CASE STAFFING FORM – Monthly Report

Month: **Year**

Therapist: **Probation Officer**:

Person on Supervision:

PACTS #:

Purpose: A treatment staffing was conducted regarding this client for the purpose of discussing the client's overall adjustment in treatment.

Staffing Method (check all that apply):

☐ In-person ☐ Telephone ☐ Email ☐ Video Conference

Treatment Progress

Treatment Type: ☐ Mental Health ☐ Substance Abuse ☐ Co-Occurring

Goal Progress: ☐ Acceptable ☐ Unacceptable

Service Type	Weekly	Biweekly	Monthly
Individual	☐	☐	☐
Group	☐	☐	☐

Anticipated time frame for completion: ☐ ___ months ☐ TBD ☐ Other:

DYNAMIC RISK FACTORS:

☐ Cognitions ☐ Social Networks ☐ Education/Employment ☐ Alcohol/Drugs

THINKING ERRORS: (see PCRA interpretation report – elevated thinking styles)

☐ Ignoring Responsible Action ☐ Feeling Above the Law ☐ Making Excuses

☐ Lazy Thinking ☐ Asserting Power Over Others ☐ Getting Away with Anything

☐ Getting Sidetracked ☐ None

CLIENT MOTIVATION FOR TREATMENT:

INDIVIDUALIZED AND CULTURAL CONSIDERATIONS:

The counselor is aware and/or responsive to the following areas in the selection of treatment interventions:

☐ Low Intelligence ☐ Physical Handicap ☐ Reading/Writing Limitations

☐ Mental Health ☐ No Desire to Change ☐ Homeless

☐ Transportation ☐ Childcare ☐ Language

☐ Ethnicity ☐ History of Abuse/Neglect ☐ Interpersonal Anxiety

☐ Trauma ☐ Substance Abuse

S.M.A.R.T. TREATMENT RELATED GOALS: (specific, measurable, achievable, relevant, and time-bound; Please note if Treatment Plan still in development)

CLIENT SUPPORT SYSTEM & COUNSELOR REFERRALS:

CLINICAL UPDATES

Changes Shared with Treatment Provider:

☐ None considered clinically significant ☐ Significant changes shared (explain below)

Client is: ☐ Compliant with treatment ☐ Not compliant with treatment

Additional Comments / Notes:

Recommendations

☐ No Changes ☐ Reduction to:

Type	Weekly	Biweekly	Monthly
Individual / Group	☐	☐	☐

Discharge Status

☐ Successful Discharge ☐ Unsuccessful Discharge ☐ Terminate contract

Treatment Provider Signature: _____ Date: _____