the abuse), contemplation (i.e., ambivalent but questioning), preparation (i.e., exploring options for change), action (i.e., breaking away or curbing abuse), and maintenance (i.e., establishing

a healthier new life). The process of behavior change in intimate partner relationships is often cyclical, with progress and relapse between stages (Burke, Mahoney, Gielen, McDonell & O'Campo, 2009). By assessing what stage of change a woman may be in at any given time, the provider's interventions can target specific needs at each stage. A potential limitation of this approach is it may not account for relational components unique to the process of leaving, in particular parenting and partner factors. For example, gender roles of women as wives/partners and as mothers may be barriers to them leaving (Brooks & Hesse-Biber, 2007; Burman, 2003).

Motivational Interviewing (MI)

MI is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. MI has been applied to a wide range of maladaptive behaviors, including intimate partner violence, related to alcohol and substance abuse as well as health promotion, medical treatment adherence, and mental health issues. Providers can use MI to help victims progress through the Transtheoretical or Stages of Change Model above (Burkitt & Larkin, 2009; Anderson, 2018).

Curriculum

Treatment goals should be case specific, based on structured clinical assessment and review of collateral materials supplied by the PSW. Outcomes should be measured by increased safety and capacity for protection of the child(ren), and changes in three (3) core components: attitudes, beliefs, and behaviors that have perpetuated violence and maltreatment. The suggested core topics below should be incorporated into the Intimate Partner Violence Victim group curriculum, with additional topics to be added as clinically appropriate at the provider's discretion.

What is Intimate Partner Violence?

- Definitions
- Patterns and cycle of abusive behavior
- Myths and beliefs regarding intimate partner violence
- Tactics of power and control that include isolation, emotional abuse, economic abuse, sexual abuse, using children, using male privilege, intimidation, and threats

Obstacles to Leaving

- Readiness for change
- Identifying internal (emotions, beliefs, attitudes, cultural and family values) and external (money, transportation, family and social pressures) barriers that may keep victims stuck
- Co-dependency
- The process of leaving

Safety Planning (Refer to online appendix Safety Plan Guidelines, on the Optum website under the TERM Group Standards Tab, for elements)

- Development of a safety plan for parent victims and their children, including:

- Identification of immediate and long term safety needs for both clients and children. Each identified safety threat should be included, along with detailed safety interventions
- Building a safety network, identifying community resources, and building skills for independence
- After-care safety planning
- Stalking
- Stalking & technology

Recognizing Warning Signs

- Recognizing risk of lethality and red flags
- Recognizing and responding to triggers for both victim and batterer
- Recognizing signs of exposure to violence and abuse in children

Legal Aspects

- TRO, Criminal Protective Orders, etc.
- Effects on immigration status
- Custody and family court

Alcohol, Drugs and Codependency

- Definitions of alcoholism and other forms of substance abuse, their impact on the individual and the family system
- Development of a relapse prevention plan (if indicated)
- Relationship between intimate partner violence and substance abuse, and substance abuse and trauma

Effects of Intimate Partner Violence

- Understanding its impact on individual and family
- Effects of strangulation
- Motivations for continuing abusive relationships versus leaving
- Identify what roles were played

Understanding the Effects of Intimate Partner Violence on Children

- Neurobiology of trauma (please refer to the Little Eyes, Little Ears link in the resources section below for a summary of the effects of abuse on the development of children or Bruce Perry's (1995 and 2009) articles in the references section below for more detailed information about the neurobiology of trauma)
- Relationship between intimate partner violence and risk for child abuse
- Risk intimate partner violence poses to the emotional and physical well-being of child(ren)
- Short and long term signs and symptoms of trauma on child(ren)
- Impact of trauma at different developmental stages

Setting Boundaries

- Assertiveness, conflict resolution, communication
- Anger management and behavioral control
- Sexuality and intimacy

Parenting and Developing the Protective Role

- Identify barriers and strengthen skillset for parenting
- Focus on safety, strategies for regulating affect and behavior in children, improving the child-caregiver relationship, normalization of child's trauma related response and helping children heal from trauma
- Reunification (anticipating and overcoming common challenges with reunifying)
- Co-parenting effectively
- Changing maladaptive patterns of interactions
- Establishing appropriate parent-child roles
- Appropriate limit setting

Understanding Trauma Responses

- Guilt, shame, and denial
- Grief and loss
- PTSD, depression, other mental health symptoms
- Mind-body connection

Trauma Recovery and Empowerment

- Coping skills to include self-soothing, grounding, distress tolerance, emotional and regulation skills
- Recovery plan to include identification of trauma triggers and strategies to proactively use coping skills during stressful times
- Building self-esteem, self-efficacy and resiliency
- Understanding linkages between past experiences and current thoughts, feelings and behaviors and the impact on parenting practices
- Learning how to develop more empowering and balanced thoughts
- Ability to identify and address trauma triggers

Understanding Healthy Relationships

- Family of origin patterns and behavior as it relates to partner violence
- Attachment styles
- Power sharing and decision making issues in a relationship
- Skills for gaining intimacy in relationships
- Cultural and societal basis for violence to include values, beliefs, and behaviors
- Non-violence and equality model for relationships that includes non-threatening behavior, respect, trust and support, honesty and accountability, shared responsibility, economic

partnership, negotiation and fairness, and responsible parenting

Documentation Requirements

All providers are expected to keep a clinical record to document service provision, including a progress note of each service provided, Intake Assessment, documentation of informed consent and coordination of care, quarterly Group Progress Updates, and Discharge Summary. For additional documentation requirements refer to online appendix Documentation Requirements (Optum website under the TERM Group Standards Tab).

Treatment Progress Reporting

Intake Assessments, Group Progress Updates, and Discharge Summaries are required to be submitted to Optum TERM at 877-624-8376 on the most current version of the required reporting forms (please note that the most up to date versions of the forms can be located on the Optum website under the TERM Group Standards tab). Once the Intake Assessments, Group Progress Updates, and Discharge Summaries have passed clinical review, they will be forwarded by Optum TERM to the client's assigned PSW.

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

Intake Assessment

A written individualized Intake Assessment (located on the Optum website under the TERM Group Standards Tab) listing the goals and objectives of the treatment program shall be developed during the intake process and submitted to Optum TERM **within fourteen (14) days from the date the initial authorization** for treatment is issued. A copy should be maintained in the client's case file.

The Intake Assessment must include a complete diagnosis from the most current DSM (*Note: As of the publication date of these standards, DSM-5 has not yet been adopted by the State of California Department of Health Care Services*). The Intake Assessment should include results of formal assessment measures and case specific treatment goals that address the identified client risk factors and curricula elements specified above.

Quarterly Group Progress Updates

A progress report indicating client's individual progress in group treatment should be submitted to Optum TERM **every twelve (12) weeks after the Intake Assessment is submitted**. Group Progress Update forms are located on the Optum website under the TERM Group Standards Tab. A copy should be maintained in the client's case file.

Discharge Summary

A Discharge Summary should be submitted to Optum TERM **on completion or termination of services** using the Group Progress Update form located on the Optum website under the

TERM Group Standards Tab. A copy should be maintained in the client's case file. Progress toward treatment goals will be used to determine whether a client will be given a certificate of completion.

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

- Successful completion of the program with fulfillment of established treatment goals.
- Re-admission following a termination may be permitted based on re-evaluation by the referring agency and the treatment provider. If the program is then successfully completed, a certificate should be given.

A certificate of completion will be withheld if:

- An administrative discharge is given (e.g., Child Welfare Services case is closed).
- An inability to continue in the program (e.g., a move out of state or a referral to another treatment program).
- Violation of the conditions of the client agreement for services (any additional treatment needs must be communicated proactively to the PSW for continuity of care).

Quality Review Process

All Intake Assessments, Group Progress Updates, and Discharge Summaries are subject to review by an Optum TERM clinician. The goal of the review process is the provision of reports to the Court that meet professional standards of practice and assist Child Welfare Services and the Court with case planning.

During the quality review process, Intake Assessments and Progress Updates are reviewed against quality standards outlined in the Standards. The reviewer ensures the guidelines for treatment and client plan requirements are followed. In addition, the following elements are also reviewed:

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

When an Intake Assessment or Progress Update does not meet quality review standards, or the reader of the report (e.g., judge, PSW, or attorney) expresses concerns or files a complaint, the Optum TERM reviewer may contact the provider by telephone or written correspondence (sent via mail or fax). The reviewer then discusses the specific concerns that were identified. If the provider concurs with these concerns, the provider revises the client plan and/or report and

forwards it to Optum TERM. The provider has the right to disagree with the Optum TERM reviewer and to decline to submit revisions. This may result in notification to the PSW, and subsequently the Court, that the report did not pass quality review. In addition, at any time, Optum TERM may choose to implement the complaint process if there are significant concerns regarding the work product or if there are ongoing issues that cannot be resolved. Per contractual agreement, Optum TERM panel providers are required to comply with quality improvement initiatives, including the quality review and complaint resolution processes.

Actions related to complaints could include, but are not limited to, the following: responding to inquiries by Optum TERM reviewers, meeting with Optum TERM staff, completing requested revisions to the treatment plan and/or progress report, fulfilling requirements for additional education, training, or consultation, adhering to a quality improvement plan, or being made temporarily unavailable to new referrals. Formal review by an Optum quality committee or referral to the Credentialing Committee may also occur in relation to any significant quality of care issues.

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

Site Monitoring

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

Complaint Process

Providers understand that TERM, CWS, and the Probation Department will communicate regularly and specifically when issues arise regarding monitoring and/or certification, quality of care issues, ethical and/or professional concerns and any other issues relevant to TERM, CWS, or the Probation Department. For general information on the Optum TERM complaint process, please refer to the Optum TERM Provider Handbook (Optum website under the TERM Manuals tab) page 59.

Recommended Resources

California Partnership to End Domestic Violence: The California Partnership to End Domestic Violence is on the forefront in advocating for social change through innovative solutions to ensure safety and justice for victims and victims of intimate partner violence and their children.

Child Witness to Violence Project: Offers general information about the effects of intimate partner violence on children, statistics, and the *Report on Violence and Children.*

Coercion Related to Mental Health and Substance Use in the Context of Intimate Partner Violence: A Toolkit for Screening, Assessment, and Brief Counseling in Primary Care and Behavioral Health Settings. National Center on Domestic Violence, Trauma & Mental Health.

Family Justice Center San Diego: A public safety initiative launched by the City of San Diego to assist victims of family violence. Known as the "One-Stop-Shop" for family violence needs.

The Greenbook Federal Initiative: Provides resources and information regarding the six federally funded communities implementing the National Council of Juvenile and Family Court Judges guidelines, Effective Intervention in Domestic Violence & Child Maltreatment Cases: Guidelines for Policy and Practice.

Little Eyes, Little Ears: How violence against a mother shapes children as they grow. Cunningham, A. & Baker, L. (2007). Provides a brief overview of how abuse affects children at various developmental stages.

National Center for Victims of Crime: NCVC strives to forge a national commitment to help victims of crime rebuild their lives. They provide important links as well as current issues relevant to individuals, families, and communities harmed by violence and crime.

National Child Traumatic Stress Network: A national organization whose mission is to raise the standard of care and improve access to services for traumatized children and their families and communities.

National Center on Domestic Violence, Trauma & Mental Health: A national organization whose mission is to promote survivor-defined healing, liberation, and equity by transforming the systems that impact survivors of domestic and sexual violence and their families.

National Coalition Against Domestic Violence: The National Coalition Against Domestic Violence (NCADV) is dedicated to ending violence in the lives of women and children.

National Network to End Domestic Violence: The NNEDV is an advocacy organization for intimate partner violence coalitions and is a leading voice among intimate partner violence advocates in public policy, as well as providing support to local programs and coalitions through information, research, funding, and training.

National Partnership to End Interpersonal Violence: The NPEIV is a policy advocacy program whose mission is to make the prevention of interpersonal violence a national priority. The program works to address gaps and barriers through education, nationwide campaigns, and research.

Resource Center on Domestic Violence: Child Protection and Custody: Comprehensive publications and technical assistance to the fields of intimate partner violence, child protection, and custody regarding policy and practice issues inherent in work with children exposed to intimate partner violence.

Safe Start Initiative: A federal initiative with the mission to broaden the knowledge of and promote community investment in evidence-based strategies for preventing and reducing the impact of children's exposure to violence.

San Diego Domestic Violence Council: An organization that works with community partners to collaboratively promote initiatives to reduce intimate partner violence. The website has a complete list of nationwide resources.

San Diego Domestic Violence Hotline: (888) DV-LINKS (888-385-4657).

San Diego Regional Guide Domestic Violence Resources: Resources for Domestic Violence needs, such as counseling, legal, and shelter information.

Substance Abuse and Mental Health Services Administration (SAMHSA): Substance Abuse Treatment and Domestic Violence Treatment Improvement Protocol (TIP).

The 12 Core Concepts: Concepts for understanding traumatic stress responses in children and families.

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Appendices

All appendices mentioned are listed below and available on the Optum website https://www.optumsandiego.com/ under the TERM DV Victims Group Treatment tab.

- Assessment Tools
- Safety Plan Guidelines
- Intake Assessment Form
- Group Progress Report Form
- On-Site Group Monitoring Tool
- Documentation Requirements

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Assessment Tools

*Formal substance abuse and domestic violence risk assessment are required during the intake process. Many of the measures can also be used to assess treatment progress. Below is a non-exhaustive list of potential measures to be included in the intake and treatment process:

Domestic Violence Risk Assessment (required)*	***Substance Abuse Assessment (required)****	***Mental Health Assessment***	***Trauma Assessment***	***Domestic Violence Treatment Needs Assessment***
Danger Assessment (DA) (Campbell, 2019): Structured guidelines for assessing the risk of lethal domestic violence; identifies 15 risk factors for violence coded on the basis of interviews with victims. Designed to diagnose risk of lethal violence and extreme dangerousness. According to Roehl et al. (2005), using the DA combined with the individual's perception of risk was the best model for predicting re-assault. Alone, perception of risk was not as predictive as the DA (Campbell, Sharps & Glass, 2000).	*The Drug Abuse Screening Test (DAST), 1982:* A 28 item self-report scale that has been found to be a sensitive screening instrument for the abuse of drugs other than alcohol. Ages 18 and up.	*Beck Depression Inventory - II (BDI-II), 1996:* A 21 question multiple choice self-report inventory, one of the most widely used instruments for measuring the severity of depression. The test is designed for ages 13-80 and is available in both English and Spanish.	*Posttraumatic Stress Diagnostic Scale (PDS), 1995:* A 49 item self- report inventory that helps providers screen for the presence of PTSD and can be used over the course of treatment to gauge changes in symptom severity. It requires an 8th grade reading level and is designed for individuals ages 18 to 65.	*Domestic Situation Inventory (DSI) (Brady, 2004):* A counseling tool that provides awareness, promotes prevention, enhances resiliency, and encourages early intervention in violent relationships. It consists of 155 questions about women's home-life situations. It yields a score on a continuum of risk for further DV. Supplemental scales include: Hopelessness/Depression, Powerlessness/Helplessness, Threatening Behaviors, and Violent Behaviors.
	The Michigan Alcoholism Screening Test (MAST), 1986: Devised to provide a consistent, quantifiable, structured interview instrument to detect alcoholism, consists of 25 questions that can be rapidly administered. Ages 18 and up.	*Beck Hopelessness Scale (BHS), 1993:* A 20 question multiple choice self-report inventory that was designed to measure three major aspects of hopelessness: feelings about the future, loss of motivation, and expectations. The test is designed for adults 17-80.	*Detailed Assessment of Posttraumatic Stress (DAPS), 2003:* A 104 item measure that assesses both current and historical trauma exposure and dissociative, cognitive, and emotional responses. Ages 18-91 years.	*The Domestic Violence Survivor Assessment (DVSA) (Dienemann, 2007):* Based on Prochaska's Trans-theoretical Model of Change. The model helps health care providers and abused individuals identify issues and feelings created by DV to guide counseling. It is easy to administer and has been used in outcome studies. The DVSA assesses both perceptions of the relationship with the abuser and individual's needs, along with gives information on stages of change. The scale provided is for individual use only.

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Assessment Tools

*Domestic Violence Risk Assessment (required)**	*Substance Abuse Assessment (required)**	*Mental Health Assessment*	*Trauma Assessment*	*Domestic Violence Treatment Needs Assessment*
	Adult Substance Abuse Subtle Screening Inventory - 3 (SASSI-3), 1998: Identifies high or low probability of substance dependence disorder and provides clinical insight into level of defensiveness, willingness to acknowledge problems and the desire for change. For ages 18 and up, available in English and Spanish.	*Suicide Probability Scale, 1998:* A self-report measure, which gives an overall indication of suicide risk and 4 subscales (hopelessness, suicidal ideation, negative self-evaluation, & hostility). Ages 18 and older.	*Trauma Symptom Inventory - 2 (TSI-2), 2011:* A 136 item measure that measures 3 scales (Insecure Attachment, Somatic Preoccupations, and Suicidality) and 4 summary factors (Self-Disturbance, Posttraumatic Stress, Externalization, and Somatization). Have improved validity scales to assess either over reporting or misrepresentation of symptoms. Ages 18-88 years.	*Dyadic Adjustment Scale (DAS), 1985:* A 32 item self-report measure to assess degree of relationship satisfaction for individuals in marital or cohabitating relationships. It can be administered to an individual or couple. Scales: Dyadic Satisfaction, Dyadic Cohesion, Dyadic Consensus, and Affectional Expression. Ages 18 and older.
		Brief Symptom Inventory (BSI), 1993: A 53 item self-report scale used to measure 9 symptom dimensions (somatization, obsessive-compulsive behavior, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism), and three global indices [Global Severity Index (GSI), Positive Symptom Distress Index (PSDI), and Positive Symptom Total (PST)]. Ages 13 and older.		*Women's Experiences with Battering Scale (WEB) (Smith, Thornton, DeVellis, Earp, & Coker, 2002):* A 10 item scale assessing women's experiences when feeling controlled, vulnerable, and fearful in the context of an abusive relationship. It addresses the experiential, rather than behavioral features of battering, in particular, its meaning and consequences of battering for victims.

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Assessment Tools

*Domestic Violence Risk Assessment (required)**	*Substance Abuse Assessment (required)**	*Mental Health Assessment*	*Trauma Assessment*	*Domestic Violence Treatment Needs Assessment*
		Beck Scale for Suicide Ideation (BSS), 1991: A 21 item multiple-choice self-report inventory that was designed to measure suicidal intent. The test is designed for ages 17 and older and is available in both English and Spanish.		
		Beck Anxiety Inventory (BAI), 1993: A 21 item multiple-choice self-report inventory that was designed to measure severity of anxiety. The test is designed for ages 17-80, and is available in both English and Spanish.		

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Intimate Partner Violence Safety Plan Guidelines

A. The following guidelines are intended to provide assistance with safety planning in Child Welfare Services cases involving domestic violence.

B. **Submission of written domestic violence safety plans to Child Welfare Services is not required. For client protection, please do not release this information.**

C. The domestic violence safety plan is intended to facilitate empowerment of the victim or non-protective parent by providing concrete steps for preventing exposure to future acts of physical or emotional abuse through proactive behaviors.

D. The domestic violence safety plan should address the emotional as well as technological and physical safety and well-being of the child(ren) and identified victim(s). The identified action steps and behaviors must be very specific and must incorporate the case-specific risks identified in the Therapy Referral Form that the client and therapist are addressing.

E. Protective actions include identification of specific triggers or conditions under which the child and client may be put at risk. These triggers may be external or internal to the non-protecting parent AND /OR to the offending parent that signal danger. These are best organized on a continuum from earliest warning signs to signs of imminent danger.

F. The safety plan should identify what the victim or non-protecting parent will do if the identified triggers or “red flags” occur.

G. The plan should consider and address client logistics, support system, and access to specific resources such as:

- **a.** Emergency phone numbers (police, crisis lines, battered women’s hotlines, safe individuals in their support system)
- **b.** List of available resources (legal guidance, medical, advocacy)
- **c.** List of phone numbers to shelters, safe houses, or other safe places where the client can go
- **d.** Temporary Restraining Order information
- **e.** Concrete behavioral steps to take in an emergency
- **f.** Rehearsal of safety plan steps when appropriate

A sample personalized safety plan for domestic violence survivors can be found online at http://www.ncdsv.org/NCDSV_DVSafetyPlan-updated_8_2016.pdf (Accessed November 2022)

Intimate Partner Violence Victim Treatment
Intake Assessment

Client Name: Client DOB: Date of Report: Click or tap to enter a date.

(Due to Optum TERM within 14 calendar days of the initial authorization start date)

I received and reviewed the following records provided by the SW (required prior to the intake assessment):

- ☐ Detention Hearing Report
- ☐ Jurisdiction/Disposition Report
- ☐ Copies of significant additional court reports
- ☐ Copies of all prior psychological evaluations and Treatment Plans for the client
- ☐ All prior mental health and other pertinent records
- ☐ Copies of History & Physical and Discharge Summary written by psychiatrist
- ☐ For Voluntary Services cases: Summary of case information and protective issues

Facilitator:		Phone:	Agency:
SW Name:		SW Phone:	SW Fax:
Date of Intake:			

DEMOGRAPHIC INFORMATION

The client is Choose an item. and self-identifies as Choose an item. . The client's preferred language is Choose an item..

Client states that the reason for referral to treatment is [brief description reflecting client's understanding of CWS involvement and reason for referral to IPV services]: .

This case is currently Choose an item..

Client and/or family have immigrated to the United States to escape war, persecution, or poverty ☐ Yes ☐ No

If "Yes", describe how immigration history and/or cultural/identity factors may have influenced client's understanding of the protective issues or willingness to collaborate with CWS:

Mental Status/Psychiatric Symptom Checklist:

The following *current* symptoms were reported and observed:

☐ Angry mood	☐ Dissociative reactions	☐ Fatigue	☐ Isolation
☐ Anhedonia	☐ Distorted blame	☐ Flashbacks	☐ Memory challenges
☐ Anxious mood	☐ Distress and/or physiological reactions to trauma reminders	☐ Helplessness	☐ Psychomotor agitatic
☐ Appetite disturbance	☐ Distressing dreams	☐ Homicidality	☐ Sleep disturbance
☐ Avoidance	☐ Euphoric mood	☐ Hopelessness	☐ Somatic complaints
☐ Concentration challenges	☐ Euthymic mood	☐ Hypervigilance	☐ Suicidality
☐ Depressive mood	☐ Exaggerated startle response	☐ Intrusive memories	☐ Other:
☐ Derealization	☐ Fatalistic cognitions	☐ Irritable mood	

Screening Tool Results (indicate name and results of all tests administered):

Substance Abuse Screening Tool Administered (*Required)*:	Results:
Danger Assessment Tool (*Campbell, 2019*) (*Required):*	Results:
Other Screening Tool Administered:	Results:
Other Screening Tool Administered:	Results:

Strengths and Barriers (indicate client's readiness to change, barriers to engage in treatment, and strengths):

Level of commitment to attend, participate and change through the treatment program: .

☐ Client is appropriate for Domestic Violence Victim group treatment

Additional suggestions to SW for adjunctive treatment while client is in Domestic Violence Victim group treatment (if applicable)**:**

☐ Client is **not** appropriate for Domestic Violence Victim group treatment (client to be discharged)

Reason/s client is not appropriate for group at this time:

a. ☐ Actively abusing drugs & alcohol; chemical dependency treatment is to precede treatment for child abuse
b. ☐ Serious emotional disturbance, requires appropriate psychiatric and medical care to be addressed prior to group involvement
c. ☐ Unable to tolerate involvement in a group (e.g., due to personality characteristics
d. ☐ Other (describe):

Recommended alternative treatment:

Additional information referring party should know, including additional clinical concerns that require adjunctive treatment:

Date SW Notified:

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-5-TR Diagnostic Code or V Code	Corresponding DSM-5-TR Diagnostic Description or V Code Description

Comments (Document criteria met for diagnosis, any diagnostic rule outs, reason for diagnostic changes and any other significant information):

GOALS TO ADDRESS IN TREATMENT

A. Client is able to develop a written safety plan to protect self and child(ren) from IPV, including warning signs of abusive behaviors, identification of safety network, and action steps to implement safety planning strategies.

B. Client is able to demonstrate understanding of the cycle of violence, types of abuse, role played in IPV dynamics.

C. Client is able to demonstrate effects of IPV on child(ren)/parenting and identify effects on their children.

D. Client is able to demonstrate the actions of protection over time in role as a parent.

E. Client is able to demonstrate understanding of healthy/safe relationships and impact on child development

Additional Treatment Goals (if indicated for this client):

F. Other:

G. Other:

SIGNATURE

Provider Signature:	License/Registration #:
Print Name:	Signature Date:
Provider Phone Number:	Provider Fax Number:

Required for Interns Only

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 Intake Assessment to the SW.

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

Intimate Partner Violence Victim Treatment
Quarterly Progress Report

Client Name: Client DOB: Date of Report: Click or tap to enter a date.

(Due to Optum TERM 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***:**

Select	**Engagement:** Participates constructively and actively, motivated, initiates dialogue, incorporates feedback from others
Select	**Awareness of Protective Issues:** Demonstrates awareness of protective issues, no minimizing and no denial
Select	**Communication:** Maintains respectful and considerate interactive style with peers when receiving feedback

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

Select	On time, as assigned
Select	Completely and thoroughly
Select	Applied homework topic to own case, as appropriate Examples:
Select	If not completed, what were client's reported challenges:

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

Select	A. Client is able to develop a written safety plan to protect self and child(ren) from IPV, including warning signs of abusive behaviors, identification of safety network, and action steps to implement safety planning strategies. Comments regarding progress:
Select	B. Client is able to demonstrate understanding of the cycle of violence, types of abuse, role played in IPV dynamics. Comments regarding progress:
Select	C. Client is able to demonstrate effects of IPV on child(ren)/parenting and identify effects on their children. Comments regarding progress:
Select	D. Client is able to demonstrate the actions of protection over time in role as a parent. Comments regarding progress:
Select	E. Client is able to demonstrate understanding of healthy/safe relationships and impact on child development. Comments regarding progress:

ADDITIONAL TREATMENT GOALS (If indicated for this client):

Other:
Comments Regarding Progress:

Other:
Comments Regarding Progress:

ADDITIONAL INFORMATION (include any relevant information pertaining to readiness to change, curricula topics that have been covered, current risk factors/how risk has been reduced, strengths, any barriers to change, and other services that would be recommended):

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:

☐ Angry mood	☐ Dissociative reactions	☐ Fatigue	☐ Isolation
☐ Anhedonia	☐ Distorted blame	☐ Flashbacks	☐ Memory challenges
☐ Anxious mood	☐ Distress and/or physiological reactions to trauma reminders	☐ Helplessness	☐ Psychomotor agitation
☐ Appetite disturbance	☐ Distressing dreams	☐ Homicidality	☐ Sleep disturbance
☐ Avoidance	☐ Euphoric mood	☐ Hopelessness	☐ Somatic complaints
☐ Concentration challenges	☐ Euthymic mood	☐ Hypervigilance	☐ Suicidality
☐ Depressive mood	☐ Exaggerated startle response	☐ Intrusive memories	☐ Other:
☐ Derealization	☐ Fatalistic cognitions	☐ Irritable mood	

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, reasons for diagnostic changes, and any other significant information):

SIGNATURE:

Provider Printed Name:	License/Registration #:
Signature:	Signature Date:
Provider Phone Number:	Provider Fax Number:

Required for Interns Only

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**:

Optum

Optum TERM					
IPV Psychotherapy Group Monitoring Tool					
Clinician/Facility Name:			Date of Review:		
Reviewer Name:	Provider Name:		Client Gender:	Client Age:	
Rating Scale: Y = Yes N = No NA = Not Applicable			**Y**	**N**	**NA**
Intake and Assessment Documentation					
	1	The reasons for admission to group are indicated.			
Comments:					
	2	A mental health history, substance abuse history and medical history is documented.			
Comments:					
	3	The record documents the presence or absence of suicidal or homicidal risk.			
Comments:					
	4	The mental health treatment history includes the following information: dates and providers of previous treatment (including therapeutic interventions and responses) and relevant family history information.			
Comments:					
	5	If the screening indicates an active alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.			
Comments:					

Rating Scale: Y = Yes N = No NA = Not Applicable			Y	N	NA
	6	The record documents a risk assessment with considerations for physical, emotional, and technological safety.			
Comments:					
	7	The psychosocial assessment documents the cultural variables that may impact treatment.			
Comments:					
	8	The record documents the presence or absence of relevant legal issues of the patient and/or family.			
Comments:					
	9	Client records include TERM required assessment instruments.			
Comments:					
Intake Assessment Form					
	10	A completed Intake Assessment is in the record.			
Comments:					
	11	A complete mental status exam recorded, documenting the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.			
Comments:					

Rating Scale: Y = Yes N = No NA = Not Applicable			Y	N	NA
	12	Intake Assessment includes the client's strengths, including treatment interventions that are consistent with goals.			
Comments:					
	13	A DSM diagnosis is documented, consistent with presenting problems, history, and mental health assessment.			
Comments:					
	14	Most recent DSM is used for diagnoses and signed by a licensed clinician.			
Comments:					
	15	The treatment record documents and addresses the adequacy of safety network and safety plan.			
Comments:					
	16	The treatment goals are consistent with diagnosis and are objective and measureable.			
Comments:					
	17	There is evidence that assessment measurements are used in developing the treatment plan and goals.			
Comments:					
Group Quarterly Progress Report					
	18	The Group Quarterly Progress Report indicates the client's participation and involvement in group.			
Comments:					

Rating Scale: Y = Yes N = No NA = Not Applicable			Y	N	NA
	19	The Group Quarterly Progress Report reflects ongoing risk assessments (suicide and homicide) and monitoring of at-risk situations.			
Comments:					
	20	The Group Quarterly Progress Report describes/lists patient strengths and limitations in achieving treatment plan goals and objectives.			
Comments:					
	21	The Group Quarterly Progress report documents any referrals made to other clinicians, agencies, and/or therapeutic services.			
Comments:					
	22	A Discharge Summary is submitted upon completion of treatment.			
Comments:					
Client Record					
	23	Each client has a separate treatment record.			
Comments:					
	24	Each record includes the client's address, employer or school, home and work telephone numbers (including emergency contacts), marital or legal status, appropriate consent forms and guardianship information if relevant.			
Comments:					

Rating Scale: Y = Yes N = No NA = Not Applicable			Y	N	NA
	25	All entries and in the treatment record include the responsible clinician's name, professional degree and relevant license/registration number, and dated and signed where appropriate.			
Comments:					
	26	Client record includes a progress note for each group session including specific and observable treatment goals with a proposed intervention for each goal consistent with the diagnosis and results of assessment.			
Comments:					
	27	Provider utilizes interventions that are consistent with those recommended in Optum TERM standards.			
Comments:					
	28	All entries include the date and duration of service.			
Comments:					
	29	The client record is legible.			
Comments:					
	30	Missed appointments (client "no shows") have not been claimed.			
Comments:					

Rating Scale: Y = Yes N = No NA = Not Applicable			Y	N	NA
	31	There is documentation that communication/collaboration with CWS occurred.			
Comments:					
	32	The clinician uses Consent for Treatment or Informed Consent forms with all clients. Informed consent includes TERM site monitoring visit			
Comments:					
	33	If the client in being seen by another mental health clinician, there is documentation that communication/collaboration occurred.			
Comments:					
On-Site Group Monitoring					
	34	Facilitator demonstrates cultural sensitivity.			
Comments:					
	35	Group size is between 3-12 participants.			
Comments:					
	36	Participants attend group session free of substances.			
Comments:					
	37	Facilitator addresses off-topic behaviors (i.e. disruptions, inappropriate comments, blaming, denial, etc.).			
Comments:					

Rating Scale: Y = Yes N = No NA = Not Applicable			Y	N	NA
	38	Facilitator uses appropriate curriculum topics consistent with Optum TERM standards.			
Comments:					
	39	Group members appropriate for group (no signs of dual relationships or inability to participate).			
Comments:					
	40	Facilitator appropriately reports any high-risk behavior and makes mandated reports as needed.			
Comments:					
	41	Facilitator demonstrates use of psychotherapy best-practice-informed interventions.			
Comments:					
	42	Facilitator presents evidence-informed psychoeducation.			
Comments:					
	43	Supervisory log reflects licensing board rules and guidelines for the practice of interns			
Comments:					
TOTAL Audit Score:					

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TERM IPV Group Standards Documentation Requirements

General documentation requirements are provided as follows and should be applied to all CWS client records regardless of funding source. The following information is required to be included in the client's medical record. Documentation must be timely, legible, and support the claims information submitted to Optum for provider reimbursement:

- Informed Consent/Agreement for Services
- The client's name or identification number on each page of the record
- The client's address; employment status; home and work telephone numbers, including emergency contacts; marital or legal status; and guardianship status
- Treatment records should be made contemporaneously with treatment description and dated with the date of entry; if records are not contemporaneously made with treatment, then the date of service should be noted along with the date of entry
- Clear and uniform modifications; any error is to be lined through so that it can still be read, then dated and initialed by the person making the change
- Relevant physical health conditions reported by the client must be prominently identified and updated as appropriate
- A clear summary of presenting problems and relevant conditions affecting the client's physical health and mental health status must be documented; for example, living situation, daily activities, and social support
- A mental health history must be documented, including previous treatment dates and providers, therapeutic interventions and responses, sources of clinical data, relevant family information, and relevant results of lab tests and consultation reports
- A mental status examination must be documented
- Documentation must include and describe client strengths and any limitations in achieving treatment plan goals and objectives, and reflect treatment interventions that are consistent with those goals and objectives
- A complete diagnosis from the most current DSM, or a diagnosis from the most current ICD, must be documented, consistent with the presenting problems, history, mental status evaluation, and/or other assessment data
- Special status situations that present a risk to client or others must be prominently documented and updated as appropriate
- Documentation of continuity and coordination of care activities between the primary clinician and other behavioral health or medical clinicians, referring agency, or other professionals involved in the client's case; if the client refuses to allow such communication, this must be documented; the client's reason for refusal should also be noted
- Time spent face-to-face with the client must match CPT code on the contracted rate schedule. The CPT code submitted on a claim form and the amount of time a provider spends face-to-face with a client must match the amount of time associated with that CPT code in the provider's contract fee schedule and the American Medical Association Current Procedural Terminology