Cairnmillar INSTITUTE

School of Psychology
Counselling & Psychotherapy

Case Report Guidelines

Graduate Diploma and Master of Counselling and Psychotherapy

This document outlines the specific aims and academic requirements for case reports in the Cairnmillar Institute School of Counselling and Psychotherapy. Case reports are a unit requirement for each placement and will be marked by the placement coordinator.

AIMS:

The aims of case reports are for students to demonstrate:

- Strong skills in case formulation and planning the counselling process
- An ability to recognise and, where appropriate, tentatively assess disorders using the Management of Mental Disorders manuals
- A strong understanding of evidence-informed treatments
- Develop critical reflective practice.

GENERAL GUIDELINES:

Requirements

1. Students are required to submit one case report for each placement.
2. Each case report is to be 2000 - 2500 words using the format outlined below.
3. Each case report (CAP461 and CAP561) has a different presenting problem or assessment to demonstrate the breadth of knowledge.
4. Students are required to deidentify the client by using a pseudonym (first name only), code (initials) or referred to as 'the client.'

Expression and Formatting

5. Quality of expression is to be written clearly and succinctly in plain English without jargon and with correct spelling and grammar.
6. The report is to be written in prose (no dot points)
7. Formatted in APA 7 style
8. Provide evidence with relevant and current academic literature to support your claims. Include a minimum of 8 academic references.
9. Clearly links the client's presenting symptoms, assessment, formulation, evidence-informed treatment plan and counselling interventions.
10. The presenting problem and treatment plan are to be presented in a straightforward and simple manner. It is not necessary to present all aspects of an actual case or present your most complex and challenging case.

Case Report Marking

The case report will be marked as satisfactory/unsatisfactory, and the placement coordinator will provide feedback via Canvas. Where a case report is marked as unsatisfactory, students have two weeks to resubmit a modified case report. If a resubmitted case report is marked unsatisfactory, students may be at risk of failing a placement and will be referred to the Academic Integrity Progress Committee (AIPC) for review.

CASE REPORT FORMAT

Present the case report using the following headings and content, written in prose (no dot points.

Referral Details

- Referral reason and source (maybe self-referred)
- Context (the agency name)
- Date first seen
- Number of sessions
- Period of treatment (e.g., 2 months)

Client Presentation

- Assessment of client presentation using appropriate observations based on Mental Status Examination – appearance, speech, mood, affect, thoughts process and content, behaviour, insight and judgment.
- Assessment of risk and risk factors, including recent or current:
  - Self-harm or harm to others
  - Suicidal ideation/ attempts
  - Family violence
  - Acute and severe mental health problems.

Presenting Problem

Client's description of the problem(s), including:

- Onset, duration, frequency and intensity
- Emotional, behavioural, cognitive and interpersonal aspects
- Client's view and understanding of the problem/s
- Coping strategies, both helpful and unhelpful; including current or recent medication use, substance use or addictive behaviours

Relevant Background History

- Personal and family history
- Psychosocial/ educational
- Medical/psychiatric (where applicable)
- Substance use including alcohol, drug illicit and subscription (where applicable)
- Forensic history (where applicable)
- Previous treatment intervention and response (if relevant)

Formulation

Clearly identify and integrate the four Ps with the presenting problems:

- Predisposing factors that make the client vulnerable to the presenting problem;
- Precipitating factors are recent factors that triggered a client to seek help;
- Perpetuating factors that contribute to maintaining the problem and
- Protective factors (strengths and supports) that contribute to the process of change in a supportive way

Goals of counselling:
Describe clearly and succinctly the short and long term (if relevant) goals for counselling, as agreed with the client.

Discussion of the working model for counselling and treatment focus:

Discuss the working model of counselling based on your assessment and understanding of the client's problems, relevant contributing factors, and your chosen relevant evidence-informed theories and models. Explain:

- Your selection of the evidenced informed approach chosen and based on a coherent philosophy of counselling practice and its appropriateness for working with this client.
- The treatment focus, in the context of the client's presenting problem/s, agreed goals of counselling, and the evidence-informed approach to counselling applied.

Treatment plan(s) must be realistic, given the complexity of issues, the number of sessions available and experience of the therapist.

Intervention Delivery

The analysis and evaluation of the delivery are to clearly link intervention approaches to the issues specified in the assessment and formulation sections supported by evidence-informed theories. This section includes:

- A succinct summary of specific interventions and methods used to follow the treatment plan and achieve goals.
- An analysis of two to three intervention skills used, with examples, including the student's intention in the selection of skills, and the impact the skills had on the client
- Evaluate and specify what was effective for the client and what required refinement. Include the client's stated response to interventions and what was observed by the student counsellor and linked to the theory of the approach.
- The analysis must be clearly linked with formulation and evidence-informed theories with academic references.
- Provide a plan for managing risk factors, where applicable.

Do not introduce any symptoms and aspects (or client's struggles) that were not included in the 5 Ps section.

Reflection

- An overview of how the intervention was evaluated or the outcomes measured
- Details of specific improvement(s) in presenting symptoms and behaviour
- An assessment of how this experience would be used to inform future practice
- How the work might be modified in future to improve outcomes.

Counselling and Psychotherapy Case Report Assessment Criteria		
CRITERIA	**Satisfactory**	**Not Satisfactory**
Case Report Structure follows recommended format • Client is deidentified by using a pseudonym (first name only), code (initials) or referred to as 'the client. • Written expression is clear and concise, without grammar or spelling errors • Case report headings and content are presented as per the guidelines and report is written in prose (no dot points) • Terminology is correctly employed and is written in plain English without jargon • Includes minimum of 8 academic references to support claims • There is a clear link between the client's presenting symptoms, assessment, formulation, evidence-informed treatment plan and counselling interventions. • The report is approximately 2000 to 2500 words		
Referral Details include: • Referral source and reason • Context (agency, setting) • Date first seen • Number of sessions • Period of treatment.		
Client Presentation and Presenting Problem Client presentation section uses appropriate observations based on Mental Status Examination – appearance, speech, mood, affect, thoughts process and content, behaviour, insight and judgment. Client's description of the problem(s) is outlined appropriately and includes: • Triggers, Onset, duration, frequency and intensity, course • Emotional, behavioural, cognitive and interpersonal aspects • Client's view and understanding of the problem/s • Coping strategies, including current or recent medication use, substance use or addictive behaviours.		
Assessment of risk and risk factors, including recent or current: • Self-harm or harm to others • Suicidal ideation and previous attempts • Family violence • Acute and severe mental health problems		
Relevant Background History is presented appropriately and includes: • Personal and family history • Psychosocial and educational • Medical and psychiatric (where applicable) • Substance use including alcohol, drug illicit and subscription (where applicable) • Forensic history (where applicable) • Previous treatment intervention and response (if relevant).		
Formulation is clearly outlined and integrates the 4P's with the presenting problems and includes: • Predisposing factors that make the client vulnerable to the presenting problem • Precipitating factors are recent factors that triggered a client to seek help • Perpetuating factors that contribute to maintaining the problem, and		

• Protective factors (strengths and supports) contribute to the process of change in a supportive way.		
Goals of Counselling The short and long term (if relevant) goals for counselling, as agreed with the client, are described clearly and succinctly.		
Discussion of the working model for counselling and treatment focus Discussion of the working model of counselling based on the assessment and understanding of the client's problems, relevant contributing factors, and the chosen relevant evidence-informed theories and models is clearly stated and includes: • The selection of the particular evidenced informed approach based on a coherent philosophy of counselling practice and its appropriateness in working with this client. • The treatment focus, in the context of the client's presenting problem/s, agreed goals of counselling, and the evidenced informed approach to counselling applied. The treatment plan is realistic, given the complexity of issues, the number of sessions available and the experience of the therapist.		
Intervention Delivery: The analysis and evaluation of the delivery clearly link intervention approaches to the issues specified in the assessment and formulation sections and are supported by evidence-informed theories. This section includes: • A succinct summary of specific interventions and methods used to follow the treatment plan and achieve goals. • An analysis of two to three intervention skills used, with examples, including the student's intention in the selection of skills, and the impact the skills had on the client. • Clear evaluation and specification of what was effective for the client and what required refinement. Include the client's stated response to interventions and what was observed by the student counsellor and linked to the theory of the approach. • The analysis is clearly linked with formulation and evidence-informed theories and appropriately referenced. • A plan for managing risk factors to be provided, where applicable. • Student has not introduced any symptoms and aspects (or client's struggles) that were not included in the 5 Ps section.		
Reflection • An overview of how the intervention was evaluated or the outcomes measured • Details of specific improvement(s) in presenting symptoms and behaviour • How this experience would be used to inform future practice • How the work might be modified in future to improve outcomes.		
Final assessment		
Feedback		