OPEN ARMS
Veterans & Families Counselling

Care Plan Report – Tips for completing the document

Purpose:
This instruction provides information and tips to assist you in completing the care plan report.

General information

- The Care Plan is drafted over sessions one to three and **must be submitted and approved** by Open Arms **prior to further sessions being delivered**.
- The report template is located on the provider portal.
- Always use “he/she/they reported” or “stated” for information you gleaned from the client.

Please click on respective components of the Care Plan Report for relevant tips and guidance.

Care Plan Report – Tips for completing the document 1
Purpose: 1
General information 1
Presenting concerns 2
Client History 2
Treating Health Providers and Medications 2
Risk Update and Safety plan 3
Outcome Assessments Results of DASS/ AUDIT 4
Case Formulation 4
Goals 5
Strategies 6
Outcomes 6
Client Exit Plan 6
Recommendations 7
Who to contact for support 7

Presenting concerns

- Information included should provide a clear account of presenting issues to allow for targeted and relevant goals to be set with the client and to provide a baseline for measurable tracking of progress and change across the episode of care.
- This may include what the referral issue was stated as.
- Use of full sentences to describe these is recommended. The following examples may be used as a guide.

For Example:	
The client was referred for the following issues: • *Pain management linked to defence related injury* • *Transition challenges*	*The client presented with the following issues:* • *Increased anxiety* • *Difficulty sleeping*

Client History

- Client history should be sufficiently detailed to provide appropriate context and history to inform care planning and present a holistic picture of the client.
- A description of the relevant service history is useful - e.g., *the client was a Corporal in the Australian Army from 2010 to 2017 and was deployed to Afghanistan in 2015 and 2016.*
- Provide demographics plus any relevant history that contextualises the presenting problems that you have listed.

For Example:
Mrs Jones is a 32 year old apprentice baker. She is married to a current serving member with three children whose ages range from 2 to 5yrs. She reports a long history of anxiety issues and indicates she was diagnosed with Generalised Anxiety Disorder by a Psychiatrist in 2007. She reports that she has a supportive partner. However, he is currently deployed to Afghanistan, and is due to return in six months. The client reports that she has few supportive friends, and her family live in Western Australia.

Treating Health Providers and Medications

1. List who the client is seeing including GP, psychiatrists, other allied health practitioners
2. List the medications, the dosage and if known, who prescribed and when (if required).

For Example:
Medical Officer: Dr Wolfe
Psychiatrist: Dr Stones
Rehab manager: Kate Cox

Medication:
Movox 50 mg, by GP in 2015

Risk Update and Safety plan

1. Client Risk needs to be assessed across the three domains: harm to self, harm to others and harm from others.
2. It needs to contain 3 clear parts per domain.

1. LEVEL OF RISK:

Make a clear statement of your assessment of client exposure to risk.
Normal | Elevated

For Example:
The client presents as being at Normal | Elevated risk of harm to self

Only use normal or elevated, as descriptions of the client's exposure to risk. (do not use nil or little or no risk).

2. JUSTIFY YOUR ASSESSMENT:

Provide an explanation of how you arrived at that conclusion. Report the risk and protective factors that were identified to justify your assessed exposure to risk.

The degree of detail here is dependent upon two things:

a. Risk severity/number of risk factors identified (the greater the exposure to risk, the greater the explanation needed)

b. Sufficient detail to allow the reader to see that the assessment is consistent with the rest of the information provided within the report. For example, you may have a client who denies thoughts, plans or intent but has mentioned severe depression and symptoms of hopelessness in their presenting issues. In this case, an assessment of normal exposure to risk would need to be justified more fully.

3. SAFETY PLAN:

Clients require a safety plan if indicated in the RAMP.

For Example:
A safety plan was discussed and provided to the client and her partner. The plan includes weekly sessions with me, contact with her GP immediately and then regularly after that, management of potentially hazardous medication, coping/distraction strategies available include taking the dog for a walk, phoning partner, playing favourite music, calling Open Arms 24/7 if in distress

Outcome Assessments Results of DASS/ AUDIT

1. You need to ensure the Outcome Assessments have been included in the Care Plan.
    - Although DASS21 and AUDIT are required, circumstances may arise where completion is not possible. If the client did not complete the outcome assessments, provide a reason and/or clinical justification in the comments section.

Case Formulation

Present your understanding of the factors that are pertinent to your chosen treatment. Usually, you use these to present a hypothesis about how the problem has developed and what treatment will have an impact on this. Open Arms recommends the *Five Ps Model*, but you are welcome to use your preferred case formulation model.

The *Five Ps model* includes:

1. **Presenting issues** – list of the main themes
2. **Predisposing factors** – list the historical factors that have possibly predisposed the client to the current presentation
3. **Precipitating factors** – list the factors that have led to or contributed to the client's current presentation
4. **Perpetuating factors** – list the maintaining factors that keep the problems from resolution
5. **Prognostic factors** – a list of the positive and negative indicators that are likely to affect the client's successful treatment

These lists should be followed by a summative hypothesis as to the course and success of a chosen treatment – what treatment is proposed; what is likely to hinder change and what is likely to support change.

For Example:
***Presenting issues**: Emily reported overwhelming feelings of anger, frustration, and stress at this time.*

***Predisposing factors**: Emily reported a history which suggests developmental trauma which likely to have contributed to her difficulty regulating her emotional states and her tendency towards internalisation and self-dependence. In addition, Emily's experience of bullying and instability throughout her childhood and adolescent years, and the modelling of maternal anger and paternal avoidance may further maintain her current coping styles (anger and avoidance) and her internalised beliefs about herself (I am in danger), others (People will hurt me and let me down), and the world (The world is hostile and unsafe).*

***Precipitating factors**: Emily's current concerns appear to have been precipitated by her experience of bullying/hazing on her recent deployment. Additional triggers include increased stress and concerns regarding outcome of disciplinary action at work.*

***Perpetuating factors**: Emily's current concerns appear to be maintained by her limited emotional regulation strategies and her reliance on anger and avoidance in an attempt to meet her need for safety and protection. Emily appears to engage with entrenched threat-based cognitions which further perpetuate her hyperarousal in the day-to-day.*

***Prognostic factors**: Emily presents as an intelligent, resilient, and proactive woman who is future-oriented and motivated to support herself. Emily has positive, supportive relationships, and presents as open and willing to engage in therapy at this time. However, Emily's level of anxiety and avoidance may hinder growth if she disengages from counselling / interventions.*

Goals

List the goals of the client.

Usually, they are behavioural and measurable goals. They should also be specific and achievable for the client.

For Example:

1. *Reduce Anxiety, to comfortably attend more social events*
2. *Improve sleep onset and duration*
3. *Acquire skills to better manage anxiety symptoms, to reduce frequency of avoidance and physiological responses*

Strategies

The interventions you will utilise to address the above goals.

Note you can be more specific about which elements of interventions you will use.

For Example:

1. *CBT and ACT to reduce anxiety and improve sleep.*
2. *EMDR for trauma symptoms, targeting assault trauma memory*
3. *Relaxation training (PMR, Mindfulness, Breathing)*

Outcomes

What do you expect will happen to show the goal has been achieved?

There should be one for each goal.

For Example:

1. *The client will report a reduction in anxiety and improved experience at social events*
2. *The client will report an improvement in sleep*
3. *The client will acquire a variety of skills to manage anxiety and report confidence in her use of these skills.*

Client Exit Plan

1. Noting that Open Arms works within an episode of care approach which includes planning for and anticipating a closure of episode, where the client's individual circumstances warrant, the episode can be extended.
2. Document the estimated length of the episode of care, that you have discussed the treatment plan with the client and that this has been agreed to with the client.
3. Outline any other exit planning that you will undertake e.g. referral to other services and client knows how to re-engage etc.
4. Exit is likely to occur within 6 months. However, the client's specific circumstances may be a factor that may delay treatment outcomes and efficacy.
5. Should the client require further support this will be identified at review

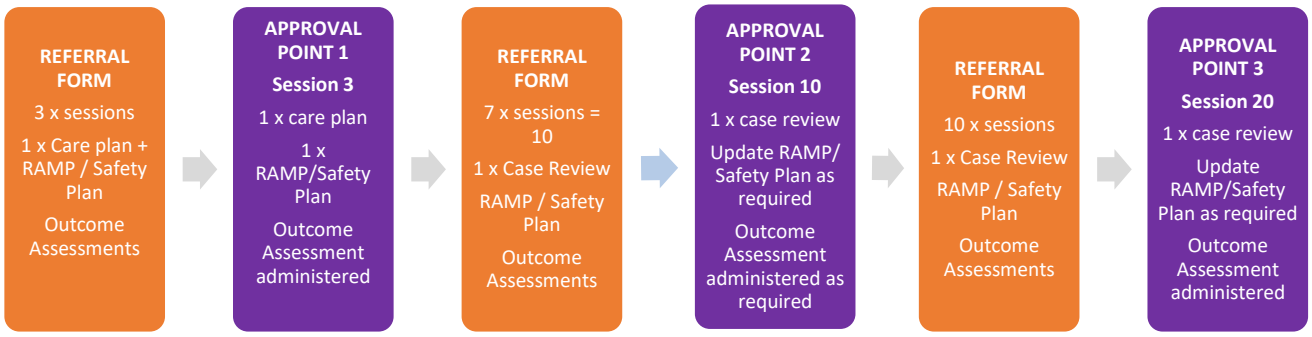
For Example:

It has been explained to the client that services received from Open Arms are to be episodic in nature, with the focus to target the presenting issue of anxiety. It is anticipated that 10-12 sessions in total will be required over 6 months, with referral back to client's GP and linkages in community social networks. The client may also benefit from inclusion in the Open Arms Anxiety management program. The client has read and agreed to the treatment plan. Client is aware to call Open Arms on 1800 number to re-engage in counselling post-discharge.

Recommendations

1. Include a short statement of how you plan to use the extension of care sessions
2. Specify a time frame (the time frame should calculate so that the requested number of sessions can be utilised within, at most, a 6-month time frame)
3. Specify if there are other programs or services that the client needs or has been referred for.

For Example:
I am requesting a further 10 sessions to deliver the proposed intervention. To be delivered fortnightly. I have also referred the client to an Open Arms Sleeping Better Group Program.



Who to contact for support

Contact your Regional Team anytime during office hours, we are here to help.

If you need to contact Open Arms after hours, please call Client Assist on 1800 011 046.

Regional Teams • SA | openarms.sa@dva.gov.au • NQLD | openarms.northqld@dva.gov.au • SQLD North - openarms.sqld.north@dva.gov.au • SQLD South - openarms.sqld.south@dva.gov.au • GNSW | openarmsgnsw@dva.gov.au • ACT/SNSW | openarmsactsnsw@dva.gov.au • VIC | openarms.victoria@dva.gov.au • TAS | openarms.tasmania@dva.gov.au • WA | openarms.wa@dva.gov.au • NT | openarms.nt@dva.gov.au	All client related matters such as risk and clinical and operational practice requirements