OPEN ARMS
Veterans & Families Counselling

Case Review Report – Tips for completing the document

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

Please click on respective components of the Case Review Report for relevant tips and guidance.

General information

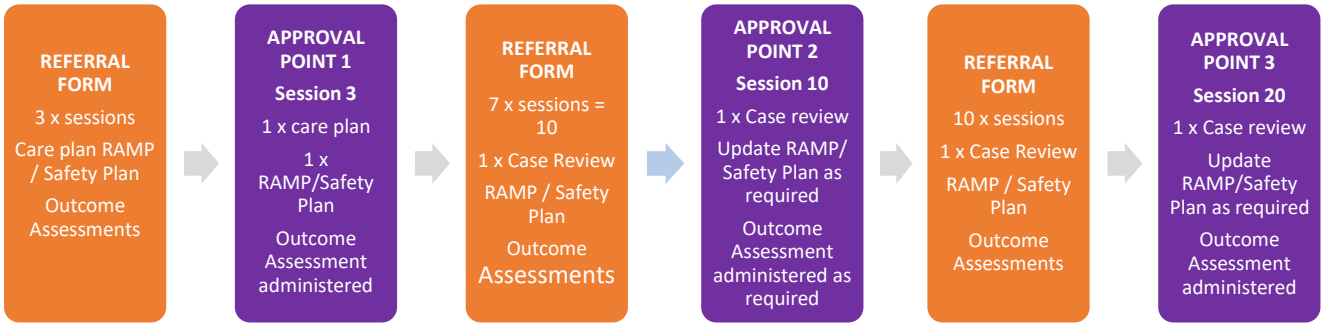
Periodic review and assessment of progress is facilitated through the Case Review reports. The Case Review provides an opportunity to reflect upon progress made by the client and whether the Care Plan goals are being progressed or have been met.

Importantly, the Case Review provides an opportunity to identify where a client is not making progress as expected and invites consideration of alternative strategies or approaches to care, where relevant or indicated.

Where a clinician is recommending further sessions, the clinician must provide a clear rationale for the request and the goals for the next extension of care must be clearly articulated. The rationale for further sessions should not include "*to continue current care*" or similar circular justifications.

As part of a client-centred approach to care, the Case Review process is recommended to be a collaborative process with the client, including providing feedback from outcome assessments and discussion around goal progress and change, in order to inform the Case Review report.

- The Case Review is used to request further sessions or to close the episode of care.
- The Case Review **must be submitted and approved** by Open Arms **prior to further sessions being delivered**.
- The report template is located in on the Provider Portal.
- Always use "he/she/they reported" or "stated" for information you gleaned from the client.



Recommendation

You will need to indicate whether the recommendation is to **Continue** with treatment or **Close**.

To Select Continue

- Select the session within the episode of care that you are submitting the report at.
- Select the frequency of ongoing sessions, noting that extension of care requests are approved in blocks of 10 sessions with the exception of the first block of 10 sessions which is approved after session 3 for a further 7 sessions. The frequency of sessions should be consistent with the therapy you are embarking on.
- Provide further details in the Comments section to support your recommendation.

Follow the steps outlined in Rationale to Continue to complete the Case Review for continuation.

To Select Close

- Click on Close
- You can provide further details in the comments section to support your recommendation
- Follow the steps Rationale to Close to complete the Case Review for Closure.

Rationale to Continue

Summary of Previous Reports Goals and Status.

Please list each of the previous reports goals and answer the below questions for each goal:

- Has the goal been met | partially met | not met
- What behavioural evidence supports your claims regarding the achievement of goals - for example: changes in Outcome Assessment scores, return to activity, self-report from client
- Provide a summary of what intervention was conducted during the preceding sessions (you might like to report what has been done, what is left to do, the client's response to the intervention)
- Were/are there any barriers to completing the goals of the previous report
- Were/are there any new situations/presenting problems that have arisen

For Example:
Max attended 10 of 10 approved sessions. The goal of reducing depression was partially achieved. Max reported an improvement in mood; he reengaged in activities he previously enjoyed such as swimming and learning to play guitar.

Results of the DASS indicate a reduction in depression symptoms consistent with Max's self-report (scores now in the Mild range, previously Moderate).

Intervention during this period has mainly focussed on behavioural activation. Cognitive strategies have not been implemented due to Max experiencing significant conflict in his relationship during this episode of care.

As a result, time was spent supporting Max with his relationship, dealing specifically with communication and conflict resolution strategies.

Max would benefit from further support with his relationship issues and further intervention for depressed mood.

Goals, strategies and outcomes for the next block of approved sessions
Note: If you are requesting further sessions, this section must be completed.

Goals

- List the goals of the client. Usually, they are behavioural and measurable goals.

For Example:

1. *Improve relationship (fewer arguments, more productive discussions and fewer parenting disagreements)*
2. *Further reduction in depression symptoms and DASS score*
3. *Further develop healthy thinking patterns and beliefs about self, others and the world that increase usual activities, realistic expectations and goal directed behaviour to achieve a level of effective functioning. 'Usual activities' would be recorded in the reports of the clients current functioning deficits.*

Strategies

- The interventions you will utilise to address the above goals.

For Example:

1. *Gottman strategies, communication and assertiveness skills training, referral to couples therapy*
2. *A CBT/ACT based intervention which will focus primarily on cognitive strategies (diffusion, thought challenging, identifying thinking errors)*

Outcomes

- This is where you will put what you expect will show the goal has been achieved. There should be one outcome statement for each goal.

For Example:

1. *The client will report an improvement in his relationship functioning and report a better understanding of how problems in his relationship develop.*
2. *The client will report improvement in symptoms of depression; this will be further supported by a reduction in DASS scores for depression.*

Outcome Assessments Results

- Outcome Assessment scores are required in the Case Review template.
- 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.

Attendance History

- Add attendance history

Risk Update

Please provide an update on the client's current risk state:

- If risk has changed significantly since your last Risk Assessment Management Plan (RAMP), please complete a new RAMP.
- A safety plan should be developed with the Client if required. A Safety Plan is required if indicated in the Summary of Risk section of the RAMP. Please document and ensure a copy of the safety plan is shared with the client.
- Client Risk needs to be assessed across the three domains: harm to self, harm to others and harm from others.
- It needs to contain 3 clear parts per domain.

1. LEVEL OF RISK:

This is a clear statement of your assessment of the level of risk.
Normal | Elevated |

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

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

2. JUSTIFY YOUR ASSESSMENT:

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

Level of detail here is dependent upon two things:

a. Risk severity/number of risk factors identified (the greater the 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 thought, plans or intent but have mentioned extremely severe depression, and symptoms of hopelessness in the presenting issues. In this case the risk assessment needs to be justified more fully.

For Example:
The client reports no thoughts, plans or intentions of self-harm and no history of suicidal risk and reports good support from his partner or *the client has repetitive thoughts of harming herself has previously engaged in harming behaviours and has no significant protective factors*

3. SAFETY PLAN:

Where risk is identified, risk formulation and safety planning must be completed and provided to Open Arms. Research shows that people assessed as at normal risk can also go on to attempt or

complete suicide. Safety planning should be proportionate with the level of risk. State what you have done to mitigate risk.

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, removal of access to 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

Client Exit Plan

Document the estimated remaining length of the episode, that you have discussed the treatment plan with the client, that this has been agreed by the client and any other exit planning that you will undertake, e.g., referral to other services, group programs, and client knows how to re-engage.

For Example:
Exit is likely to occur in 6 months. The client's lack of support may be a complicating factor that may delay treatment outcomes and efficacy. Should the client require further support this will be identified at review. The client may also benefit from inclusion in the Open Arms building better relationships program and referral to couples counselling. The client has read and agreed to the treatment plan.

Rationale to Close

A paragraph that provides a summary of the current treatment to date, such that a new clinician would have a fair understanding of the client's prior treatment from reading this report alone.

Ideally the summary should address the below:

- How many sessions have been completed to date?
- What were the goals, as outlined in the previous report?
- Were these goals achieved, partially achieved or not achieved?
- A summary of interventions conducted during the preceding sessions (you might like to report what has been done, what has not been done and why, and the client's response to the intervention).
- Why the episode is being closed (e.g., *"As the goals have been met the client has agreed to closure at this time"* or *"the client disengaged from treatment and attempts to contact have been unsuccessful, as such the case will now be closed"*). Please document evidence of attempts to contact (e.g., *"Author attempted phone contact on 5/2/25 and 12/2/25. Voice messages were left however the client has not responded"*).

Previous Goals

- A summary of therapeutic interventions conducted during the preceding sessions to address each of the goals (you might like to report what has been done, what has not been done and

why, and the client's response to the therapeutic intervention. For each goal apply a status of whether the goal was not achieved | partially achieved | achieved.

Outstanding Concerns

- Identify any barriers to completing the goals of the previous report.
- Note any new goals, situations or presenting problems that have arisen, or issues you believe may require further intervention in the future.

Outcomes Assessments

Open Arms administers the following outcome assessments throughout a client's episode of care:

- DASS-21
- AUDIT
- PCL-5 (to be administered where the client presents with indicators of trauma)

All outcomes must be scored and included in the Care Plan/Case Review report.

NOTE: The CAPS-5 or another appropriate posttraumatic stress disorder (PTSD) psychometric instrument is to be administered when the PCL-5 screening instrument indicates elevated trauma, and in the absence of a medical diagnosis of PTSD. The score and interpretation of the CAPS-5 is to be recorded as a clinical note in the client's file prior to the commencement of a PTSD treatment.

Attendance History

- Add attendance history

Risk Update

- Provide a current risk assessment using the tips outlined above as required for the Case review.

Client Exit Plan

- Provide an exit plan using the tips outlined above as required for the Case review.
- The exit plan should focus on having completed exit planning, including the client being aware how to re-engage, what supports they have been referred to or connected with.

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	All client related matters such as risk and clinical and operational practice requirements

• VIC | openarms.victoria@dva.gov.au • TAS | openarms.tasmania@dva.gov.au • WA | openarms.wa@dva.gov.au NT | openarms.nt@dva.gov.au	