

SET Connects		
Document Code: SC/P03		Title: Procedure for assessment and therapy
Issue Date: October 2013	Issue No: 2	

1. The consent form (SC/F04) is posted to the Social Worker along with the appointment letter (SC/L04). The social worker is asked to bring the signed consent to the first appointment and the carers to bring the completed outcome measures.

2. An initial consultation takes place with the foster carers, residential/supervising/field social worker and other professionals as appropriate. The team member will also liaise with the external agencies that are also providing support to the young person.

3. The initial consultation summary form is completed (SC/F06), which is for the social workers and carers only. The summary of therapeutic intervention form (SC/F10) is also completed which is for inclusion in the child's file for LAC reviews etc. Both these forms should be produced within 15 working days of the initial consultation. Completed reports must be saved on the SET Connects shared drive. Clinicians should follow the protocol for Emotional Health and Wellbeing of foster family

4. Further assessment may be necessary following the initial consultation. Information is recorded using SC/F08. Liaise with Therapeutic LAC nurse if there are mental health concerns

5. Ongoing therapeutic consultation with foster / residential carers – appointments are given using appointment cards (SC/L06) and appointment details recorded on contact sheet SC/F01. Details of interventions are recorded on intervention sheet (SC/F08)

6. The types of therapeutic support offered include:

- Therapeutic support with the young person and their carers e.g. DDP, systemic interventions
- Therapeutic consultations
- Co-work and support residential staff
- Sessional art therapy
- Theraplay based interventions
- One to one therapeutic support for the young person
- Group work and training for foster carers, residential staff and supervising social workers

All face to face contacts are recorded on SC/F01

7. Referrals to Art Therapy are made using SC/L13 – letter to Social Worker and SC/L14 – Letter to Carer.

8. Following the therapeutic intervention a review takes place, every 6 months.

9. At every 6 months following the initial consultation, a review consultation should take place and a letter/report using the review consultation form (SC/F07) is completed and is sent to all professionals/agencies involved within 2 weeks.

10. William Street & Cuan Court-

When a young person is admitted to William Street or Cuan Court for Assessment, an Assessment Consultation takes place within one month and is recorded on the initial consultation summary (SC/F06). All subsequent assessment consultations should be recorded on the review consultation summary (SC/F07). All consultations should be sent within 2 weeks.

11. Residential homes-

- When a young person is admitted to one of the longer term units from William Street, SET Connects will facilitate a consultation within a month and complete the review consultation form (SC/F07). These consultations should be followed up every six months and the review consultation form completed (SC/F07). All consultations should be sent within 2 weeks.
- All information discussed about young people in the team meeting or individually with key workers should be recorded on the Group Consultation Record (SC/F09) and this form should be copied with one copy for the residential file and one for the SET Connects file.
- If completing direct work, details of interventions are recorded on intervention sheet (SC/F08) and contact sheet (SC/F01)