

**A difference that  
makes a difference**

*Clinical Manual*

*The Role of Clinicians in the Social Work Unit ©*



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## EXECUTIVE SUMMARY

- This Clinical Manual defines the responsibilities and tasks of the clinical staff based in the Social Work Units in Children's Social Care.
- The clinical staff (namely Systemic Family Therapists and Clinical Practitioners who will be referred to jointly as Clinicians) are a key part of the redefinition of the social work task in the Reclaiming Social Work project.
- The Clinicians within the Social Work Units (SWU) provide a Tier 2 CAMHS service located within front line social work.
- The Clinicians task is to enhance and extend the social work role of the SWU by offering a range of appropriate mental health interventions.
- The Clinicians are charged with embedding a systemic approach to the work of the SWU.
- The Clinicians have the task of complementing the social work task, rather than emulating it or substituting for it.
- The Clinician has the responsibility to conduct these interventions from the strongest evidence base relating to the issues at hand.
- The Clinicians line of accountability is to their Clinical Manager within the Clinical Service. Operational management lies with the Consultant Social Worker.
- Clinicians will become involved in the life of an active social work case at different stages and in different ways, depending upon the nature of the work of the SWU.
- All Clinicians' work has a clear procedural framework within which referral, response, assessment and commissioning processes take place.
- All interventions are time-limited to meet the definitions within the evidence base and in order to ensure that every case which needs clinical intervention may have that.

- All interventions are family focussed, in accordance with the evidence base. Individual child therapy is of value only in certain defined circumstances within the evidence base.
- The learning and development task for the Clinical Service is enormous.
- Many Clinicians will need careful guidance by their Clinical Managers in terms of areas of practice which are new to them.
- Clinical Managers will engage closely in supporting the SWUs and their attached Clinicians.
- Safeguarding Children is the highest context at all times and it will be the expectation that all Clinicians follow Safeguarding procedure and guidelines and make constant reference to them in order to achieve best practice within the SWU.

## **1. CONTEXT AS CONTEXT**

In systemic terms 'context' is one of the most important concepts. One of the foundational thinkers for systemic theorists, Gregory Bateson, spoke of the 'frame' (the precursor concept to context) as setting the meaning of an action. Later theorists from communications studies developed the ideas of the Co-ordinated Management of Meaning, which elaborated Bateson's rudimentary concept into a way of grasping the influence of multiple contexts upon meaning and upon predispositions for action. At its simplest, the same words or actions in a different context may be given different meanings and have different moral implications and that the same words or actions may lack intelligibility in a different context from the one of origin.

## **2. HISTORY AS CONTEXT**

In the year 2000-2001 money was first allocated in the CAMHS budget to fund a therapeutic service specifically for Looked After Children (LAC) in the Borough of Hackney. By 2002 Looked After Children's (LAC) Therapy was up and running in Albion Grove in Stoke Newington with a staff of four. In the early stages referrals to LAC

Therapy came from LAC, as the targeted group was children and adolescents living in foster or kinship placements (residing with an extended family member) in the Borough.

Many of the children looked after outside their families came to LAC Therapy bringing the effects of trauma and abuse. At that time in the life of the Service both the Social Service referrals and the Team's casework formulations evolved around an identified child, with the therapist initiating change in the child by means of direct work, which only occasionally involved conversations with the carer or others in the system as well. These early interventions were not inclusive of the wider system in the way we have come to work at present. Even so it is evident that what separated the LAC Therapy model from other models was the (1) speed, inclusiveness, and creativity of intervention and of course the (2) focus on primarily looked after children.

## **2.1 A WHOLE SYSTEM APPROACH**

While the child was coming as the bearer of the problem, slowly there developed the realization that working with and supporting a child in isolation from his domestic/educational system rarely produced useful results, and the children themselves informed us of this fact. Our young clients brought their personal stories of experienced difficulties as embedded within larger narratives of living in foster care, with often moving accounts of relationships with absent parents, or with their foster carers or other children in the placement. Our staff came to understand *the inevitability of engagement with those others within the system of the child*. Failure to include in a holistic fashion the system of concern minimized meaningful and sustainable change, and frustrated the child's efforts in making sense of his or her life experiences.

While the therapeutic referrals continued to name the child or young person(s) whose symptoms had alerted professionals that something was amiss, there was for us a deep-felt and overwhelming recognition of *the complexity of all human systems*, and a belief that trying to change a child without effecting symmetrical changes in the environment of the child's daily life was not a solution. Thus we came to embrace all aspects of and individuals within the child's particular sphere – from Foster Carers to Social Workers, from teachers to GP's, in seeking change. Professionals discovered they began to think very differently about the children and their families, and to specify the more targeted

interventions which were really needed. Within the ambit of this expanded insightfulness we were enabled to see *not problem children, but problem systems*.

Through the child's 'symptoms' practitioners will be alerted to the need to engage with the child's wider system. Sometimes holding a systemic perspective can mean looking beyond the child entirely to work on the fringes of his or her situation to support those who support that child. Peter Stratton, who speaks of his work with families in numerous articles and family therapy journals, says that the basic insight in working as a systemic practitioner is this:

*'When one member of the family - most frequently a child - seems to have, or be, a problem (hatred of school, inability to sleep, whatever), it turns out that the problem has become interwoven with the whole of family life. ... Families often come to [therapy] with the idea that the child needs medication, or if only this child behaved better, then everything would be all right. ...and parents often feel so trapped in troubles of their own that they have no strength left with which to help things improve.'*

Stratton illustrates here the misconception that fixing the child means everything will suddenly improve; that by somehow regulating the offending behaviors (symptoms) which the child is showing in certain contexts, he or she will cease to carry around the internalised distress which brought him or her to general attention in the first instance. A practitioner may indeed help the child by offering a supportive and understanding relationship for the duration of the work, but once completed, the child may be returning to the same environment where his long-term needs are not being met.

It was at this moment that the new Therapeutic Intervention Service was born, and staff were recruited who were Family Therapists or Clinicians dedicated to systemic working; not only with looked after children, but with an expanded remit to respond to all referrals coming from CSC.

## **2.2 BUILDING ON RESEARCH EVIDENCE, POLICY GUIDANCE AND EXPERIENCE**

This change was followed on a year and a half later – and as a response to the Every Child Matters' recommendations to develop services with “on the spot service delivery” – by the pilot scheme to introduce a team of front-line therapists operating within Social

Services' Duty & Assessment Teams in Morning Lane. These workers would be able to provide rapid responses – in conjunction with the relevant Social Worker – in order to carry out assessments as to the nature of the risk, and what appropriate responses need to be implemented. This innovative method of embedding Clinicians directly within SW teams served as a pilot for what was to come two years later: the embracing of collaborative working within social services itself, paving the way for the current developments which are taking place right across HCYPSC.

The effectiveness of formulating a systemic understanding of a child's needs at the point of entry (i.e., in A&A) and the joining together of various agencies to provide those needs – is a formula that not only protects the child, but can through assertive provision, actually prevent any further damaging psycho-social difficulties from developing. In fact the role of preventative work, which heralds perhaps a new level of social provision still largely on the drawing board so to speak, may be considered prior to work described as early intervention, and may be seen as an initiative which represents a more strategic approach to service delivery. Anticipating children's needs would help to grow a community of resilient young people with built-in safeguards against future personal or social difficulties.

Finally, since its inception five years ago the Therapeutic Service has been guided by a belief in new ways of working. The ideas we use are neither unproven nor alien, nor are they random beliefs which must be awkwardly transplanted onto more traditional structures, which anyway would not work. Their derivation of is largely based on feedback from research and experience, and tempered above all to fit to the particular social and ethnic particularities which Hackney embodies. The current core methodologies (Systemic Family Therapy and Social Learning Therapy) are grounded in an evidence base which says that they do in fact work, and as such they will be fundamental to our interventions as we move forward into Social Work Units.

We must continue to view our Service as provisional – as still evolving – as very much a work\_in progress. As we learn from our context – Hackney, and its people – we change, and we improve. Working collaboratively within Children's Social Care means that not only we move forward, but all those individual people, services, agencies, professionals, with whom we work and share ideas also move forward to better address our Borough's needs in supporting its families and producing.

### 3. THE RECLAIMING SOCIAL WORK CONTEXT

Hackney is the first Children's Social Care Service in the country to introduce small multidisciplinary Social Work Units as a way of supporting families towards change. In our new structure, **RECLAIMING SOCIAL WORK**, we have created the SWU so as to enable those engaged in direct work with the children and families to benefit from the support inherent in the Unit structure. Having a range of professionals available in the Units means we are able to provide assessments for young people and their families using the expertise of several disciplines, with direct lines of communication to more specialist services within the Borough if such a need is identified.

Each of the forty-eight new units is lead by a Consultant Social Worker, who will have working alongside them another Social Worker, a Children's Practitioner, a Unit Coordinator and a Clinician ( .5 Clinical Practitioner or Systemic Family Therapist); fundamentally changing the skill-set of the SWU by the inclusion of non-social work practitioners. The Units meet on a weekly basis to confer about cases and assessments – both from a social work as well as a therapeutic perspective – and agree tasks with the Consultant Social Worker who has overall case responsibility.

#### 3.1 WHY THE WORKING MODEL WAS CHOSEN

Primarily it was chosen as a response to a strategic vision that – if at all possible – we want children to remain within their families and to be safe. We believe that we are most likely to achieve these objectives through the provision of high quality Social Work and therapeutic and practical support. In addition to the provision of a family sensitive service supporting families and safeguarding children, and as a response to Lord Lamming's Inquiry (Report on Victoria Climbié; January, 2003), we share the view that *child protection cannot be separated from policies to improve children's lives as a whole*. Our work is therefore defined by the five outcomes as set out in Every Child Matters, and are to ensure that our children

- Enjoy good physical and mental health
- Stay safe, protected from harm and neglect
- Enjoy life while developing skills for adulthood

- Make a positive contribution within the community and society, avoiding anti-social behaviour
- Experience economic well-being in order to achieve their potential in life

Reflecting once again the ethos of Every Child Matters, we also believe that early identification and intervention at the point of need can make all the difference in keeping a family together in one way or another. While there may be exceptional times when children will need to be placed either temporarily or long-term in kinship or foster care placements, we will always continue to nurture the idea of the integrity and importance to the child of his or her family of origin. The thinking and striving on behalf of an individual child or family is therefore to be held in mind within the Social Work Unit, a focus shared by the five members of the team, each of whom will know and have a unique duty of care to that particular child or family.

Additionally, each unit member is bringing a high level of skills and experience to bear on the work, employing a systemic lens as a way of embracing the totality of a family's situation and environment, and adopting the behavioural approach of Social Learning Theory to help implement change in families through the acquisition of behaviour management techniques. These core methodologies underpin and inflect all the work to be done across Children's Social Care, viewing our families as embedded within a wider frame of references and relationships, a view which enables us to more fully enter the particular environment in which the child's and the family's life is unfolding.

### **3.2 ADDITIONAL FAMILY SUPPORT**

The SWU will frequently call upon the assistance of others within CSC; The child protection co-ordinators, Fostering Service, Adoption Service, Independent Reviewing Officers, the Parenting Support Service, the Contact Service, the Family Network Meeting Service, Drug and Alcohol Specialists etc.

The SWU can also access Tier 2 multi agency support via the Joint Allocation Resource Panel (JARP) from the myriad agencies across Hackney currently working with young people, whether it is Youth Offending Team, The Youth Service, the Youth Inclusion Team, the Learning Trust, the Early Intervention Parenting Programme, the Child and

Family Consultation Service, or the wider Child and Adolescent Mental Health Service (Tier 3). Referrals to the JARP will reflect the needs identified in the Care Plan.

We see our vision of joint-working beginning with our own Parenting Support Team, who will collaborate closely with the Social Work Units to ensure that families have the practical support they need, whether there is an expectation around helping parents to develop improved organisation within the home, developing schedules for the young people in their care, ensuring that GP and other medical appointments are kept, or organising an intervention with the help of behavioural models of working such as Social Learning Theory (SLT) or Mellow Parenting skills. In this way families will be supported as they discover their own competencies and resources, and have a positive experience of their own abilities around implementing change.

Equally positioned to partner the work done in the Social Work Units is the Early Intervention Parenting Program (EIPP) a Tier 2 Family Support Service, whose highly trained facilitators are available to work with parents around developing those parenting skills which may be missing, and which could make a very big difference in the life of the family and to the life of the child in their school setting. The model chosen is Webster-Stratton, which invites parents to learn to use and benefit from Social Learning Theory techniques in managing the unwanted behaviours of children in their care. The programme is delivered in community settings, children's centres and school settings. The outcomes achieved by parents in these trainings have been outstanding.

Other supporting services at Tier 2 include the cluster based Social Work Teams whose remit is to work in schools and Children's Centres in the six clusters, enabling a preventative multi agency approach to work and service delivery. This service is targeted at those children from 0-11. The Youth Support Teams have a similar preventative role and multi agency approach and work with young people 11+ and their families. All the Social Workers work with children and families with additional needs identified through the Common Assessment Framework (CAF) and where there are no child protection concerns.

As outlined in the paper Every Child Matters: Change for Children (Schools), the government has acknowledged that schools are "often the last remaining neighbourhood facility in many communities". As such they are ideally positioned to work collaboratively with the cluster based Social Workers who will engage with the children and young

people in their schools and in their communities, including the young person's family when that is possible.

#### **4. SOCIAL WORK UNIT AS CONTEXT**

Safeguarding Children is the highest context within the SWU and it will be the expectation that all Clinicians follow Safeguarding procedure and guidelines and make constant reference to them in order to achieve best practice through the incorporation of the Every Child Matters 5 outcomes.

The Clinician has a specific clinical role within the SWU, and if requested has specific tasks and responsibilities within the overall Care Plan for each child & family worked with in the SWU. The expectation of the Clinician is to support the SWU's core tasks and will do so by working from a clinical perspective.

#### **5. CAMHS AS CONTEXT**

Many of the clinical posts are funded from the CAMHS grant allocation. This being the case, CSC is required to provide data according to the funding guidelines. Specifically, this means that outcome measures must be used for each piece of clinical work. In addition to this we must be able to measure the efficacy of our interventions. To this end the Strengths and Difficulties Questionnaire (SDQ) will be used by Clinicians at the beginning and end of any clinical intervention. User satisfaction questionnaires will also be used in all commissioned work.

The Clinical Service within Children's Social Care is best described as a CAMHS Tier 2 service. The clinical staff in the SWU's thus have a responsibility to provide a high quality child and adolescent mental health service to all the children, young people and families who require such an intervention. The Clinicians in the SWU's need to be able to screen all referrals in which a mental health component is identified. On this basis they will offer an initial clinical judgement concerning mental health risk if required. Consultation and guidance from the relevant Clinical Manager will be available as and when required.

A variety of screening tools will assist this screening process, although the Clinician is expected to use their clinical skills to identify potential concerns such as risk of self-harm

or suicide, low mood and depression, ADHD, PTSD, Eating Disorders, emerging Psychosis, concerns about parental mental health. The SDQ will be used as an aid to screening in every case, and then more specific tools such as the Moods and Feelings Questionnaire (MFQ) where there are concerns about a young person's mood or possible depression, or the Conners Questionnaire where there are concerns about ADHD, can be utilised. This will always be in consultation with the relevant Clinical Manager.

The identification of such concerns, which will require a Tier 3 multi-disciplinary CAMHS intervention, must be discussed with the appropriate Clinical Manager, and then referred to the Tier 3 CAMHS service as appropriate through the identified interagency referral process, namely the JARP. This referral process will need to take account of any identified urgent responses required, for example in the case of suicide risk and the need for an urgent mental state examination where direct contact will be made with the appropriate Tier 3 service. In terms of concerns about parental mental health, the joint mental health protocol will need to be referred to.

The adult psychiatrist will offer consultation as and when needed. These consultations are available to all CSWs.

In accordance with the defined function of a Tier 2 CAMHS service the Clinicians in SWU's will have the task of intervening at an early point to prevent mental health deterioration in children, young people and their families, by assessing and working with familial difficulties utilising the core methodologies as appropriate. At all points in their clinical work they will need to be attuned to the possible development of mental health difficulties and be able to take the outlined action. The completion of the Clinician's Assessment is of crucial importance as are the screening tools, and this will be reviewed on a regular basis.

## **6. EVIDENCE BASE AS CONTEXT**

The Methodologies: Evidence Based Practice in Social Care:

We use the evidence based methodologies which have the broadest base and greatest support through random controlled trials and meta-analyses in work with Children & Families. Social Learning Theory based interventions are used in a range of modalities such as group learning, family interventions and school-based. Also used are Systemic

Family Therapy based interventions, using a range of different technical methods for the issue in hand.

Staff will be trained in both methodologies and will then be expected to use the most appropriate assessment and intervention approaches (i.e. what the evidence base best supports) with each child and family case.

Other evidenced based interventions that will be used in our work are for example the Webster-Stratton Parenting Programme and CBT interventions.

## **7. SYSTEMIC FAMILY THERAPY & SOCIAL LEARNING THEORY**

Hackney Children's Social Care has elected to privilege the two working methodologies of Systemic Family Therapy and Social Learning Theory. These two evidence based models of working are fundamental to our new vision of multidisciplinary working, without which the integration of a multi-professional group of people would lack the tools – both at the level of joining up the widely differing experiences which the various professionals are bringing – as well as at the level of being able to provide families with the tools they need via behavioural interventions to change their functioning - tools which build on the resources our families already possess.

We believe another advantage of Systemic Family Therapy and SLT is their potential to provide a framework most often experienced as respectful and empowering, enabling partnership working within a multicultural community, exemplified by both Hackney residents and our CSC staff. Through positive and appreciative joined up working we are more likely to deliver the positive outcomes which form our vision for Hackney's children. To further enhance that vision, and to assist in delivering the best outcomes, staff will be trained to effectively use Social Learning Theory techniques and engage in systemic practice at all levels, so that CSC staff will possess the means to address complex and challenging behaviours in the home, and to ensure that at least some part of those skills are transferred to the parents or carers.

The evidence base for our chosen methodologies is derived from ongoing research, with both models recommended for their efficacy in different contexts and with different client groups (see the NICE Guidelines, 2002; DoH 2003, National Service Framework; Leff et al., 2000, 2003, etc.). To be sure we were making the right choice regarding the way

were proposing our staff might work, Hackney piloted a scheme for two years in which clinical staff were embedded in the Access & Assessment Teams in Morning Lane. This helped to ensure that children on the edge of care were helped to return home or to their placements. We believe that our work has shown that we can – with the right level of support – keep families together if at all possible. And equally significantly our user feedback from families – largely measured in terms of engagement – tells us that the families that we have worked with are not unhappy to work in these ways.

## **8. WHAT WE MEAN BY FAMILY THERAPY & SYSTEMIC PRACTICE**

Systemic Practice is where the practitioner is using a range of techniques and methods of work from the systemic tool kit, but is not engaged with the family as the focus of therapeutic practice in what could be described as family therapy. This may involve using systemic techniques with the professional network, school staff plus young person, etc. Family Therapy is where the Clinician is engaged in a therapeutic session (or series of such sessions) with the family in an explicit agreement to address their issues by meeting together in a managed conversation. This will be of a specific technical kind, depending upon the issues and the evidence base.

### **8.1 LEVELS OF SYSTEMIC PRACTICE:**

- Reflecting on your own practice with a systemic lens - active reflexivity
- Bringing in the 'wider system' in discussion - introducing a view of the systems
- Thinking systemically with colleagues - case discussions with systemic input
- Networking - working systemically with SWU colleagues with the wider network
- Formal consultation to professionals, including within the SWU
- Systemic practice - using systemic tools in a broader range of practices
- Family Therapy - systemic FT sessions in a course of work

## **9. WHAT WE MEAN BY SOCIAL LEARNING THEORY (SLT) PRACTICE**

This is where the practitioner is using the tools and techniques of SLT in order accurately to assess the situation and in order to intervene in an evidence based way. There are different levels of practice, depending upon the level of training of the practitioner and on the issues involved. The form of SLT practice in Hackney CSC is a modern derivation of the behavioural principles developed through the lineage of Skinner, Bandura and others. The UK heritage is through the work of Herbert and has been further developed into a modern, reflexive practice.

### **9.1 LEVELS OF SLT PRACTICE**

- Modelling behaviour and reinforcing parent to child behaviour in order for the parent to reinforce the child's positive behaviour.
- Coaching parents in the actions necessary to sustain an agreed plan of action
- Implementation of a pre-determined plan of action, as the key agent of change (alongside the parent or carer) and gathering data about its efficacy.
- Gathering assessment data as part of a comprehensive assessment
- Formulating a plan of action from the detailed assessment
- Intervening as lead agent of change alongside parents and coaching other professionals in the practice
- Supervising the assessment and intervention processes conducted by other professional staff.

## **10. A SYSTEMIC APPROACH**

Systemic Family Therapy is often construed both as an approach – and a technique. A systemic approach will be privileged so that it becomes embedded in the Units while staff are trained in the core methodologies. Adopting a systemic approach to our work will

support our vision for improved outcomes for the children and families of Hackney and lead to:

- A decrease in the number of children and young people accommodated and a concomitant increase in the number of children subject to child protection plans
- A decrease in the number of children subject to child protection plans
- An increase in the number of children rehabilitated safely home.

Insofar as Systemic practice may be seen as an approach, it will be connected with collaborative and respectful working, inviting the family and all the members of the therapeutic system (including the professionals and others in the child's wider system - from family, to school, to other services) to join in finding a solution to the presenting difficulty. The question of who constitutes 'the family' will need to include the extended family, and those from the wider support network who are described by the families we are working with as family, as may be the case in some cultures.

In this way the professionals are not seen to have all the answers, but instead look to the family's own understanding and particular knowledge of what is not working, and help them to identify their own skills to create a way to go forward. By privileging the voices of parents/carers and children and those involved in their lives, we feel we can provide a context in which families gain enough confidence to rely on their own strengths and resiliencies, and to play a greater role in finding a solution.

We know that in general family systems are self-regulating and can manage most difficulties on their own, or with minimal support. This is the everyday resilience by which most families survive the challenges they encounter over time. However the children who arrive in CSC will – by the intensity of their difficulties – already have alerted someone by communicating behaviorally or emotionally their inability to cope, both with the fragility and with the stress present in their young lives. And through what the young person is demonstrating – traditionally thought of as a symptom – practitioners will be alerted to the need to engage with the child's wider system.

Sometimes holding a systemic perspective can mean looking beyond the child entirely to work on the fringes of his or her situation to support those who support that child.

A long-cherished therapeutic notion, almost sacred for some, which has formed a major part of the belief system in mental health thinking and practice for well over a century, is

that of assuming that the problem belongs to the [individual] young person, or indeed any individual. True, the young person is indicating – like a barometer for the arrival of stormy weather – that a problem exists, but discovering the scope of the problem is the brief of those who are observing – and to some extent implicated in – the child's wider system.

In CSC we firmly believe that by positioning ourselves as thinking – and acting – within a systemic context we more nearly approach a non-blaming and collaborative dialogue, by means of which higher levels of engagement appear to follow. Bebe Speed has usefully expressed her view of the value of the systemic perspective in an article in the Association of Family Therapy Journal (2004):

*'Family therapists are alive to the bigger picture – the team, the team/client/family network, the department, the committee, interfaces between [young person's] and adult services, issues across the whole organization and beyond into the even bigger picture of society-wide aspects of our work such as gender, power and race.'*

She goes on to discuss perhaps *the most critical aspect of any work which is engagement*, and which she believes flows from a “can-do, optimistic outlook”, finding a way around complex and stuck systems, demonstrating an ability to look for positive framings, openings and possibilities, to be unflappable, and to assume “we can do something”.

## **11. DEVELOPING THINKING AND PRACTICE**

As part of the SWU we are part of a system, which adopts a systemic approach in order to function optimally. A systemic approach contextualises all the work of the unit.

It is best described as the process through which the core principles of a systemic practice are embedded into the work of the Unit and informs all our actions and interactions with the professional and family system. It is the responsibility of all Clinicians to speak, listen, engage, record and work with the professional and family system in a way which evidences a systemic approach to their work and to model this approach in the Unit.

In adopting a systemic approach to their work the clinician will:

- Acknowledge and work with the expertise of the CSW
- See themselves as an integral part of the Unit
- Ensure that their clinical voice informs all case work in their unit
- In Unit meetings ask questions of the other professionals, to bring out some of the more knotty issues into the conversation and help these to be addressed more fully
- Assist the system to explore the stories that we may tell about families, particularly when a case appears to be stuck, creating opportunities for different narratives to emerge
- Promote the idea that all clinical consultations do not necessarily lead to a clinical intervention, but can act as a lens which can both guide and influence outcomes.
- Question some of the problem saturated descriptions which tend to accompany referrals as a way of liberating professional energy and attention.
- Ensure wider family and professional network involvement at an early stage in the work.
- Ensure that the voice of the family and wider professional system are heard throughout the commissioning process
- Ensure that attention is paid at all times to the ethnicity, race, gender, disability, sexuality, religion of the children and families we work with at all times.
- Support the social work and professional system to think about the dilemmas families present and identify appropriate therapeutic methodologies to support the family's efforts towards change.
- Seek clarity around the care plan so that all who contribute to it are aware of their responsibilities

## 12. CLINICAL CONSULTATION

### The role of Clinical Consultation within the Social Work Unit

The idea behind clinical consultation within the SWU is twofold. Firstly it brings a clinical lens to casework discussions which are often complex, and can serve to highlight a myriad of inter-generational dilemmas and patterns of family functioning that are often detrimental to the well being of the child or young person. In such instances, systemic methodology will complement robust social work case management aimed at supporting practice outcomes which see families work towards addressing the issues of concern. Central to this collaboration will be clinical interventions that will draw upon family resources and support behavioural change.

Secondly, clinical consultation will support direct social work interventions within the SWU through all key stages of the Child Care planning process.

Clinical consultation will involve:

- Providing a clinical perspective to support SWU case discussions
- Working alongside colleagues in an advisory capacity to assist the social workers intervention with the family.
- Undertaking therapeutic interventions in which a request for collaboration with their colleagues during the work may be needed.

Primarily, clinical consultation is there to assist the SWU in developing a different perspective to their work with children, young people and their families which can lead to:

- Identifying risk and implementing effective interventions
- Undertaking a joint home visit with the social worker to assess initial therapeutic support needed
- Identification of appropriate therapeutic resources – which may lead to an immediate referral to Tier 3 CAMHS or to the JARP for access to Tier 2 or Tier 3 services, multi agency support or input from the Community or Voluntary Sector

- Making clear recommendations which can support Child Care planning outcomes. For example if an opinion is required for the purposes of a court report, the clinician may be invited to the Legal Planning Meeting to help shape the therapeutic aspect of the Letter of Instruction
- Providing the opportunity for all practitioners in collaboration to enhance existing skills while developing new ones.

## **12.1 THE INITIAL CLINICAL CONSULTATION WITH THE CONSULTANT SOCIAL WORKER**

The relationship between the Consultant Social Worker (CSW) and the Clinician is pivotal in achieving successful case work. This collaboration usually begins on any given case with the Initial Clinical Consultation. (Appendix 1)

The purpose of the Initial Clinical Consultation is to ensure that any new or existing cases held in the SWU are discussed between the Clinician (or in their absence or as well as, the Clinical Manager) and the CSW prior to presentation at the Social Work Unit Meeting. The rationale behind this is to ensure a thorough exploration of the facts and issues of concern from both a social work and a clinical perspective. At the subsequent Unit meeting the CSW will be able to present the case for discussion, having taken into consideration the outcome of the Initial Consultation which has usually – though not always - taken place prior to the actual meeting.

As the Clinicians will have sight of all cases coming into their SWU and be able to explore the history of the case on Comino, they will form a view in regard to whether there is an identified need for therapeutic input, or will advise on whether referrals are to be made to adult psychiatry for case consultation, or to the JARP for Tier 2 or Tier 3 services. In line with clinical governance arrangements, the Clinical Manager will have the responsibility of ensuring that any cases identified for therapeutic support are suitable.

While differences of opinion regarding decisions around individual cases may arise as a natural part of the referral process within the Unit, such dilemmas may be resolved by means of a collaborative discussion involving the CSW, the Clinician and the Clinical Manager. Where the lack of consensus on the handling of any given case persists, then the meeting may be expanded to include the Group Manager, at which juncture an outcome acceptable to all parties can be arrived at.

## **13. THE COMMISSIONING PROCESSES**

### **The Process of commissioning within the SWU**

The Commissioning Meeting is no longer a stand alone process but will instead sit within the wider context of Child Care Planning within the SWU. The commissioning process begins with the initial clinical consultation with the CSW and ends when the CSW or Social Worker and Clinician have met with the family and safeguarding concerns and expectations of change have been outlined by the CSW, and the nature of the therapeutic intervention explained by the Clinician and agreed with the family.

From a Clinical Services perspective, it is recognised that each service area may require different processes for the commissioning of therapeutic work. Over time, as the Units evolve, they will need to establish their own thresholds as to how therapeutic work is commissioned and when therapeutic action is taken to fit within the wider context of CSC. Tailoring the process to meet the needs of each individual Unit will ensure that the appropriate timescales are met in respective service areas, and that all participants – children, adults and professionals - have the opportunity to ensure that their views are incorporated into the assessment and plan of work.

### **Commissioning Process:**

- The initial consultation takes place between the Clinician and the CSW.
- Once agreed there is a need for a therapeutic support, it will be discussed within the SWU at the Unit meeting as part of the overall care plan.
- It may be necessary in some instances for a joint home visit to be undertaken prior to the Unit meeting being held if it is agreed that an initial view of mental health and psychological wellbeing of a family member is required.

- If additional family support is required then the CSW is able to make a referral to the JARP. If a Tier 2 or a Tier 3 CAMHS referral is necessary, the Clinician - with the CSW's agreement - will make a referral to the JARP in order to access services in line with the agreed care plan.
- The first meeting with the family, The Commissioning Meeting, provides an opportunity to hear and record the voices and ideas of the child/ren or young person, and the family/carers - as well as those of the Consultant Social Worker and the professional network - regarding past and present concerns. It will also focus on the family's understanding of the safeguarding concerns, as well as its desire to change. A proposal for therapeutic work may be made to the family at this time, which will need to be carried out from within a Safeguarding perspective, highlighting at the same time the family's stories of resilience and strengths.
- The family and the SWU agree the care plan

\* Flow of work chart – Appendix 5

### **13.1 ADDITIONAL COMMISSIONING**

Not all cases will require therapeutic intervention, but may require additional family support and/or the involvement of partner agencies: This additional support can be identified and accessed through the weekly JARP meetings.

If the Clinician recommends that therapeutic support is not appropriate, and it is agreed that alternative Family Support provision (Family Network Meeting, Contact, Parenting Support Service) and/or the involvement of partner agencies is needed, the CSW will refer to the JARP.

### **14. THE TRACKING FORM (Appendix 2)**

In order that the Clinical, Group Managers and senior management are aware of the level of clinical consultations being undertaken within each Social Work Unit and the level of direct therapeutic support offered by the Clinicians, they will use the Unit Tracking Form which they will be responsible for keeping up to date on a daily basis. The information that will be recorded will enable the Clinical and Group Managers and the Consultant Social

Workers to have an overview of the level of clinical activity, the methodologies used, the progress of the work and the outcomes achieved. The use of the Tracking Form will also provide the relevant information to support any statistical information required for data analysis of therapeutic interventions.

The Tracking Form should contain a brief description of the nature of the consultation, child, young person and adult mental health diagnosis, domestic violence, drug and alcohol and substance misuse etc

The tracking form will also be used to inform clinical supervision sessions, and **ALL ACTIONS** - as agreed by the CM and the Clinician - will be recorded on the form.

## **15. ASSESSMENT AS CONTEXT**

The core business of the Social Work Unit is that of assessment, whether it is to arrive at a decision regarding whether to return a child to his or her home, to assess the fitness or state of mental health of the child's carers to continue to parent that child, or to address abusive practices which have become apparent to Social Services. As an ongoing activity throughout the life of any piece of work in CSC, all members of the Units respectfully adhere to the seriousness of this aspect of our work, as the safeguarding of Hackney's children will ultimately rest on those decisions collaboratively arrived at within the SWU. Assessment is the product of all other activities conducted within the Unit, from studying the case history in Comino, to consulting with the relevant SW or other professional, to meeting with the child/ren and carers, etc.

Sometimes additional assessment will need to take place within the CAMH or AMH Service settings when there are concerns around mental health of any person *around* the child, or on occasion the child or young person herself. It is therefore critical that a high quality of assessment pertains at every stage of our work, as it will inform everything else which happens for the children and families with which we work.

Sometimes assessment will begin with the first engagement with the child and carers, while at other times it may commence after the initial consultation and commissioning processes have been put in place. As an activity, assessment runs parallel to any other aspects of a particular piece of work, so that we can say it is comprised of a body of

information/facts, as well as a bundle of views, decisions and perspectives - constantly in flux, much as the situation within the families we are working with.

In general, once a case forms part of a Commissioning Process, the Clinician and other members of the Social Work Unit – notably the Consultant Social Worker – will have collaboratively decided to proceed with an assessment of the child and other members of the child/ren’s system of concern. In the majority of cases a Clinician’s Assessment will lead to some form of intervention – either therapeutic, or a referral to another service for additional assessment or direct work.

Usually the agreement to undertake an assessment (and possibly a piece of work) will have been agreed between the Clinician and the Consultant Social Worker prior to the weekly Unit meeting during the Initial Consultation. Assessments can also take place as part of a planned course of intervention over time leading to an outcome, as in cases held in the Children in Need Team where a case might be progressing towards a Court Hearing - or in Looked After Children where the case is reviewed periodically to determine its conformity to the terms of a Care Plan, and to ascertain whether therapeutic support might be useful.

Regardless of the service in which a case is being held, the initial and ongoing task of the Clinician will be that of assessing for need, whether that need turns out to be therapeutic, or for additional support needs from the wider Family Support Service.

## **16. THE CLINICIAN’S ASSESSMENT (Appendix 3)**

A clinical assessment is required to inform any clinical intervention (Appendix 3).

The *Clinician’s Assessment Form* provides an inclusive structure to record the range of discrete processes which the Clinician will need to undertake in the SWU’s. The new revised form provides ample scope for recording all aspects of child/family life as revealed in the Commissioning Process/Meeting - which forms the point of entry for any therapeutic intervention - and includes a detailed family history regarding parenting, mental health, a trans-generational genogram, child/ren’s educational history, mental

health history within the family system, etc., with much of the information available on Comino.

Following the collation of the family's history as indicated above, a case formulation and plan of work needs to be recorded, with indicators as to who will be doing the work (clinician or other Tier 2/3 Services), and their timescales. The final requirement is a Review of the work, and any further recommendations for additional work.

### **16.1 SERVICE AUDIT AS REFLECTED IN SDQS AND CHI**

As part of the overall assessment the family will be provided with a Strengths and Difficulties Questionnaire (SDQ) to completed at the first meeting. SDQ's provide a measure to reflect family functioning and change, and can often be integrated into the early sessions as useful tools. SDQ's also need to be sent to the young person's school, and to any other relevant members of the family system. These initial forms will be followed up with a second form to be presented to all at the end of the intervention, and which will be able to measure ideally positive change within the family system. These forms represent the most fundamental and important sources of service audit as they to record and reflect change over time It is vital that we do not fail to implement them on every occasion.

As well as well as the SDQ the user satisfaction questionnaire (CHI) which measures service user satisfaction will be used at the end of each piece of work

It will be the responsibility of the Clinician to ensure that a Permission to Share Information form (Appendix 4) has been completed by the family.

## **17. ROLES & RESPONSIBILITIES OF CLINICAL STAFF**

### **The Role of the Family Therapist (FT) & Clinical Practitioner (CP)**

The roles of the Family Therapist and Clinical Practitioner are very similar, as both will automatically adopt a systemic clinical lens to support all interventions and conversations with the family, inclusive of the wider system of concern. Although the methodological approaches may each bring to the work varying techniques ranging from more cognitive based approaches (such as CBT or SLT) to classical family approaches utilizing reflecting teams and the use of video, all work is to be grounded in a systemic understanding of the

families we see, an understanding which can be obtained by having gained a thorough prior knowledge of the families (through both consultation with colleagues and by reading the history on Comino).

The Clinicians will provide a clinical view on all cases discussed within their SWUs to complement the social work views of their colleagues. This clinical view will include the method of engagement within the SWU, such that a systemic (and SLT) way of talking and engaging is demonstrated at all times in professional discussion. Use of basic systemic tools and techniques are to be viewed as the bread and butter of everyday talk in the SWU as well as in case discussion.

The Clinicians will provide clinical consultation in different forms.

- All Clinicians in the Units will be expected to help with the discussion about a case and assist their colleagues in drawing out creative thinking and practice in relation to that case. This may include the construction of issue-focussed genograms, or the mapping of the professional and family system in order to privilege a systemic perspective on the case in question.
- A second form of clinical consultation is one which may be arranged at any time, either prior to the Unit meeting or when it becomes expedient. Such a consultation might involve the Clinician and the CSW, and could also include the Clinical Manager, or in instances when certain concerns warrant it – the Group Manager. The conversation would be collaboratively managed amongst the various colleagues in a respectful and generative way in order to elaborate the issues, the dilemmas and the potential routes to solution, focussing on systemic or SLT possibilities.

## **18. ROLE OF FAMILY THERAPISTS (FT) WITHIN SOCIAL WORK UNIT**

The FT will engage systemically with a number of cases within the SWU, often initially collaborating with other Unit colleagues or clinical staff. The range of duties will include:

- Attending SW Unit meetings
- Supporting the Consultant Social Worker and team colleagues in managing the work of the SWU

- Providing a clinical lens around the thinking and practice of the Unit as it is needed for the families concerned
- Providing mentoring to Clinical Practitioners
- Providing Peer Work mentoring to those training in Family Therapy
- Providing clinical cover within clinical cluster as and when required by the Clinical Manager

## **18.1 THE ROLE OF THE CLINICAL PRACTITIONER IN THE SOCIAL WORK UNIT**

Clinical practitioners will engage systemically with a number of cases within the SWU, often initially collaborating with other Unit colleagues or clinical staff. The range of duties will include:

- Attending Social Work Unit meetings
- Supporting the Consultant Social Worker and team colleagues in managing the work of the SWU
- Providing a clinical lens around the thinking and practice of the Unit as needed for the families concerned
- Using Mentor/Peer Work arrangements as directed by Clinical Manager
- Providing clinical cover within clinical cluster as and when required by the Clinical Manager

## **18.2 RESPONSIBILITIES OF ALL CLINICIANS WITHIN THE SOCIAL WORK UNIT**

**The Clinician will be responsible for ensuring that they:**

- Take part in an Initial Clinical Consultation discussion with the CSW
- Make professional judgements as to whether a clinical assessment should take place, consulting with the Clinical Manager when necessary
- Offer clinical consultations within the SWU as well as to the professional network

- In front line SW Units, clinicians will undertake joint appointments wherever needed by the SWU at short notice
- Undertake a joint home visit with the social worker as part of the initial or core assessment, if it is agreed that an initial view of the mental health or psychological wellbeing of a member of the family is required
- Take part in case management discussions regarding new cases and helping to identify the appropriate Family Support and Children's Social Care Tier 2 services or therapeutic intervention required
- Take part in case management discussions regarding complex cases, including cases where children have been on the Child Protection register over 18 months
- Undertake detailed Clinical Assessment and Case Formulation as part of undertaking a clinical task and to assist in the completion of detailed Social Work Assessments
- When required, attend Child Protection Case Conferences both at Initial and Review stage
- Attend relevant Core Group, Network and/or Professionals Meetings.
- Undertake family work with more than one member of the family.
- Undertake direct therapeutic work with children and their carers as agreed with the Clinical Manager
- Ensure a constant throughput of cases
- Produce evidence based Court Reports as requested
- Maintain accurate and up to date Tracking Form and other information as required
- Ensure all families receiving a clinical service have SDQs completed at the correct stages of the work

## **The Clinicians have the following responsibilities to their Clinical Manager to:**

- Manage Case Load Expectations
- Keep the Tracking Form up to date
- Provide clear and concise records of therapeutic interventions
- Attend regular supervision with Clinical Manager

### **18.3 THE ROLE OF THE CLINICAL MANAGER**

- The Clinical Manager has responsibility for the standards of clinical practice of their group of supervisee Clinicians. They also have responsibility for guiding (by instruction if necessary) clinical staff in all stages of work, from referral to closure.
- The Clinical Manager will liaise with the CSW and Group Manager as necessary over clinical case practice and decisions. The decision to allocate a case for direct therapeutic practice by the Clinician is a process whereby the CSW refers to the Clinician in the weekly allocation meeting and the Clinical Manager confirms or alters that decision in consultation with the CSW and GM as necessary.
- The Clinical Manager will guide the practice of their supervisee clinicians through case management supervision on a regular basis.
- The Clinical Manager will conduct all HR related procedures in relation to their clinical staff as necessary: Probation, Appraisal etc.
- The Clinical Manager will co-work with a selection of cases.
- The Clinical Manager will also take a small caseload from the SW Units with which they work.

### **18.4 THE RESPONSIBILITIES OF THE CLINICAL MANAGER**

- The CM is responsible for ensuring that the therapeutic aims of the service are delivered.
- To CM co-ordinates and is responsible for all clinical input required to meet the needs of the client group within the SWU.
- The CM develops positive working partnerships within the SWU and is directly accessible to each Unit to provide clinical advice regarding appropriate therapeutic interventions.
- The CM will have particular regard for the specific needs of children and families from Black and minority ethnic groups, including refugees, ensuring that the work processes and the overall ethos of the therapeutic service is reflective of their requirements and needs.
- The CM promotes the wellbeing of LAC and children and young people with disabilities.
- The CM supports placement stability and helps families to remain together by ensuring a planned and speedy response to children and their carers.
- The CM manages and supervises the work of the clinical practitioners and takes overall clinical responsibility for their work.
- The CM ensures that Family Therapists and Clinical Practitioners work within their level of competence and supports staff in pursuance of their professional goals
- The CM ensures that all Clinical staff are covered by appropriate indemnity insurance each year.
- The CM ensures that staff Probations, Supervisions, and Appraisals are regularly undertaken and that staff have the opportunity to develop within the requirements of their changing role.
- The CM liaises with partner agencies and the voluntary and community sector to promote effective working partnerships alongside the Consultant Social Worker.

- The CM ensures that Clinicians are mindful of confidentiality rules if they wish to use audio or videotape recording of therapy sessions with families and that they work within ethical guidelines.
- The CM works alongside colleagues in the formulation, implementation of assessment outcomes
- The CM monitors therapeutic interventions and ensures that methodological approaches are evidenced in case work
- The CM ensures that all interventions pay particular consideration to the cultural and religious contexts of the diverse community.

## **18.5 THE ROLE OF THE CLINICAL GROUP MANAGER (CGM)**

The CGM will be to offer strategic vision for the development of Clinical Services in CSC. They will supervise and support the Clinical Managers in their role. The CGM will manage the therapeutic services overall and report to the Family Support Head of Service on a regular basis.

- The CGM will manage and set the strategy for the clinical supervision and consultation to clinical staff. See below regarding clinical supervision.
- The CGM will manage the Systemic and SLT programmes run in-house.
- The CGM will set the overall staff development and learning strategy for the Clinical Service.
- The CGM has overall clinical oversight and responsibility for the quality of clinical services (clinical governance) and of all therapeutic work undertaken by the clinical staff within the usual CSC structures and procedures.
- The CGM will set the clinical practice standards for clinical staff.
- The CGM will manage the Professional development Centre.

## **18.6 THE RESPONSIBILITIES OF THE CLINICAL GROUP MANAGER**

- To lead on the clinical performance of the service taking responsibility for assuring quality of clinical care through introducing and maintaining clinical governance which supports the general management task of delivering services within the available resources.
- To promote a clinical culture which encourages the new ways of working and promotes growth in clinical expertise across the Directorate.
- To lead Clinical Managers to maintain the clinical performance standards of individual Clinicians and to lead on addressing and rectifying poor performance using the appropriate HR policies and procedures as required and requested.
- To ensure that Clinicians liaise with and are informed by service users and carers and ensure that their experiences influence the way in which individual Clinicians practice and services are delivered.
- To disseminate the learning from complaints, critical incidents and Child Protection services within CSC and ensure that action plans are completed and monitored so that practice changes to improve services.
- To promote the understanding and management of risk in clinical practice and to develop new ways of working to mitigate risks that are inherent in child and adolescent mental health work within the context of CSC.
- Ensure that clinical systems for case supervision and monitoring standards of practice are in place and monitored and that the systems can assure quality of clinical practice.
- To lead, with clinical expertise, in the assessment and treatment of a cohort of children and young people with mental disorders and/or emotional and behavioural problems from across CSC.
- To be responsible for the clinical aspect of the case management of children, and young people who are deemed to be at risk.
- To employ notable clinical skills in carrying out standard and/or specialist mental health assessments; and standard or specialist risk assessments with other disciplines and other agencies when necessary.

To formulate care plans and organise the care pathways by:

- Directly conducting the treatment with the child, family and carer and/or
- Supervising others to deliver the treatment and/or
- Working clearly in a shared-care partnership with Social Care colleagues and/or professionals from other agencies.
- To employ notable clinical skills and expertise in delivering evidence-based interventions which are proven to be effective in the treatment of emotional and behavioural problems in the cohort of children and young people and their families that are worked with at Tier 3
- To value the contribution of parents/carers and family members and build their skills, and increase the resilience factors in their children
- To provide reports for referrers, families and other agencies on the children and young people under your care, including 'witness of fact' court reports, when appropriate
- To monitor safeguarding matters and provide second opinion clinical advice to colleagues
- To maintain good working relationships and clear lines of communication with all colleagues, professionals, agencies and departments both locally and nationally

## **19. THE DEVELOPMENT OF CLINICAL PRACTICE**

### **The Commitment to Staff Learning & Development**

Hackney's commitment to ensure best practice and Clinical Governance will see the roll out of core training in the two approaches for all staff within Children's Social Care. In addition, there will be opportunities for core staff to train at a Post Graduate level in Systemic Practice and in Social Learning Theory. There will be an In-House Foundation Year in Systemic Practice. There will be an in-house course in Social Learning Theory Applications, working towards accreditation as a Post Graduate Certificate programme.

Both programmes will be run at the Centre for Professional Development, based at 2 Oswald Street, Hackney E5.

### **The Commitment to Clinical Consultation and Clinical Practice**

Our relationship with The Child & Family Consultation Service (CFCS) will provide for the continuation of access to expert clinical case consultation from the fields of Clinical Psychology and Child & Adolescent Psychiatry. Equally, Adult Psychiatry will also play a pivotal role in providing a much needed clinical lens into adult mental health and its impact upon parenting.

In addition, clinical case consultation in Systemic Practice and Social Learning Theory, as well as clinical group supervision in Systemic Practice and also in SLT will provide the clinicians with ample clinical support to facilitate and safeguard ethical therapeutic practice.

### **19.1 SUPPORT STRUCTURE FOR CLINICAL STAFF**

Clinical Managers will meet with their clinicians for supervision 1:1 on a monthly basis for 1.5 hours. Unplanned supervisions and consultations with managers will happen during the normal course of work.

The following are also part of the comprehensive support structure:

#### **Supervision of Systemic Practice & Family Therapy**

An external Consultant Family Therapist (FT) will meet with groups of clinical staff once a month for supervision tailored to the needs of those staff. Staff will meet in groups of 4 of staff of identical status:

- Qualified and PQ experienced FTs;
- Qualified but less experienced FTs;
- Clinicians in training (Clinical Practitioners on Years 3 or 4 of a Systemic FT programme);
- Clinicians who have completed Year 2 of a Systemic Programme;

- (All Family Therapy supervision for staff who have completed Year 2 and above will be live supervision or direct supervision: i.e. staff bring a family to the session or a tape of a session)
- Clinicians who have completed the Foundation Year of a Systemic Programme;
- Clinicians who are only just starting systemic training,
- A clinical supervision group for Clinical Managers for their own clinical practice.

All the supervision will be tailored to meet staff development objectives.

## **SUPERVISION OF SLT**

This will be by the SLT Lead in the first instance. It will take the form of group consultation, co-work, direct supervision, as the staff skill levels increase. Eventually there will be a broader base of skilled and experienced SLT practitioners who will be able to offer consultation within SW Units. The SLT Lead would then consult to this cohort. Those who complete the proposed PG Cert in SLT will be able to mentor or direct the SLT practice of others and will have regular consultation with the SLT Lead.

## **MENTORING FOR CLINICAL PRACTITIONERS**

Clinical Practitioners will be paired with the FT in their cluster of SW Units. The FT will offer case practice advice (coaching in small scale techniques) as well as offering peer pair work to a Clinical Practitioner in advanced FT training. This will consist of a morning per week where each brings a case (in the case of the Clinical Practitioner it may be most helpful to see the same cases through) and they work live as a clinical pair, agreeing how they will work together.

## **MEETINGS FOR CLINICIANS**

Once every three months the clinical staff will meet for a morning to review the clinical service and to take on the next level of development of clinical practice. These meetings

are mandatory. The HoS for Family Support is the appointed champion for clinical staff and will attend these meetings in this capacity.

## **CASELOADS & CASELOAD MONITORING**

Clinical Managers will review caseload statistics regularly and keep abreast of allocation and caseload matters in between monthly meetings with each clinician. Throughput of cases will be monitored as will clinical capacity.

## Appendices

1. SWU Consultation Form - Appendix 1
2. Tracking Form - Appendix 2
3. Clinician's Assessment Form - Appendix 3
4. Permission to Share Information - Appendix 4
5. Clinical Service Flow Chart - Appendix 5

## APPENDIX 1

# ***Clinical Consultation***

*This form is to be completed by the Clinician following clinical consultation with the Consultant Social Worker (CSW) and placed on the children's file in COMINO*

Child(ren)'s Name(s)	
Care First n°.	
Consultation date	
Social Work Unit CSW	

**Clinical Case Consultation Discussion** *(A decision will be taken in consultation with the Clinical Manager whether therapeutic intervention is appropriate)*

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**Please state the Agreed Outcome.** *(If therapeutic intervention is required the Clinician should liaise with the Unit Coordinator to schedule a date for a Commissioning Meeting). If Tier 2 services are appropriate, please record the resource identified and who will refer this on.*

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Name of Clinician:		Date:	
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## **FAMILY SUPPORT SERVICES CLINICIAN'S ASSESSMENT**

**Name(s):**

**Address of Young Person:**

**Name of Carer(s)**

**Phone:**

**Phone:**

**Date(s) of Birth:**

**Ethnic Origin/Language/Religion:**

Is an interpreter or signer required?

**Carefirst Number(s):**

**Gender:**

**FSS Clinician's Assessment Made By:**

**Date Referred to FSS for Assessment:**

**FSS Clinical Manager:**

**Phone:**

**Phone:**

**Consultant Social Worker:**

**Young Person's School:**

**Phone:**

**Phone:**

**Unit Coordinator:**

**Statement:**

**Phone:**

**Person to Contact:**

**Briefly state reason for current referral to FSS:**

Who referred this child(ren) or family to CSC?

**Date and Outcome of Commissioning Process or Meeting:**

Everyone's views about issues discussed and what needs to happen now:

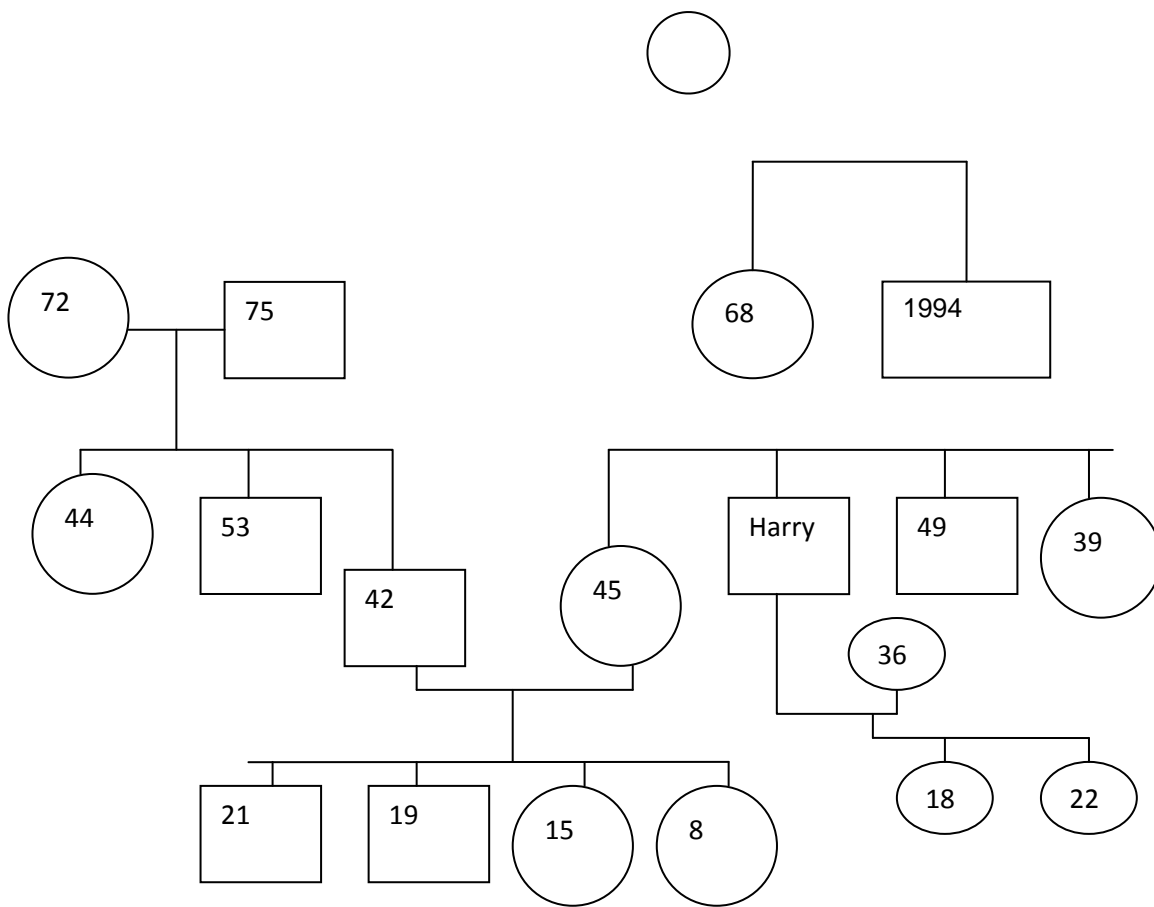
1. Parent(s) or Carer(s):

2. Child(ren):

3. The Professional(s) involved in this case:

Agreed actions, possible dates and venue for Initial Intervention:

GENOGRAM



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## **ASSESSMENT OF THERAPEUTIC NEED**

### **FAMILY BACKGROUND**

**Marital History:** When and how did parents meet?

**Details of Parents' Experiences Growing Up:** How did they relate to their parents, siblings or extended family, and what trans-generational patterns of interaction may be impacting on the current situation?

**Details of Significant Moments in the Life of the Family:** Both positive and negative moments, including possibly traumatic events which may continue to impact on the family functioning. Explore how the family coped, who supported them, and what strengths they can identify from that time which may help them in the present.

**Details of Previous Professional Involvement:** Have there been any medical conditions (to include genetic and psychiatric) with which the family has had to cope? When the family had help in the past what was most useful, and how did it help them to get back on track?

**What services are currently involved?**

### **SOCIAL HISTORY**

**Details of the Role of Environmental Factors in Family's Difficulties:** What stressors such as overcrowded housing, poor living conditions, employment history, legal status within the UK, may be influencing the current problems in the family? Home risk assessment undertaken?

**Details of any Child Protection Concerns:** Domestic violence, physical or sexual abuse, neglect, family breakdown, parental mental health, child currently on CPR (if so, under which category?)

---

**Details of Specific Difficulties Older Family Members may be Experiencing:** Gambling addiction, alcohol or drug abuse, mental health concerns, etc. History of previous specialist referrals to services such as drug advice, Adult Mental Health Services, CFCS, etc., and information regarding the usefulness of the referrals.

## **DEVELOPMENTAL INFORMATION**

**Details at the Time of the Birth of the Child(ren):** Describe mother's physical, emotional and mental health during and after pregnancy? Was family support provided? If so, was it helpful?

**Details of Child(ren)'s Physical & Mental Wellbeing:** Did child(ren) meet growth and developmental milestones? Are there any disabilities? Is there any evidence of existing or developing formal child mental health issues such as: risk of self-harm/suicide, low mood/depression, eating difficulties, etc. Please reference use of appropriate measures and questionnaires, e.g., SDQ, MFQ, Conners etc.

**Attachment Details:** Clinician's understanding of the quality of the mother/child attachment relationship.

**Child Behavioural Management:** Note any difficulties in feeding, toilet training, comforting the child or managing the child's behaviour.

**Previous Assessments:** Provide information on any past assessments or diagnoses and what outcomes were achieved.

## **EDUCATIONAL DEVELOPMENT & PROGRESS**

**Details of Child's Early Education:** Identification of any difficulties in early learning situations and any special learning needs identified. (May include reports on assessments of educational development and cognitive function)

**Current Educational Situation:** Details of attendance at school and punctuality, to include any concerns reported by school (may attach reports if necessary). Indicate any successes or achievements of the child, and details of peer relationships as described by the family, the child and the school.

## **PARENTING CAPACITY**

**Clinician's Assessment:** Evidence-based observations of parenting style and attitude. Is parenting 'good enough' from the Clinician's perspective to meet the child's physical, educational, emotional and social needs?

**Child Protection:** Has the clinician observed that the parent(s) or carers are ensuring the child's safety and protection? How? What protective factors are being considered in this assessment?

**Previous Parenting Interventions:** Has the family engaged with any assessment process in the past, and was there motivation for change? Was there a referral for parenting training? What was the outcome?

## **SUMMARY OF INFORMATION AND PLAN OF WORK**

**Summary and Case Formulation:** To include clinician's understanding of the information provided by various members of the family system, highlighting the relationships between the contextual information obtained – both recent and historical - and the family's current difficulties within the wider societal context e.g. racism, migration issues, etc., showing clear need for clinical intervention.

**Plan of Work:** Clinician to provide suggestions for therapeutic support of the child/family, with recommendations for specific evidence-based interventions which fit with the case formulation. Also list possible referrals to other agencies for work, with associated timescales.

<b>Actions (in order of priority)</b>	<b>Who will do this?</b>	<b>By when?</b>
1)		
2)		

3)		
4)		
5)		

**PARENT & CHILD(REN)'S VIEWS OF THE ASSESSMENT**

Record the views of each member of the family as they wish to record them in their own words.

**Child(ren)'s views on how the family situation is understood, and what they believe is going to help their family to move forward.**

**Parent/carers views on how the family situation is understood, and what they think will be helpful for the family to move forward.**

<b>Date of Assessment:</b>	<b>Copies provided to Parent / child / professionals</b>
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<b>Signed by Family Therapist/Clinician:</b>	<b>Clinical Manager:</b>
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<b>Date:</b>	<b>Date:</b>
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<b>Review of work and Outcomes: Review to take place after six sessions. If the work included additional methodological interventions not mentioned in the Plan of Work, please include that information here, and indicate what worked well, and what worked less well for this child/family.</b>
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<b>Recommendations for future work: If the Clinician would like to refer the child/family on for additional work in other services, please indicate that here.</b>
--

<b>Date of Closing:</b>
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## **APPENDIX 4**

### **Permission to Share Information**

A copy of this form must be given to the service user or their carer/parent.

<b>Name:</b>	<b>DOB:</b>
<b>Care First No.</b>	

### ***Confidentiality***

The detailed information about the child's/young person's difficulties that you give to members of staff, either verbally or in writing will be used by staff to make an assessment and to provide services. This means that other people such as administrative staff and managers will need to see the information so that services can be arranged. Only the people who need such information to help us make an assessment and arrange services will see it. Information about the child/young person may be recorded in writing and stored on computer for this purpose.

Certain basic information such as the child's name, age, address, ethnicity, referrer and date of referral will be kept on a database that will be accessible to staff both within the service and to other sections of the Social Services Department. We may also need to use some anonymised information to produce statistics so that we can plan services to meet the needs of other service users within the borough. Information will be kept in accordance with current data protection legislation. If you have any queries about how this information will be used, please ask staff you are meeting with.

### **Your right to see the information**

Children (if they are seen as mature enough to take such a decision); young people and their parents (with the permission of their children) have the right to see information held both on computer and on file that relates to them. You should make any request to staff you are meeting with, and the process for organising this will be explained to you.

### **Sharing information with other people**

In order to make a proper assessment and provide the right services, we may need to ask other people for information, for example, the child's/young person's GP. We will only ask for information that may be relevant. We may need to give some of the information to other professionals to help them assess the child's needs. Again, we will only give them the information they need to know on order to provide the service.

The people we may need to ask information about you, or provide information to, include:

- Child's GP
- Other staff within the mental health trust
- Any other health or social services staff you have been in contact with
- Voluntary organisations who may be providing services
- Any other professional or agency who has been involved in assessing your/your children's needs or providing services

On very rare occasions, workers within the service may become concerned about the safety of children and young people seen; they may see them as 'at risk' of harm. Under these circumstances, all workers in the service are obliged under local Mental Health Act to notify the relevant section of the services so that the risk of such harm can be properly assessed.

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Signature

*Fig*

Clinicians Role in Social Work Units

