MAKE A MELODY

ARTS THERAPIES AND COUNSELLING

MAKE A MELODY
HANDBOOK

About The Employee Handbook

Purpose of the Handbook

This Handbook serves as your guide to delivering therapeutic services while maintaining the highest standards of professional practice and client care. It is a resource that is designed to support you in understanding our clinical procedures and operational frameworks, ensuring consistency and excellence across all our therapeutic interventions. Whether you're providing music therapy, art psychotherapy, play therapy, or counselling services, this handbook will guide you through every aspect of your role - from referral to initial client assessment, from service promotion to safeguarding procedures and professional development. It serves as both a practical reference tool for day-to-day operations and a foundation for maintaining our person-centred, psycho-analytically informed approach that places the individual at the heart of everything we do.

What You'll Find in This Handbook

Service Delivery & Clinical Procedures

Comprehensive guidance on delivering therapeutic services, including clinical pathways, assessment procedures, documentation requirements, and session management across individual, group, and drop-in formats.

Documentation & Reporting Systems

Clear instructions for maintaining clinical records, completing monitoring returns, managing Google Drive resources, and fulfilling all administrative requirements for quality service delivery and contract compliance.

Safeguarding & Child Protection

Essential procedures for maintaining client safety, including risk identification protocols, safeguarding concern pathways, disclosure response guidelines, safety plan development, and child protection referral processes.

Professional Development & Support

Information about your ongoing professional growth, including external supervision requirements, area coordinator support, peer support groups, CPD journal maintenance, and continuous learning opportunities.

Welcome!

Welcome to Make A Melody! I'm delighted you've joined our team! At Make A Melody, we're committed to holding an environment where you can excel as a person-centred practitioner while finding joy in your work. We care deeply about both our clients and our team members; it is our ambition to provide person-centred support not just for our clients, but for our staff as well. We're committed to helping this role become a spring-board for your professional growth, career satisfaction, and ongoing success. Our aim is that you feel supported every step of the way as you provide your therapeutic services. I'm confident you'll experience this supportive approach as you begin your journey with our team.

Stuart Watson
Chief Executive Officer

Our Approach

We embrace a person-centred approach that places the individual at the heart of everything we do, integrating psycho-analytical insights with empathetic and developmentally-informed practice. Whether through musical elements, artistic expression, play, or counselling techniques, our interventions are tailored to the unique needs and preferences of each person, addressing emotional, cognitive, and physical aspects of wellbeing. Through active listening and collaboration across all therapeutic modalities, we seek to empower individuals, develop self-discovery, encourage self-actualisation, and promote therapeutic outcomes that resonate with their own personal journey.

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ARTS THERAPIES AND COUNSELLING

Our Role

As a counsellor or therapist at Make A Melody, you are a guide, a safe place, and a catalyst for transformation. Your role encompasses both therapeutic expertise and the profound responsibility of holding space for healing and growth.

The Therapeutic Relationship: Your Primary Tool

Building Trust and Safety
Your first and most important task is establishing a therapeutic relationship built on trust, respect, and genuine care. This relationship becomes the foundation upon which all healing can occur. Clients must feel safe before they can be vulnerable, explore difficult emotions, or explore new ways of being and thinking.

Active Presence and Authentic Connection
Be fully present with each client. Put aside distractions, personal concerns, and judgements. Your authentic presence - being genuinely yourself while maintaining professional boundaries - creates the conditions for meaningful therapeutic work.

Holding Space Without Fixing
Resist the urge to "fix" your clients or solve their problems for them. Your role is to create a supportive environment where clients can discover their own solutions, develop their own insights, and build their own resilience.

Person-Centred Practice

Person-centred practice places the individual at the heart of their therapeutic journey, recognising that each person is the expert on their own life and experiences. This approach means believing in the client's inherent capacity for growth and healing. Rather than imposing solutions or predetermined treatment paths, person-centred practice involves walking alongside clients as they discover their own insights, make their own choices, and find their own way forward. It requires genuine empathy, unconditional positive regard, and the humility to recognise that meaningful change comes from within the person themselves, not from external prescriptions or professional expertise alone.

Getting Started: Google Drive

All the essential service documentation and resources that you will need are stored centrally on our Make A Melody Google Drive for easy access and secure file management. To access your personal drive, navigate to www.drive.google.com and log in using your designated Make A Melody email address and password. Once logged in, you will have access to your complete range of working documents that support all aspects of your role delivery and professional compliance.

When in Google Drive, always click on "Shared with me"
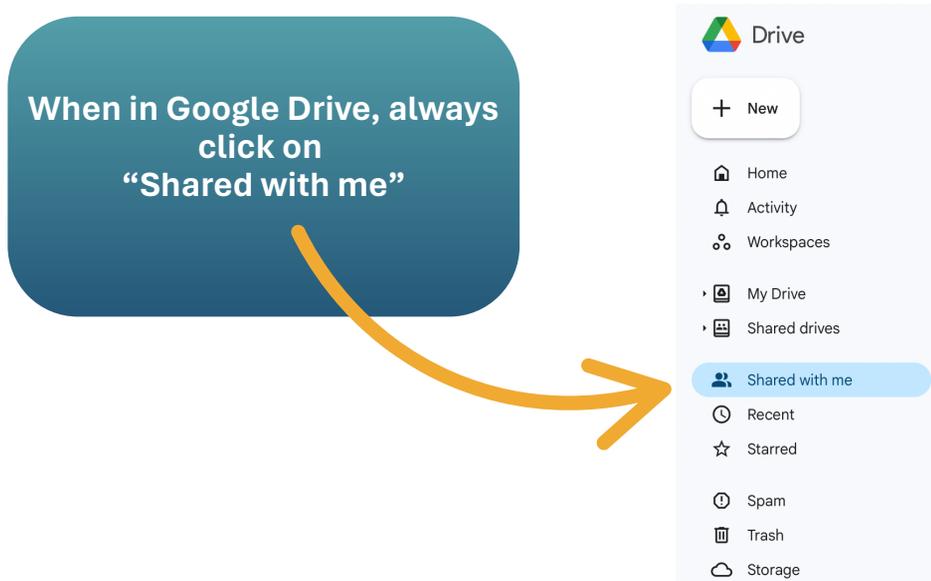
What's In Your Google Drive:

Caseload Overview

Monitoring Return

Timesheet

Travel Expenses

External Supervision & CPD

Clinical Documentation & Forms

Payroll

Induction

2. Quick Look Systems

These Pathway Flow Charts are a quick guide to understand the pathway for each of our systems.
More detail is found on each one in Section 4 of this Handbook.

Daily Clinical Day Pathway

1. Meet with Key Contact

↓

2a. Review Caseload

2b. Upload any new Referrals

↓

3. Facilitate Sessions with Clients

↓

4. Write Clinical Notes

↓

5. Update the following:

1. Caseload Overview

2. Monitoring Return

3. Time Sheet

4. Travel Mileage
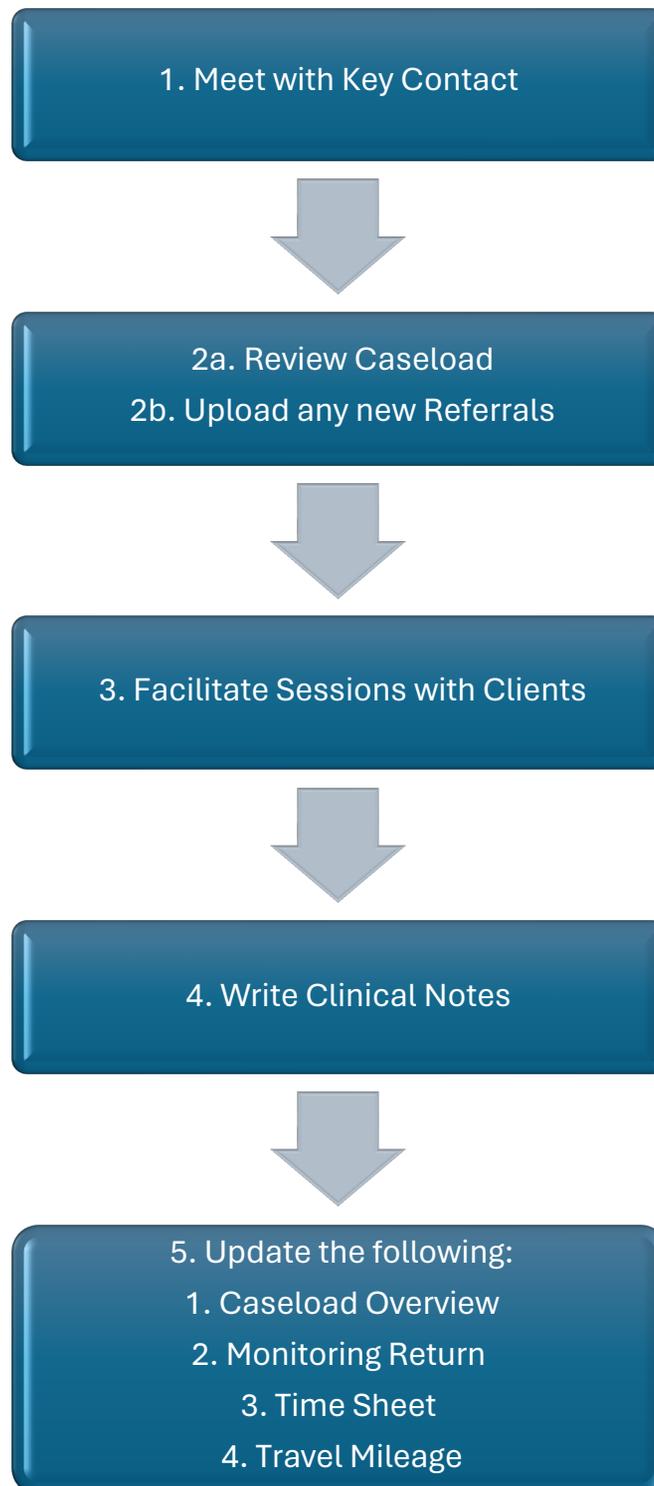
At end of month, update the External Supervision & CPD

New Referral Pathway

1. If you received a hard copy, go to the office and request it to be scanned

↓

2. Download referral from email/scan

↓

3. Open Smilenotes and Create New Client File

↓

4. Fill Out Client Details and Save

↓

5. Upload Referral to Client File

↓

6. Complete 'Client Intake' clinical note

↓

7. Go to Google Drive, Open 'Caseload Overview', and update accordingly

↓

8. Prepare for Assessment Session

Individual Sessions Clinical Pathway

1. Receive Referral
Follow 'New Referral Pathway'

↓

2. Assessment Session

↓

3. Six sessions initially offered

↓

4a. Review occurs on session 4 and 6
4b. Complete YP-CORE/CORS on each session

↙ ↘

5. Closing session on 6th session

5a. If more sessions required, contact Area Coordinator
5b. Continue for four more sessions

↘ ↙

6. Complete Discharge Note

↓

7. Complete Evaluation
(HOPE Service Only)

Clinical Note Pathway

1. Client Intake Template

2a. Clinical Heading: Session 1 Template
2b. Assessment (Intake/Parental) Template
2c. YP-CORE/CORS Template

3. Clinical Heading: Session 2-6 Templates

4. Discharge Note Template

If Required:
4. Clinical Heading: Session 7-10 Templates

5. Discharge Note Template

Group Session Pathway

1a. Receive Referrals
1b. Create One Group Client File
1c. Upload Referrals
1d. Create 'Client Intake' Note
1e. On Google Drive, update Caseload Overview

1f. If clients are not deemed Gillick Competent, phone parent/guardian and complete 'Client parental Consent' template

2. Assessment Session
Complete Group YP-CORE/CORS

3. Offer six - ten sessions

4. Closing session on 6-10th session

5. Discharge Note after closing session

6. Complete Evaluation
(For HOPE Service only)

DNA Pathway

1. Create New Note

2. Link note to the Client who has DNA'd

3. In Templates, click on 'DNA'

4. Complete DNA Note and Save

5. Reuse Session for another client

3 consecutive DNAs will result in Client being Discharged

Safeguarding Concern Pathway - With No Immediate Risk

Upon hearing a Disclosure, or suspected Abuse/Safeguarding Concern:

1a. Support the Client using the Golden Rules
1b. Inform Client of next actions and request consent
1c. Complete a Safety Plan if self-harm/suicide ideation

↓

2. After session, open Google Drive, make a copy of the Note of Concern Document and complete immediately

↓

3. Contact Area Coordinator

↓

4. Email Note of Concern Document to all required staff

↓

5. Write up Clinical Notes. Include:
- Release of Information Template
- Safeguarding Concern Template

↓

6. Upload Note of Concern & Safety Plan to client's file

↓

7. Follow through on any actions, if any

Safeguarding Concern Pathway - With Immediate Risk

Upon hearing a Disclosure, or suspected Abuse/Safeguarding Concern that places the client in an immediate risk category:

1a. Support the Client using the Golden Rules

1b. Inform Client of next actions and request consent

1c. Proceed regardless of consent

↓

2. Do not leave the client alone

↓

3. Contact Key Contact/Designated Teacher
When they have arrived, contact Area Coordinator

↓

4. Consult with Key Contact next steps. Do not take any action without prior agreement from the Key Contact

↓

5. Follow through on next steps:
- 999 call or Social Services
- Parent/Guardian call

↓

6. Remain with the client until external services have arrived

↓

7. Clinical Write Up:
- Note of Concern Document
- Email it to all required staff
- Safeguarding and Release of Information Template

Designation of Risk State

The Risk Assessment questions can be found in the Intake Assessment and the Parental Assessment. The answers to these questions will determine the client's Designation of Risk State. Please use the following Flow Chart to determine the Designation of Risk State:
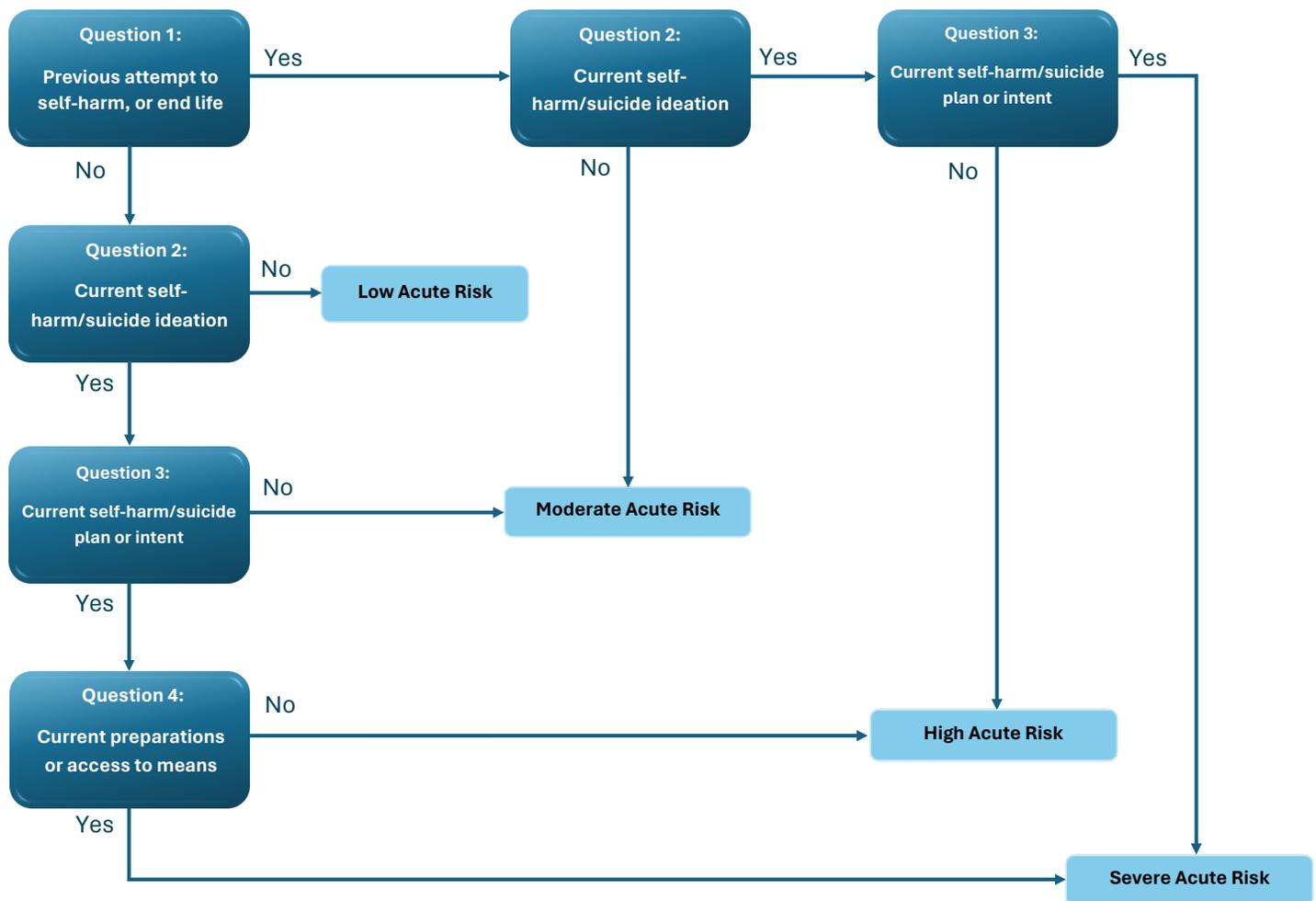
A Risk Designation State of

Moderate Acute Risk

or higher, will require a Safety Plan to be created with the client

Flowchart: Self-harm

This flowchart provides additional guidance on responding to disclosures of self-harm.

If in any doubt about correct decision, seek advice early.

Dark green boxes indicate a definite case for escalation. If unsure, seek help early.

Remain calm and non-judgemental. Find a quiet, safe place to talk.

New/recent injury or self-harm?

— NO →

— YES → Self-poisoning/overdose or injury requiring medical assistance?

NO → Follow local first aid policy as appropriate.

YES → Call 999 for an ambulance. Contact Designated Person.

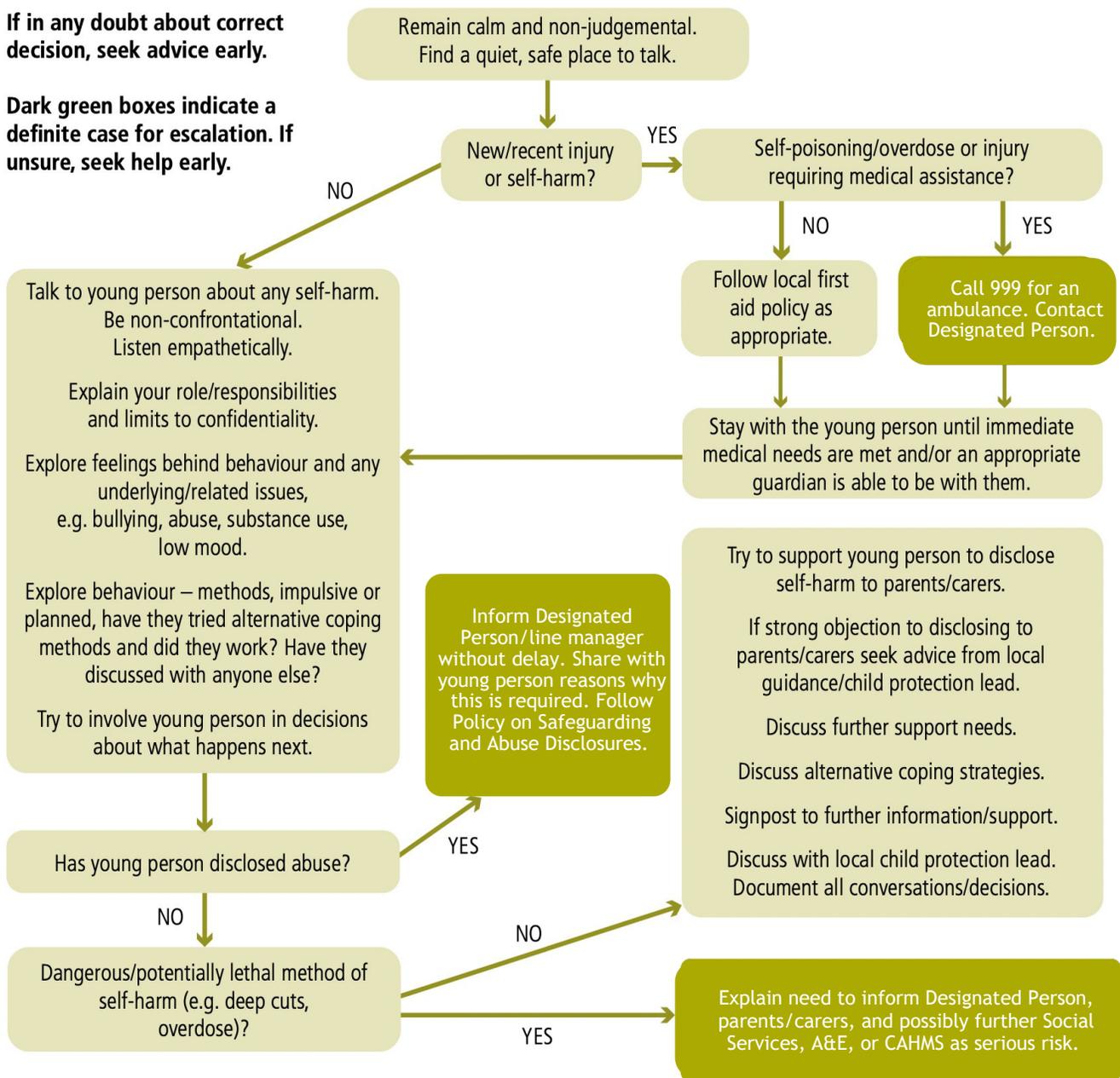Stay with the young person until immediate medical needs are met and/or an appropriate guardian is able to be with them.

Talk to young person about any self-harm. Be non-confrontational. Listen empathetically.

Explain your role/responsibilities and limits to confidentiality.

Explore feelings behind behaviour and any underlying/related issues, e.g. bullying, abuse, substance use, low mood.

Explore behaviour – methods, impulsive or planned, have they tried alternative coping methods and did they work? Have they discussed with anyone else?

Try to involve young person in decisions about what happens next.

Has young person disclosed abuse?

NO

YES → Inform Designated Person/line manager without delay. Share with young person reasons why this is required. Follow Policy on Safeguarding and Abuse Disclosures.

Dangerous/potentially lethal method of self-harm (e.g. deep cuts, overdose)?

NO →

YES →

Try to support young person to disclose self-harm to parents/carers.

If strong objection to disclosing to parents/carers seek advice from local guidance/child protection lead.

Discuss further support needs.

Discuss alternative coping strategies.

Signpost to further information/support.

Discuss with local child protection lead. Document all conversations/decisions.

Explain need to inform Designated Person, parents/carers, and possibly further Social Services, A&E, or CAHMS as serious risk.

In all cases, complete a Note of Concern, and then also complete the template 'Safeguarding Concern' in Clinical Record and follow procedure.
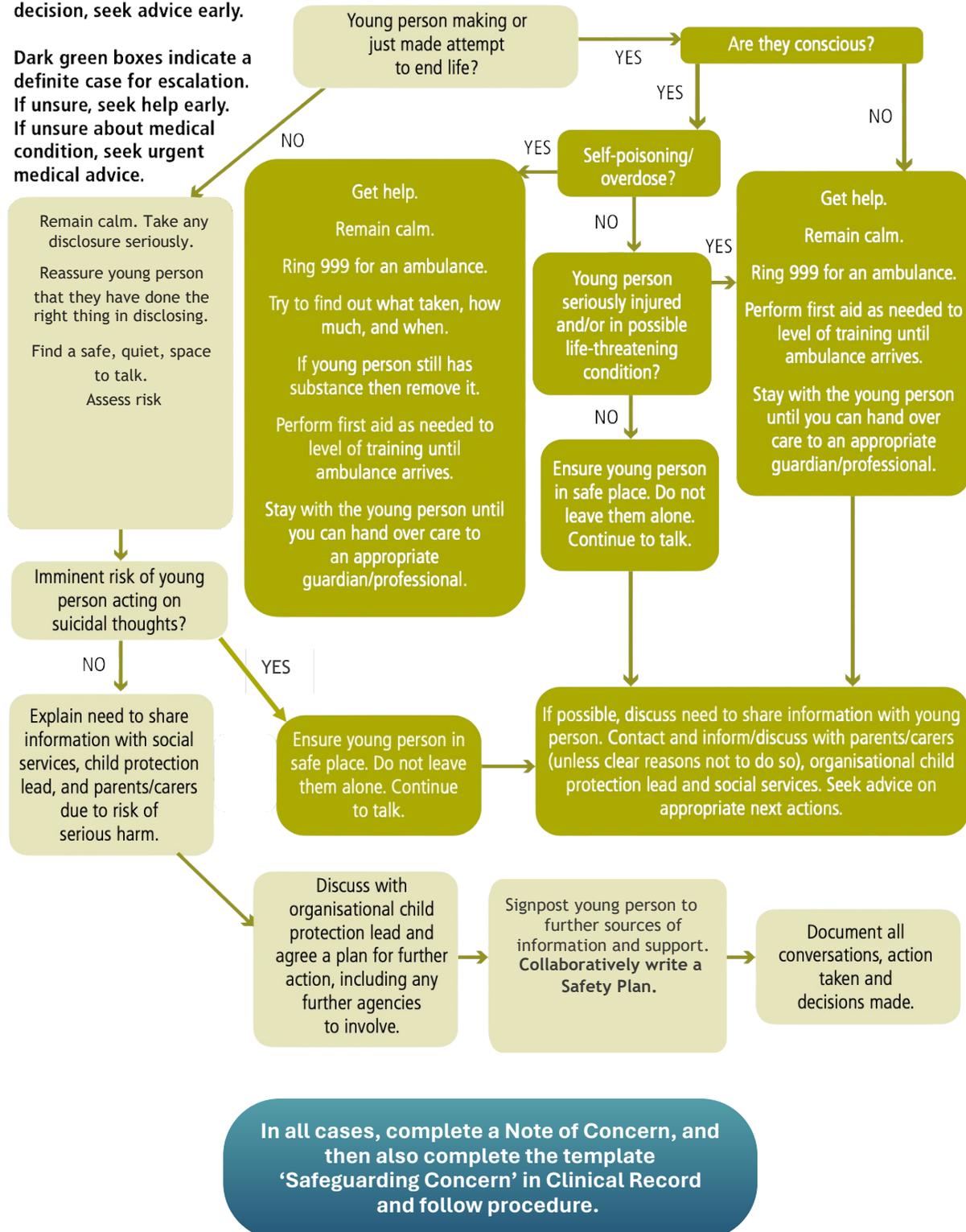
Flowchart: Suicidal Ideations/Action

This flowchart provides additional guidance on responding to disclosures of suicidal thoughts and behaviour.

If in any doubt about correct decision, seek advice early.

Dark green boxes indicate a definite case for escalation. If unsure, seek help early. If unsure about medical condition, seek urgent medical advice.

Young person making or just made attempt to end life?

— YES → **Are they conscious?**

Are they conscious? — YES ↓ — NO →

— NO →

Self-poisoning/ overdose?

— YES →

Remain calm. Take any disclosure seriously.

Reassure young person that they have done the right thing in disclosing.

Find a safe, quiet, space to talk.
Assess risk

Get help.

Remain calm.

Ring 999 for an ambulance.

Try to find out what taken, how much, and when.

If young person still has substance then remove it.

Perform first aid as needed to level of training until ambulance arrives.

Stay with the young person until you can hand over care to an appropriate guardian/professional.

Self-poisoning/overdose? — NO ↓

Young person seriously injured and/or in possible life-threatening condition? — YES →

— NO ↓

Ensure young person in safe place. Do not leave them alone. Continue to talk.

Get help.

Remain calm.

Ring 999 for an ambulance.

Perform first aid as needed to level of training until ambulance arrives.

Stay with the young person until you can hand over care to an appropriate guardian/professional.

Imminent risk of young person acting on suicidal thoughts?

— NO ↓ — YES →

Explain need to share information with social services, child protection lead, and parents/carers due to risk of serious harm.

Ensure young person in safe place. Do not leave them alone. Continue to talk.

If possible, discuss need to share information with young person. Contact and inform/discuss with parents/carers (unless clear reasons not to do so), organisational child protection lead and social services. Seek advice on appropriate next actions.

Discuss with organisational child protection lead and agree a plan for further action, including any further agencies to involve.

Signpost young person to further sources of information and support. **Collaboratively write a Safety Plan.**

Document all conversations, action taken and decisions made.

In all cases, complete a Note of Concern, and then also complete the template 'Safeguarding Concern' in Clinical Record and follow procedure.

Reporting & Monitoring

Weekly Monitoring

1.

Monitoring Return

Purpose:
To track session usage, DNAs, Key Contact Meetings, Promotional Planning

Location:
Google Drive

2.

Caseload Overview

Purpose:
To track client journey through referral, assessment, starting, and close

Location:
Google Drive

3.

Timesheet

Purpose:
To assist you in keeping track of your contract. For those on HOPE, it is a 38 week-contract.

Location:
Google Drive

Monthly Monitoring

1.

Travel Expenses

Purpose:
To track your mileage and allow you to claim back each subsequent month

Location:
Google Drive

2.

External Supervision & CPD

Purpose:
To track your external supervision sessions

Location:
Google Drive

3. Service Delivery

This step-by-step guide covers the complete journey: initial key contact meetings, promoting the service, obtaining referrals and consent, conducting assessments, and completing all necessary documentation.

Key Contact Meeting

The Key Contact is your main point of contact within the venue, ideally you will begin each day meeting with them. A good working relationship is essential for counselling/therapy; to meet the needs of clients, but also to be regarded as an integral part of the venue's pastoral care provision.

On your first day in the venue, you will have an Initial Meeting with the Key Contact, this will be a prolonged meeting and you will have a form to complete with them, it is laid out on the following page.

> **A concrete time should be arranged to meet each week with your Key Contact - otherwise, it may not happen!**

Ideally this meeting should be a weekly face to face meeting but if this cannot take place, telephone call, email or video calls is okay.

Communication will take place at an agreed time to:

>>>> Discuss new referrals

>>>> Review the waiting list

>>>> Share any relevant information about a client's priority for counselling/therapy

>>>> Deal with other issues or concerns, as they arise.

Initial Key Contact Meeting

Name of Key Contact:

Email of Key Contact:

Counsellor/Therapist Name:

Counsellor/Therapist Email:

**Details of the service delivery
(days, times and room):**

Referral Procedure:

**Plans to Promote the Service:
(Reminder of Peer-Led Initiative)**

Has the counsellor/therapist been provided with a copy of the school calendar and all relevant school policies:

Has the school has been provided with a copy of the Make A Melody's complaints procedures:

Agreed day and time for weekly Key Contact communication:

Discussed the requirements for signing Monthly Monitoring Returns:

Key Contact Signature:
(Typed is fine)

Date:

Counsellor/Therapist Signature:
(Typed is fine)

Date:

Promotion of the Service

As a team member, you're not just delivering counselling/therapy - you're building bridges to support. This guide outlines your key promotional responsibilities across the academic year. We want to make this service as accessible as possible.

September: Launch Month

1. Assemblies

2. Class-based Engagement

3. Peer-Led Initiative

Assemblies

Year 8 Welcome Assemblies:
Introduce as part of secondary school transition support, explaining what counselling/therapy involves and how it differs from disciplinary measures or academic support.

Years 9-11 Awareness Sessions:
Focus on normalising help-seeking behaviour, addressing common teenage challenges and emphasising pupil choice and confidentiality.

Years 12-14 Future-Focused Presentations:
Address examination pressure, university applications, career uncertainty, and transition anxieties, positioning counselling as proactive support.

Peer-Led Promotion Initiative

Student Council HOPE Ambassadors
Assist the Key Contact to select specific Student Council members as HOPE ambassadors to promote services through peer networks, provide feedback on promotional effectiveness, and help reduce stigma around help-seeking.

Peer Mentoring Integration
Collaborate with existing peer mentoring programmes to include HOPE awareness, with older pupils sharing experiences of support-seeking where appropriate and with consent.

Weekly Promotional Ideas

Every week, we will promote the counselling/therapy services. A client is more likely to attend counselling/therapy when they know more about it, or have seen you in person. Below is a list of different ideas to promote the service. You may pick a different one each week, or choose to focus on one for the month.

> **Each week you will record how you promoted the service on the Monitoring Return**

High-Visibility Presence

- Attend lunch periods in canteen/common areas - sit with students, be approachable
- Position yourself in corridors during break times for informal conversations
- Visit library during study periods when students are relaxed
- Attend morning registration periods for quick check-ins
- Be present at school gates during arrival/dismissal times

Interactive Engagement

- Host "Coffee & Chat" drop-in sessions with themed topics (exam stress, friendship issues, etc.)
- Run mini-workshops during lunch: "5-Minute Mindfulness," "Quick Stress Busters"
- Request to participate in form time activities
- Offer "Walk & Talk" sessions in school grounds during breaks

Communication & Documentation

- Update HOPE notice boards with fresh content, student artwork, or testimonials
- Share weekly mental health tips via school's social media/newsletters
- Send brief, positive updates to Key Contacts about service engagement
- Create weekly "HOPE Headlines" for staff newsletters

Relationship Building

- Attend weekly staff meetings when possible to maintain visibility
- Join teachers in staff room during breaks to build professional relationships
- Attend school events (sports days, concerts, award ceremonies)

Referral Pathway

The process for referral to Make A Melody's service must be discussed with and agreed with the venue, and widely publicised within the venue's community.

Please make staff aware that before making a referral to our service, it should be considered if a referral to counselling/therapy is the most appropriate response to the client's needs, or if alternative support may be more beneficial.

Counselling/therapy is not compulsory, or a disciplinary measure, and must not be used as such. Staff can encourage a self-referral or, with the pupil's permission, seek an appointment via the Key Contact.

Venue Staff

A member of staff who wishes to make a referral should discuss this first with the Key Contact. The need for the client's prior consent to engage in the counselling/therapy process must be explained to staff.

Parent or Carer

Parent/carers should be informed of the referral process by the venue. The need for the client's prior consent to engage in the counselling/therapy process must be explained.

Self-Referral

The process to self-refer should be explained to all client's by the venue. You may also consider mentioning this when you begin your promotional work.

Consent Requirements

Client's will gain maximum benefit from a counselling/therapy intervention if they have a sound understanding of the process. Clients can only benefit if they choose to engage in counselling/therapy, therefore it is your role to assess if the client fully understands what the process involves at the outset of the intervention. Their consent is essential and is a requirement before beginning any intervention.

Clients should be clear that they can refuse counselling/therapy at the outset or at any stage during the counselling/therapy process. In this case, they should be advised that there are other sources of help, and these should be explained.

Gillick Competency

Clients under the age of 18 can choose to engage with counselling/therapy without parental consent, if deemed to be 'Gillick competent'. Gillick competence is the legal principle that allows children under 16 to consent to medical treatment without parental permission if they demonstrate sufficient understanding and intelligence to comprehend the nature, consequences, and risks of the proposed treatment.

Special Educational Needs

For client's with special educational needs (SEN), you can ascertain whether they have the capacity to understand what they are consenting to (ie. Gillick Competence).

Generally, if the client is attending a special school, they are deemed to be at an increased risk of vulnerability; often being described as a vulnerable person. This classification typically requires you to seek consent from the parent/guardian. However, for those clients who are Gillick Competent and do not wish for their parent/guardian to know about their counselling/therapy, this is not necessary. You may wish to consult with the Key Contact to support your understanding of Gillick Competency for each client.

Group Consent

When a group has been referred, if they are non-Gillick Competent, a phone call home to parent/guardian must be completed to gain consent.

Assessment

The first session with a client is always an Assessment, though its format varies depending on the client's Gillick Competence status and the counsellor/therapist's modality. All clients must have their assessment session within fifteen working days of receipt of a written referral. Counselling/therapy must then commence within fifteen working days of this assessment.

Clients with Gillick-Competence

1. Intake Assessment

2. YP-CORE

For clients who are Gillick Competent, they will be assessed using an Intake Assessment and a YP-COREs. This is primarily for Counsellors; Music, Art, Dramatherapists, and Play Therapists, may use a different assessment approach.

Clients who are Not Gillick Competence

1. Parental Assessment

2. CORS

For clients who are not Gillick Competent, a Parental Assessment will always be facilitated. This serves not only as an assessment, but also as a pathway for gaining parental/guardian consent. A CORS assessment will follow the parental assessment.
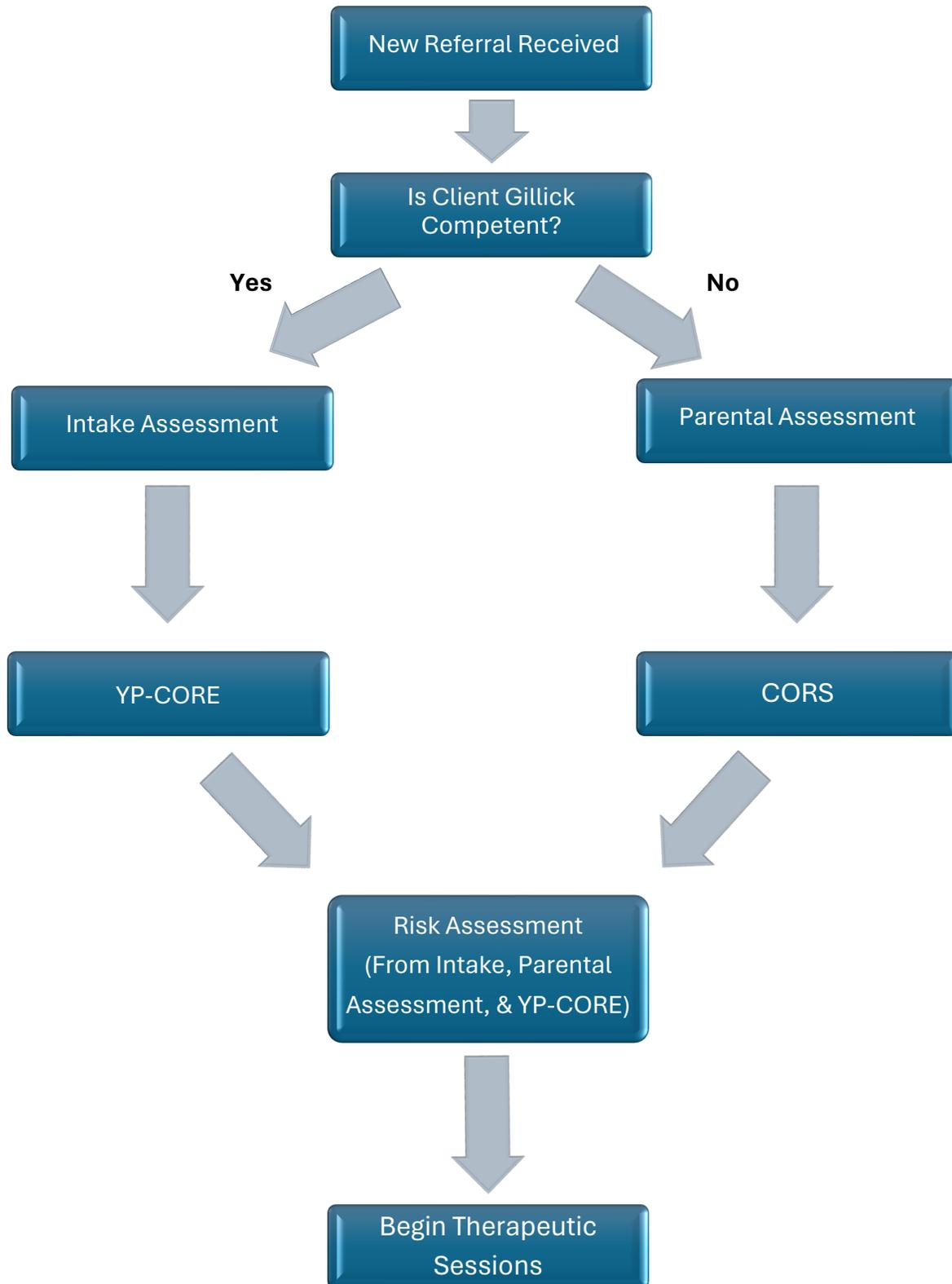
Group Work

1. Parental Phone Call

2. YP-CORE/CORS

For clients attending a group, if not Gillick Competent, you will phone their parent/guardian to receive consent; this is not an assessment. The assessment will take then either the form of a YP-CORE or CORS, depending on Gilllick Competence.

Assessment Decision Tree

New Referral Received

↓

Is Client Gillick Competent?

Yes ↙   ↘ **No**

Intake Assessment

↓

YP-CORE

Parental Assessment

↓

CORS

↘   ↙

Risk Assessment
(From Intake, Parental Assessment, & YP-CORE)

↓

Begin Therapeutic Sessions

Intake Assessment

This is an assessment that you will complete with a client who is deemed Gillick Competent and will be completed in the first session with the client. The Assessment is found on Smilenotes. While all questions are not required to be answered, the more questions answered the better an understanding you may have into the client's current experience. The Safeguarding questions are essential to be asked and answers recorded. At the end of the assessment, please follow the guidance on information to tell the client, such as, confidentiality and its limitations, how many sessions will be offered etc.

An Outcome section is found at the end of the assessment. Please use this to discuss with the client and come up with an outcome together that is most appropriate for the client. It is important that the client is involved in this decision.

Section A: Family

1. Tell me about your family. Who lives at home with you?

2. What are your parents like? How is your relationship with them?

3. How about your siblings, what are your relationships like with them?

4. What do you struggle with most in your family?

5. If you could change anything about your family, what would it be?

Section B: School Experience and Friendships

6. How do you feel about attending school?

7. Do you have any issues or problems with any teachers?

8. Tell me about your friends, do you have someone who is very close to you?

How are your other friendships?

9. Are there any pupils that you don't get on with? Is anyone unkind to you?

10. If you could change any of your experiences at school, what would it be?

11. What do you like to do outside of school, eg. sports, gaming, socialising?

Section C: Current Issues

12. Why are you here at counselling today? What are you currently struggling with?

13. On a scale of 1 - 10, 1 being the worst you've ever felt, and 10 being the best, where are you today?

14. When did these problems begin, and what was happening in your life at that time?

15. Have you had counselling before? How was this for you?

16. What would you like to achieve through counselling?

Section D: Risk Assessment

Shared with the client reasons as to why these questions are asked, and a reminder about limitations of confidentiality

1. Have you ever attempted to harm yourself, or end your life in the past?

2. Over the past 2 weeks have you had thoughts about harming yourself, or ending your life?

3. Have you thought about how and/or when you might act on these thoughts?

4. Have you taken steps to prepare for acting on these thoughts? Have you obtained the materials needed?

If yes for any of the above questions, please enter details below:

Designation of Risk State:

Safety Plan Required:

Parental Assessment

This assessment is designed for clients who are not Gillick competent and typically have additional support needs. In this case, an assessment with the parent is important to gain a better insight into the client's history, and your opportunity to gain parental consent.

You will complete this online in Smilenotes as you are on the phone with the parent/guardian. It is at your own discretion, but this may be a video call, or an in-person appointment with the parent/guardian. As these are more difficult to schedule, we would recommend that you facilitate the assessment via a phone call.

The Parental Assessment is completed on the first session, and ideally, and where possible, this should be scheduled ahead of time to ensure that the parent/guardian is available.

At the end of the assessment, there will be an Outcome Section. Please discuss this with the parent/guardian to see what is in the best interests of the client. When you meet with the client, you will use your clinical judgement to confirm these goals, or to adjust accordingly.

Name of client being assessed:

Name of parent/guardian:

Relationship to client:

General Information About Client:

Living arrangements & Parental Responsibility

Living arrangements for client:

Who has parental responsibility:

Any Legal Issues (e.g., Non-Molestation Order, Barring etc):

Client & family context

(Family makeup, who are they closest to, family situation, bereavement, changes,

attachment difficulties):

Developmental & medical history

(Milestones, physical or mental health assessments, hospitalisation):

Risk Assessment

The following questions are our Risk Assessment Questions to determine if there is an immediate risk. These may be difficult to answer, but please tell us, in as much as you know:

1. Have they ever attempted to harm themselves, or end their life in the past?

2. Over the past 2 weeks have they had thoughts about harming themselves, or ending their life?

3. Have they thought about how and/or when they might act on these thoughts?

4. Have they taken steps to prepare for acting on these thoughts? Have they obtained the materials needed?

If yes for any of the above questions, please enter details below:

Designation of Risk State:

Safety Plan Required:

Informed the parent/guardian of the following

- The Nature of Counselling/Therapy

- Recommended Number of Sessions

- Confidentiality and its Limitations

- Data collection and evaluation procedures (secure systems in line with GDPR guidelines, evaluations used for quality assurance and best practice purposes)

Outcome

Parent/guardian agreed to continue with service for client:

Goals the parent/guardian feel the client could work towards in counselling:

The Client will be referred to other services following assessment:

If yes, please give details:

YP-CORE

Assistance given? ☐
(If yes, please tick)

Client ID								Age		Male ☐

Female ☐

Date form given

D	D	M	M	Y	Y	Y	Y

Stage completed ☐

S Screening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last Therapy Session
X Follow up 1
Y Follow up 2

Site/service ID

Therapist ID

Episode ☐

Subcodes

These questions are about how you have been feeling –
OVER THE LAST WEEK.
Please read each question carefully.
Think how often you have felt like that in the last week
and then put a cross in the box you think fits best.

OVER THE LAST WEEK...

		Not at all	Only occasoinally	Sometimes	Often	Most or all of the time
1	I've felt edgy or nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2	I haven't felt like talking to anyone	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3	I've felt able to cope when things go wrong	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4	I've thought of hurting myself	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5	There's been someone I felt able to ask for help	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
6	My thoughts and feelings distressed me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7	My problems have felt too much for me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8	It's been hard to go to sleep or stay asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9	I've felt unhappy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10	I've done all the things I wanted to	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

THANK YOU FOR ANSWERING THESE QUESTIONS .

Child Outcome Rating Scale (CORS)

Name _____

Age (Yrs): _____ Sex: M / F_____

Session _____   Date: _____

Who is filling out this   Child_____

form? Please check one: Caretaker_____

If caretaker, what is your relationship to this child? _____

How are you doing? How are things going in your life? Please make a mark on the scale to let us know. The closer to the smiley face, the better things are. The closer to the frowny face, things are not so good. If you are a caretaker filling out this form, please fill out according to how you think the child is doing.
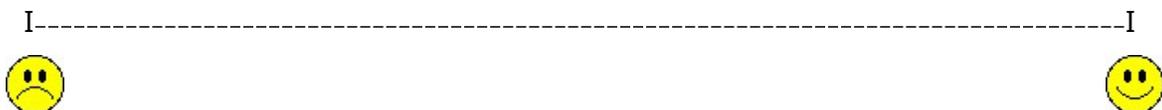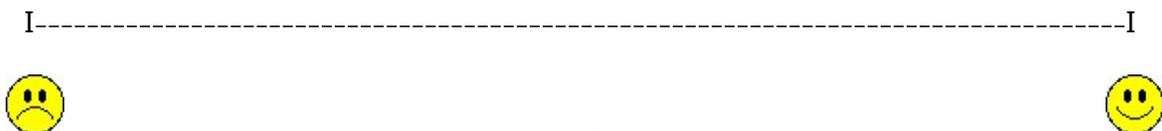

Me
(How am I doing?)

I--I
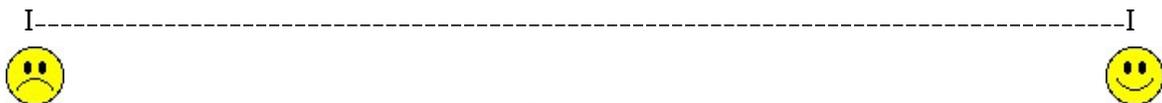
Family
(How are things in my family?)

I--I

School
(How am I doing at school?)

I--I

Everything
(How is everything going?)

I--I

Institute for the Study of Therapeutic Change

www.talkingcure.com

Review Session

4th Session

6th Session

On the 4th and 6th week of intervention, the client will undergo a review session. This is completed alongside the client to reflect over their progress and determine where their current need is. A further YP-CORE/CORS will be completed each session to assist in this review process. Generally, the Review Session ensures that the intervention is meeting the client's needs and allows for adjustments if necessary. For many clients, intervention will close after six sessions, but if their need continues, sessions will continue for another four sessions, after which, you will close sessions and discharge.

What is Involved in the Review?

- Discuss with the client and review their goals and progress made

- Are there any adjustments required to their treatment plan?

- If yes, the adjustments being made are:

- Discuss the upcoming ending with the client

- Provide recommendations for alternative/additional ongoing support

Two options

The client consents and agrees to continue for further sessions

The client consents to closing sessions and being discharged from service

Closing, Discharge & Evaluation

A clear ending to the counselling/therapy intervention must be recorded in the session notes. This should include evidence that:

- Discussed with the client and reviewed their goals and progress made
- Discussed ending with the client and transitioning without counselling/therapy support
- Provided recommendations for alternative ongoing support
- Reminded the client that they can be re-referred at any time

After you have completed your final session clinical note, please create a 'Discharge Note'. This will discharge the client from our service.

Reason for Discharge

- Planned termination
- Client-initiated
- Therapist-initiated
- External factors
- Continued non-attendance

Evaluation (HOPE Service Only)

At the end of each counselling/therapy intervention each pupil will be asked to complete a confidential survey to gather their views of the HOPE service provision. Please open this either on their phone, or on your laptop and leave the room for them to complete. A unique QR Code will be given to you for our organisation: please know that this is not linked to you in anyway, just for Make A Melody!

Drop-In Service

Drop-in sessions provide immediate, low-barrier access to mental health support when clients need it most. Unlike scheduled appointments, these sessions embrace the unpredictable nature of adolescent emotional needs, offering a safety net for client's experiencing crisis moments, sudden anxiety, or simply needing someone to talk to during a difficult day.

Service Structure

Mainstream Schools: 1 hour per session
Special Schools and EOTAS: 30 minutes per session
Timing: Primarily during lunch breaks

Core Principles

No appointments required - open access for all clients

Immediate support for urgent emotional needs

Follow-up care for critical incidents

Crisis intervention capabilities

If no one uses the Drop-In:

- Classroom visits and re-introduce the service
- Take time to promote the service
- Meet with staff to identify potential client's who may benefit
- Drop in with a class, or the library, or a common area

We can 'drop-in' to different rooms to promote the service, further introduce ourselves or begin working on other promotional strategies.

There should never be no clients recorded in our drop-ins.

Group Sessions

Group counselling offers a unique therapeutic environment where clients can discover they are not alone in their struggles. Unlike individual therapy, group work harnesses the natural power of shared experiences, mutual support, and collective problem-solving.

Pre-Group Planning and Assessment

Referral & Assessment Process:

- Referrals received in the same pathway as individual sessions
- Pre-emptive groups may be identified by Key Contacts
- An individual referral must be completed for all members of the group
- Assessment tools: YP-CORE and CORS measures
- For clients who are not Gillick Competent, a phone call home to parent/guardian should be made to gain their consent

Group Composition (2-6 pupils):

- Similar age ranges (within 1-2 years)
- Compatible presenting issues
- Balanced gender consideration
- Cultural and diversity factors

Exclusion Criteria:

- Severe mental health crisis
- High self-harm/suicide risk requiring intensive support
- Significant behavioural disruption issues

Possible Session Structure (50 minutes)

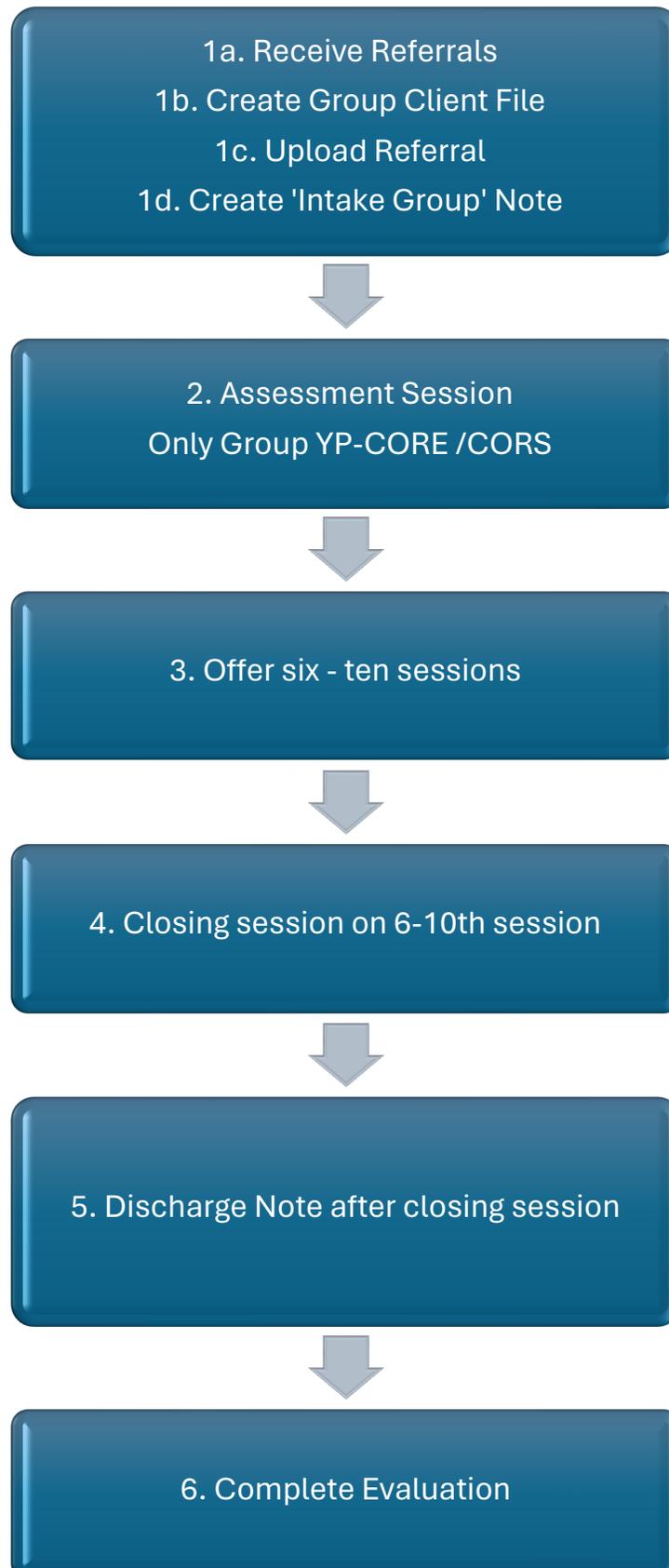| Phase	Duration	Activities	Purpose
Opening/ Check-in	10 min	Welcome, mood check, group agreements review	Establish safety and reconnection
Main Activity	25 min	Structured interventions	Deliver core therapeutic content
Processing (if required)	10 min	Reflection, sharing insights, real-life applications	Consolidate learning
Closure	5 min	Summary, affirmations, preview next session	Provide closure and continuity

Group Example Themes

Programme	Sessions	Key Focus Areas
Anxiety Management	6-8 sessions	Understanding anxiety manifestations Personal trigger identification Breathing and relaxation techniques Cognitive strategies and exposure work
Bereavement Support	6-10 sessions	Grief process normalisation Memory and celebration activities Coping with difficult emotions Building ongoing support networks
Exam Stress	6 sessions	Building ongoing support networks Stress response understanding Study skills and time management Managing perfectionism
Self-Esteem Building	6-8 sessions	Building resilience and self-compassion Self-concept exploration Strengths identification Challenging negative self-talk
Cultural Responsiveness	6-8 sessions	Assertiveness and boundary setting Cultural identity validation Navigating cultural expectations Addressing discrimination
Creative Expression & Communication (SEN Focused)	6-8 sessions	Using music for improvisation & songwriting Using art for expression through drawing, painting Using play for games and role-playing activities Movement and music integration for regulation Multi-sensory storytelling and narrative creation
Social Skills Through Creative Arts (SEN Focused)	6-8 sessions	Musical ensemble activities for turn-taking Collaborative art projects building teamwork skills Role-play for practicing social-interactions Creative problem-solving through artistic challenges

Managing Challenges:

- **Resistance**: Respond with curiosity, not confrontation
- **Conflict**: Use as learning opportunity for communication skills
- **Quiet Members**: Offer alternative participation methods
- **Dominant Personalities**: Set gentle limits while validating contributions
- **Crisis Situations**: Follow clear safeguarding protocols

Order of Group Sessions

1a. Receive Referrals
1b. Create Group Client File
1c. Upload Referral
1d. Create 'Intake Group' Note

2. Assessment Session
Only Group YP-CORE /CORS

3. Offer six - ten sessions

4. Closing session on 6-10th session

5. Discharge Note after closing session

6. Complete Evaluation
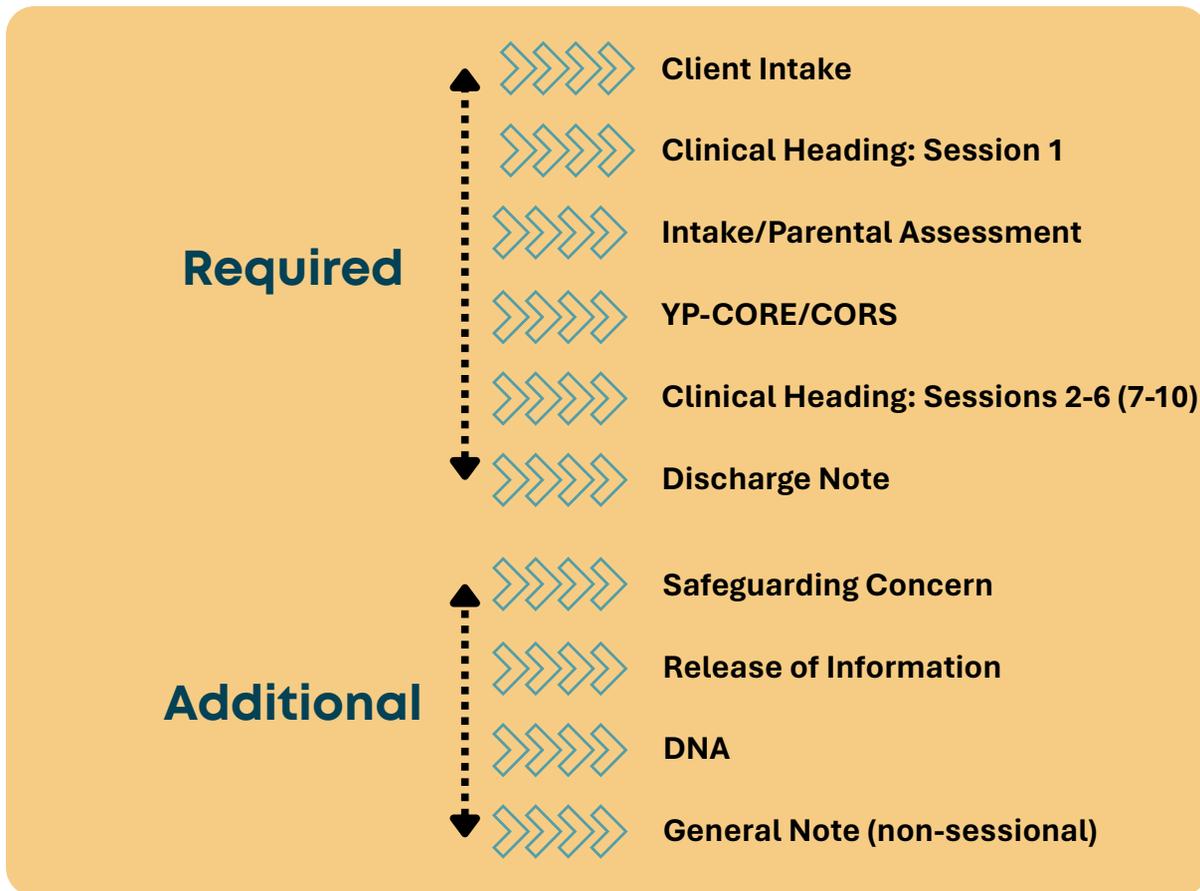
Clinical Notes

Clinical Notes are an integral task of our professional practice and an ethical requirement for all counsellors and therapists. Below are the required templates:

Required

- Client Intake
- Clinical Heading: Session 1
- Intake/Parental Assessment
- YP-CORE/CORS
- Clinical Heading: Sessions 2-6 (7-10)
- Discharge Note

Additional

- Safeguarding Concern
- Release of Information
- DNA
- General Note (non-sessional)

Clinical Note

Our clinical note template captures the essential elements of a counselling/therapy session by documenting the therapeutic interventions and focus areas, the client's observable responses to the work, and the planned direction for future sessions.

Intervention(s) Used; Session Focus:

Client's Response Observed:

Next Steps:

Professional Development & Support

Area Coordinator Support

Each member of the team will have a dedicated Area Coordinator who will facilitate your on-boarding process, induction, line management, general week-by-week support, and assist in auditing your clinical data so that we can help you maintain highest quality of therapeutic support

External Supervision

We are all required to receive a minimum of one hour of external clinical supervision per month. For those on the HOPE Contract, the minimum rises to 1.5 hours per month. This provides an objective outside perspective and brings fresh insights and expertise

Peer Support Groups

We are delighted to offer Peer Support Groups. These are groups of 3-5 of your colleagues who will meet bi-monthly online to discuss clinical work, and support each other. They are a wonderful way to informally ask questions, hear other clinical case studies, and to critically think about the work

Keeping a CPD Journal

A Continuing Professional Development journal serves as your record of learning experiences, skills development, and professional growth. This template will help you systematically document your learning activities, reflect on new knowledge and skills, track how your development impacts your practice, and prepare evidence for any audit from your professional or regulatory body. Under the Learning Segment, input the name of the course and place it in the most accurate column.

CPD Journal							
No. for Evidence	Date	Learning Segment				What I learned	How learning may impact clients
		Work-Based Learning	Professional Activities	Formal Learning	Self-Directed Learning		

Reporting & Monitoring

Weekly Monitoring

1.

Monitoring Return

Purpose:
To track session usage, DNAs, Key Contact Meetings, Promotional Planning

Location:
Google Drive

2.

Caseload Overview

Purpose:
To track client journey through referral, assessment, starting, and close

Location:
Google Drive

3.

Timesheet

Purpose:
To assist you in keeping track of your contract. For those on HOPE, it is a 38 week-contract.

Location:
Google Drive

Monthly Monitoring

1.

Travel Expenses

Purpose:
To track your mileage and allow you to claim back each subsequent month

Location:
Google Drive

2.

External Supervision & CPD

Purpose:
To track your external supervision sessions
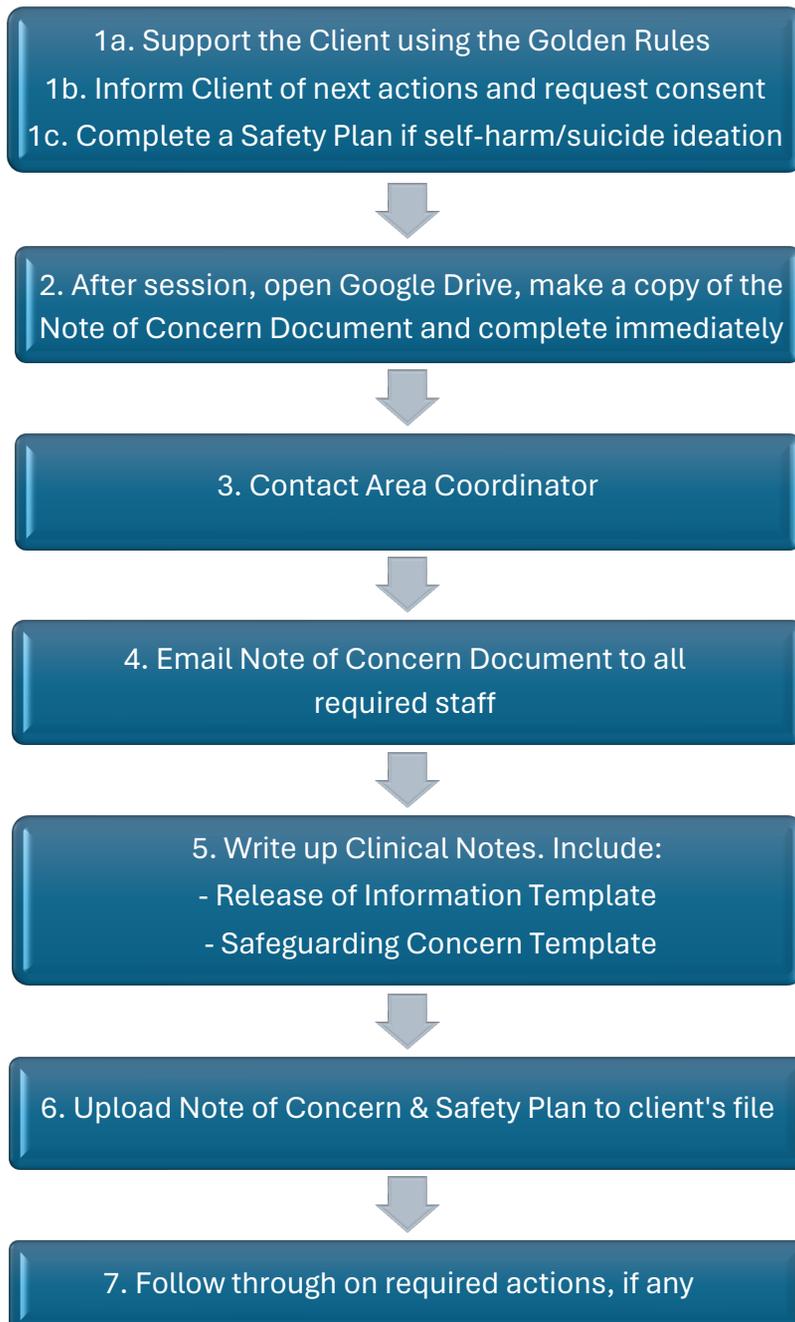
Location:
Google Drive

4. Safeguarding

This section outlines our safeguarding policies and procedures to ensure the protection and wellbeing of all clients, particularly children and vulnerable adults, in accordance with legal requirements and best practice standards.

Safeguarding Concern Pathway
- With No Immediate Risk

Upon hearing a Disclosure, or suspected Abuse/Safeguarding Concern:

1a. Support the Client using the Golden Rules
1b. Inform Client of next actions and request consent
1c. Complete a Safety Plan if self-harm/suicide ideation

⬇

2. After session, open Google Drive, make a copy of the Note of Concern Document and complete immediately

⬇

3. Contact Area Coordinator

⬇

4. Email Note of Concern Document to all required staff

⬇

5. Write up Clinical Notes. Include:
- Release of Information Template
- Safeguarding Concern Template

⬇

6. Upload Note of Concern & Safety Plan to client's file

⬇

7. Follow through on required actions, if any

Safeguarding Concern Pathway - With Immediate Risk

Upon hearing a Disclosure, or suspected Abuse/Safeguarding Concern that places the client in an immediate risk category:

1a. Support the Client using the Golden Rules
1b. Inform Client of next actions and request consent
1c. Proceed regardless of consent

2. Do not leave the client alone

3. Contact Key Contact/Designated Teacher
When they have arrived, contact Area Coordinator

4. Consult with Key Contact next steps. Do not take any action without prior agreement from the Key Contact

5. Follow through on next steps:
- 999 call or Social Services
- Parent/Guardian call

6. Remain with the client until external services have arrived

7. Clinical Write Up:
- Note of Concern Document
- Email it to all required staff
- Safeguarding and Release of Information Template

The Golden Rules for Disclosure Response

Our response to any disclosure is guided by principles that ensure both immediate safety and long-term therapeutic benefit. These Golden Rules provide clear guidance for every member of our team when responding to disclosures.

What we WILL DO:

- Take the child seriously - validating their courage in sharing their struggles
- Tell the child they have done the right thing by telling us - reinforcing positive help-seeking behaviour
- Clarify information if necessary - seeking understanding gently and appropriately
- Make an accurate record as soon as possible - ensuring proper documentation
- Inform the designated person, or Key Contact, and your Area Coordinator without delay - when safety concerns arise.

What we will NEVER DO:

- Promise confidentiality - when safety is at risk, as this would be unethical and dangerous
- Investigate - recognising this is not our role and can be harmful
- Ask leading questions - which can contaminate disclosure and cause distress
- Repeatedly question/ask the child to repeat the disclosure - which can be re-traumatising and counterproductive.

These principles ensure our response builds trust while maintaining safety, avoiding actions that could discourage future help-seeking behaviour.

Risk Identification Procedures

There are several key times during intervention when Risk is assessed; in the Referral, in the Intake and Parental Assessment, and in the YP-CORE. However, Risk assessment is not a one-time activity but rather an ongoing process that continues throughout our counselling relationship with each client. Below are the early Risk Identification Procedures:

Risk Identification at Referral Stage

Risk identification begins in our referral form, which includes specific safeguarding questions designed to capture concerns before intervention begins:
Question 21: "Are there any Safeguarding or Risks that have been identified?"
Question 22: "If yes, please give details"
Question 20: "Any other services involved with this child?"

When Risk is identified at referral, this enables you to prepare appropriately before the first session; ensuring proper supervision is in place, and coordinate with existing services already supporting the young person.

Risk Assessment in Intake/Parental Assessment

During the first assessment session, either the Intake/Parental Assessment, you will systematically ask four Risk questions to establish baseline Risk State:

1. Have you ever attempted to harm yourself, or end your life in the past?
2. Over the past 2 weeks have you had thoughts about harming yourself, or ending your life?
3. Have you thought about how and/or when you might act on these thoughts?
4. Have you taken steps to prepare for acting on these thoughts? Have you obtained the materials needed?

These questions form part of our structured approach to ensuring that no client's risk level goes undetected, providing immediate clarity about safety concerns and informing our decision-making about the level of support and intervention required.

YP-CORE

Question 4 of the YP-CORE specifically addresses risk by asking: "I have thought of hurting myself" with response options ranging from "Not at all" to "Most or all of the time." Any response other than "Not at all" is deemed a Risk and concern.

Approaching the Risk Assessment

1. Establishing Confidentiality Limits

Before beginning any risk assessment, clearly explain confidentiality boundaries:

> *"What we discuss will be private and I will not share it with others unless necessary to keep you safe. If I have safety concerns, I may need to speak with other people, including your parents, but I will only share information necessary for your safety."*

2. Introducing the Topic

Begin with language that reduces defensiveness and encourages disclosure:

> *"My number one priority is your safety and well-being. Sometimes when people feel upset or go through difficult times, they have thoughts about hurting themselves or wanting to die. Is it okay if I ask you some questions about those types of thoughts?"*

This approach:
- Normalises self-harm/suicidal thoughts as common experiences
- Uses matter-of-fact language to lower defenses
- Asks permission to convey respect for autonomy

3. Handling Permission Responses

If permission is granted: Proceed with risk assessment questions.
If permission is denied:
- Explore the client's concerns (e.g., fear of hospitalisation, people finding out)
- Return to discussing the importance of safety assessment

4. When Clients Refuse Assessment

Risk assessment is not optional. If a client continues refusing:
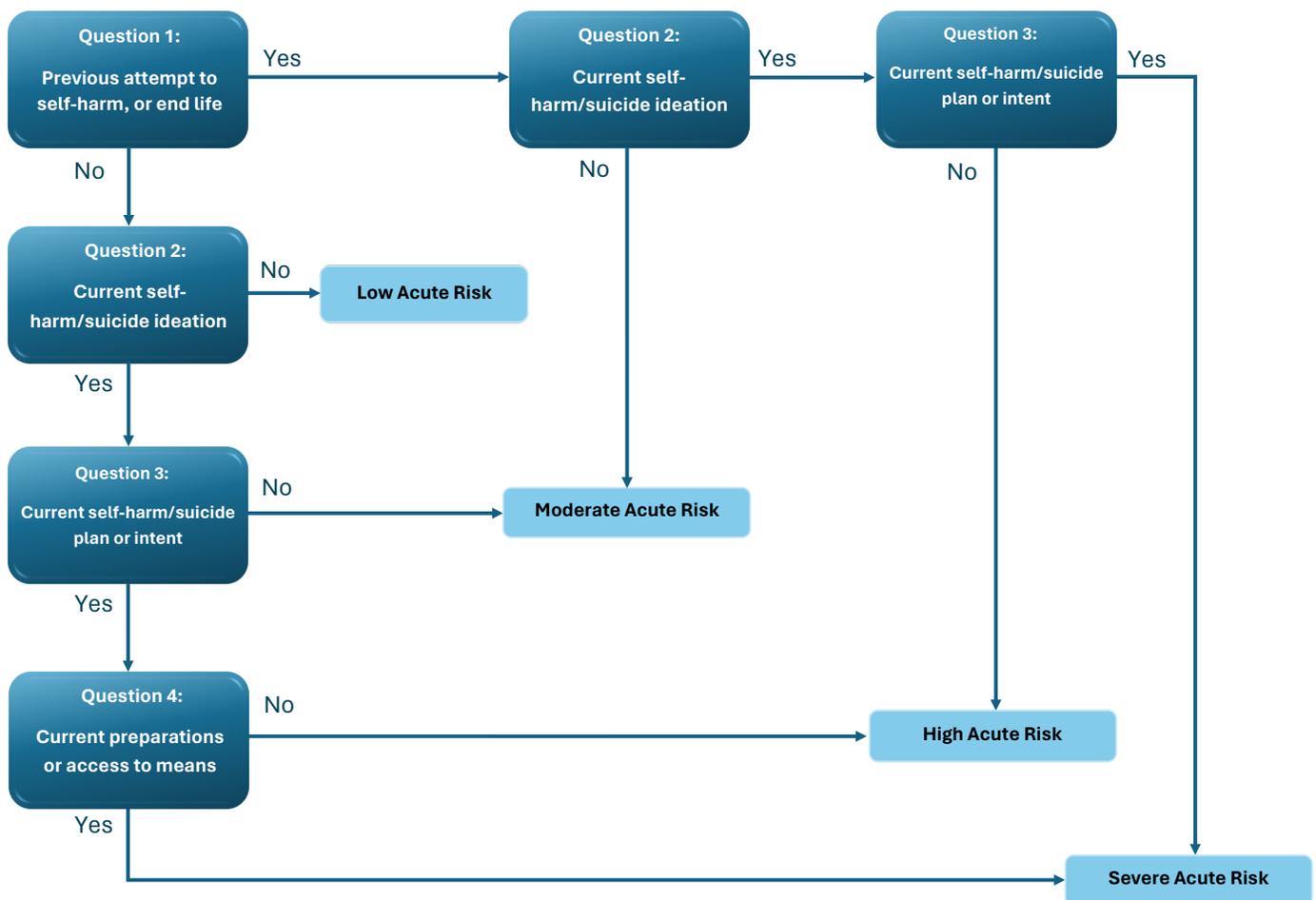
1. Explain that risk assessment is your ethical and professional responsibility
2. Warn that you may need to take safety steps if unable to assess risk
3. If refusal persists, classify client as 'High Acute Risk' and follow Safeguarding pathway

The Risk Assessment Questions

1. Have you ever attempted to harm yourself, or end your life in the past?

2. Over the past 2 weeks have you had thoughts about harming yourself, or ending your life?

3. Have you thought about how and/or when you might act on these thoughts?

4. Have you taken steps to prepare for acting on these thoughts? Have you obtained the materials needed?

Designation of Risk State:

Question 1:
Previous attempt to self-harm, or end life
— Yes → **Question 2:** Current self-harm/suicide ideation
— No →

Question 2: Current self-harm/suicide ideation
— Yes → **Question 3:** Current self-harm/suicide plan or intent
— No →

Question 3: Current self-harm/suicide plan or intent
— Yes → Severe Acute Risk
— No → High Acute Risk

Question 2: Current self-harm/suicide ideation
— No → Low Acute Risk
— Yes →

Question 3: Current self-harm/suicide plan or intent
— No → Moderate Acute Risk
— Yes →

Question 4: Current preparations or access to means
— No → High Acute Risk
— Yes → Severe Acute Risk

- Low Acute Risk
- Moderate Acute Risk
- High Acute Risk
- Severe Acute Risk

Risk Management Plan: Safety Plans

After assessing risk and making a risk state designation, it is important to develop a corresponding intervention and management plan to decrease risk. When a Moderate Acute Risk, or higher, has been identified for self-harm, and/or suicide, you will complete a Safety Plan with the client. A template of the Safety Plan can be viewed on the following page.

A Risk State Designation of
Moderate Acute Risk
or higher, will require a Safety Plan to be created with the client

Our safety planning process is collaborative, recognising that the most effective Safety Plans are those developed with the full participation and ownership of the young person themselves. Our Safety Plan framework addresses the following interconnected areas:

Step 1

Risk Reduction Strategies

Environmental safety measures and modifications
Removal or restriction of access to means of self-harm
Specific actions to reduce risk of acting on suicidal thoughts

Step 2

Past Successful Strategies

What has helped them in previous difficult times
Existing coping strategies they can access
Building upon demonstrated strengths and resilience

Step 3

Self-Soothing Techniques

Personalised calm-down strategies and distraction activities
Mindfulness and grounding exercises (such as 5-4-3-2-1 technique)
Physical activities or creative outlets that provide relief
Age-appropriate digital wellness tools and apps

Step 4

Positive Self-Talk

Alternatives to dark thoughts in their own voice
What they would say to a close friend feeling this way
Affirmations and hope-focused statements that feel authentic

Step 5

Social Support Network

Specific people they can contact (friends, relatives, trusted adults)
Safe places they can go when feeling overwhelmed
Social activities or environments that provide support

Step 6

Professional Support Contacts

Venue counsellor/therapist contact information
Emergency mental health services and GP contacts
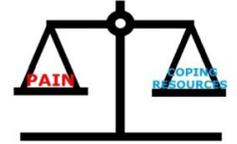Crisis helplines

Step 7

Emergency Actions

Clear plan for persistent suicidal feelings
Agreement to go to A&E Department if needed
Understanding to call 999 if unable to get there safely

Safety Plan

These feelings will pass Keep the plan where you can easily find it when you'll need it.

What I will do to stop myself from acting on my thoughts:

What have I done in the past that helped?

What I will do to help calm and soothe myself:

What I will tell myself:

What would I say to a close friend who was feeling this way?

What could others do that would help?

Who can I call?

Friend or relative:	Name: Tel:	Another:	Name: Tel:
Health Professional:	Name: Tel:	Another:	Name: Tel:
Telephone Helpline:	Name: Tel:	Another:	Name: Tel:

A safe place I can go to:
If I still feel suicidal and out of control: I will go to the A&E Department. If I can't get there safely, I will call 999

Flowchart: Self-harm

This flowchart provides additional guidance on responding to disclosure of self-harm.

If in any doubt about correct decision, seek advice early.

Dark green boxes indicate a definite case for escalation. If unsure, seek help early.

Remain calm and non-judgemental. Find a quiet, safe place to talk.

New/recent injury or self-harm?

NO

YES

Self-poisoning/overdose or injury requiring medical assistance?

NO

YES

Follow local first aid policy as appropriate.

Call 999 for an ambulance. Contact Designated Person.

Talk to young person about any self-harm. Be non-confrontational. Listen empathetically.

Explain your role/responsibilities and limits to confidentiality.

Explore feelings behind behaviour and any underlying/related issues, e.g. bullying, abuse, substance use, low mood.

Explore behaviour – methods, impulsive or planned, have they tried alternative coping methods and did they work? Have they discussed with anyone else?

Try to involve young person in decisions about what happens next.

Stay with the young person until immediate medical needs are met and/or an appropriate guardian is able to be with them.

Inform Designated Person/line manager without delay. Share with young person reasons why this is required. Follow Policy on Safeguarding and Abuse Disclosures.

Try to support young person to disclose self-harm to parents/carers.

If strong objection to disclosing to parents/carers seek advice from local guidance/child protection lead.

Discuss further support needs.

Discuss alternative coping strategies.

Signpost to further information/support.

Discuss with local child protection lead. Document all conversations/decisions.

Has young person disclosed abuse?

YES

NO

Dangerous/potentially lethal method of self-harm (e.g. deep cuts, overdose)?

NO

YES

Explain need to inform Designated Person, parents/carers, and possibly further Social Services, A&E, or CAHMS as serious risk.

In all cases, complete a Note of Concern, and then also complete the template 'Safeguarding Concern' in Clinical Record and follow procedure.
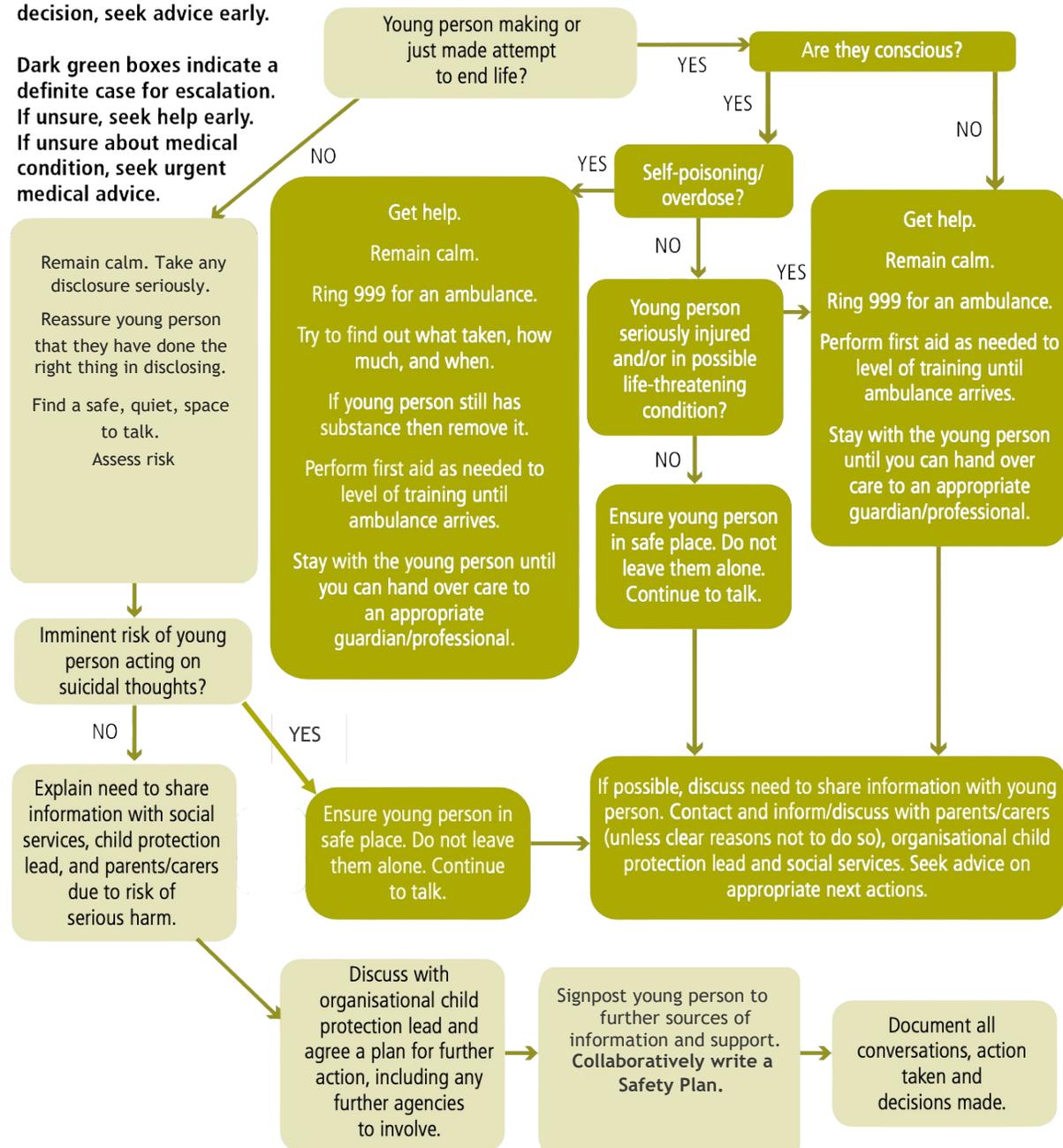
Flowchart: Suicidal Ideations/Action

This flowchart provides additional guidance on responding to disclosure of suicidal thoughts and behaviour.

If in any doubt about correct decision, seek advice early.

Dark green boxes indicate a definite case for escalation. If unsure, seek help early. If unsure about medical condition, seek urgent medical advice.

Young person making or just made attempt to end life?

YES → Are they conscious?

YES

NO

NO

YES → Self-poisoning/overdose?

NO

Remain calm. Take any disclosure seriously.

Reassure young person that they have done the right thing in disclosing.

Find a safe, quiet, space to talk.
Assess risk

Get help.
Remain calm.
Ring 999 for an ambulance.
Try to find out what taken, how much, and when.
If young person still has substance then remove it.
Perform first aid as needed to level of training until ambulance arrives.
Stay with the young person until you can hand over care to an appropriate guardian/professional.

Young person seriously injured and/or in possible life-threatening condition?

YES →

NO

Ensure young person in safe place. Do not leave them alone. Continue to talk.

Get help.
Remain calm.
Ring 999 for an ambulance.
Perform first aid as needed to level of training until ambulance arrives.
Stay with the young person until you can hand over care to an appropriate guardian/professional.

Imminent risk of young person acting on suicidal thoughts?

NO

YES → Ensure young person in safe place. Do not leave them alone. Continue to talk.

Explain need to share information with social services, child protection lead, and parents/carers due to risk of serious harm.

If possible, discuss need to share information with young person. Contact and inform/discuss with parents/carers (unless clear reasons not to do so), organisational child protection lead and social services. Seek advice on appropriate next actions.

Discuss with organisational child protection lead and agree a plan for further action, including any further agencies to involve.

Signpost young person to further sources of information and support. **Collaboratively write a Safety Plan.**

Document all conversations, action taken and decisions made.

In all cases, complete a Note of Concern, and then also complete the template 'Safeguarding Concern' in Clinical Record and follow procedure.

Information sharing and consent procedures

Our approach to information sharing is guided by the principle that effective assessment and support requires careful balance between respecting client's autonomy and ensuring their safety. We discuss confidentiality limitations at the start of every therapeutic relationship.

Release of Information Form

Our Release of Information Form provides a structured framework for documenting consent decisions and ensuring transparency in our information sharing practices. It includes:

- Date of Disclosure/Safeguarding Concern
- Detailed specification of what information will be shared
- Precise documentation of who will receive information
- Clear documentation of reasons for sharing information
- Details of client's consent

Information Sharing Without Consent

When consent is not given, or should not be sought, specific circumstances justify information sharing without consent:

- Urgent situations: Delaying to seek consent may result in serious harm
- Risk of further harm: Seeking consent is likely to cause serious harm or prejudice crime prevention
- Proportionate response: The risk is sufficiently great to outweigh potential harm from sharing information

These guidelines ensure that safety remains our primary concern while respecting individual rights wherever possible.

Note of Concern

When any member of our team observes or becomes aware of a safeguarding concern, either through disclosure or observation, they must complete a Note of Concern documenting exactly what has been shared or observed. This document must be completed immediately and action must be taken without delay.

Immediate Actions Required when Safeguarding Concerns Observed:

1.

Notify Client, Seek Consent

Purpose:
Inform the client that you will immediately follow up appropriately on the issues raised

Location:
In Session

2.

Complete Note of Concern

Purpose:
Document what has been shared or observed with specific details and exact circumstances

Location:
Google Drive

3.

Area Coordinator & Key Contact

Purpose:
Discuss concerns with your Area Coordinator and provide the completed Note of Concern

Location:
Phone Call

Creating a Note of Concern

When completing a Note of Concern, it's essential to document factual, objective information promptly after an incident or disclosure occurs. Record specific details including dates, times, circumstances, and direct quotes where possible, avoiding personal interpretations or assumptions. Include all relevant parties and witnesses, describe any immediate actions taken, and note any advice sought from colleagues or external agencies. The completed form should be passed to your Area Coordinator immediately, ensuring clear communication channels are maintained and appropriate follow-up actions can be initiated to safeguard the child or vulnerable person involved. A copy of the Note of Concern can be seen on the following page.

CONFIDENTIAL
NOTE OF CONCERN
PROTECTION RECORD – REPORT TO AREA COORDINATOR & KEY CONTACT

Name of Client:	Date of birth:
Service Involved:	
Date, time of incident / disclosure:	
Circumstances of incident / disclosure:	
Nature and description of concern:	
Parties involved, including any witnesses to an incident and what was said or done and by whom:	
Action taken at the time:	
Details of any advice sought, from whom and when:	
Any further action taken:	
Date and time of report to Area Coordinator:	

Name of staff member making report:

Signature of Staff Member: _____ Date: _____

Signature of Area Coordinator: _____ Date: _____

Child Protection Referrals

Discussion with Key Contact & Area Coordinator

Your Area Coordinator will guide you on the appropriate steps to take, which will always begin with discussions involving the venue's Key Contact. This consultation process leads to two distinct pathways moving forward:

Route 1: Child Protection Referral Required

When it is determined that a child protection referral is required:

- You, or the Key Contact will seek consent from the parent/carer and/or the client (if competent to give consent)
- If consent cannot be obtained and placing the child at risk of significant harm would result from not proceeding, the referral proceeds without consent
- Contact is made by telephone to the Children's Services Gateway Team and/or the PSNI if a child is at immediate risk
- A completed UNOCINI referral form is submitted within 24 hours
- Each Gateway Team in the different Trusts will have a unique Referral Form. Please contact them first via their phone line to request their specific Referral Form and Pathway. Their numbers are on the following page.

Route 2: Child Protection Referral Not Required

When consultation determines that a child protection referral is not required, the service may consider alternative options:

- Monitoring - Continuing to monitor the situation within an agreed timescale
- Signposting - Signpost the client to additional services that are established to support them outside of the counselling/therapeutic intervention

Secure Emails

When you need to communicate sensitive or confidential information via email, you should always include as part of the subject to such emails the words, 'Strictly Private & Confidential' to warn the recipient that the email contains confidential information, so that they know to open the document in a secure environment. When sending an email that contains sensitive personal information, ensure that this information is not in the body of the email; put this into a separate attachment and protect it with a password. Then send a second email with the password, or communicate this in-person, or over the phone.

CAMHS Referral

When a referral is required, you should keep the client informed and seek permission to share information at all stages. Any decision about an onward referral, any relevant consultation and who will take the action must be recorded in the client's notes.

As a counsellor/therapist, you can refer directly to CAMHS (Step 2 or 3) as long as both the following conditions are met:

Condition 1 (basic threshold): A client has or is suspected to have a mental ill health or other condition that results in persistent symptoms of psychological stress.

Condition 2 (complexity and severity threshold): At least one of the following exists:
· An associated serious and persistent impairment of their day-to-day functioning.
· An associated risk that the client may cause serious harm to themselves or others.

Threshold criteria for Step 2 CAMHS
Step 2 CAMHS will accept referrals for clients presenting with mild to moderate mental ill health and emotional difficulties. Consideration will be given to the complexity of the difficulties, the risk of secondary problems developing, their development, the presence/absence of protective factors and the presence/absence of stressful social and cultural factors.

Threshold criteria for Step 3 CAMHS
Step 3 CAMHS referrals will be accepted where there is a severe and/or enduring impact on the client's normal daily functioning (psychological/social/educational). However, where there is severe impairment of functioning or a life-threatening condition, a referral should be made immediately and discussed with a senior member of the CAMHS team.

Northern Ireland Health and Social Care (HSC) Trusts
Gateway Services for Children's Social Work

Belfast HSC Trust	
Telephone (for referral)	**028 90507000**
Areas	GreaterBelfast area
Further Contact Details (for ongoing professional liaison)	**Greater Belfast Gateway Team** 110 Saintfield Road Belfast BT8 6HD
Website	http://www.belfasttrust.hscni.net/
Out ofHours Emergency Service (after 5pmeachevening atweekends,and public/bank holidays)	028 95049999

South Eastern HSC Trust		
Telephone (for referral)	**03001000300**	
Areas	Lisburn,Dunmurry, Moira, Hillsborough, Bangor, Newtownards, Ards Peninsula, Comber, Downpatrick, Newcastle and Ballynahinch	
Further Contact Details (for ongoing professional liaison)	**Greater Lisburn Gateway Team** Stewartstown Road Health Centre 212 Stewartstown Road Dunmurry Belfast, BT17 0FG Tel: 028 90602705	**North Down Gateway Team** Family Resource Centre James Street Newtownards, BT23 4EP Tel: 028 91818518	**Down Gateway Team** Children's Services 81 Market Street Downpatrick, BT30 6LZ Tel: 028 44613511
Website	http://www.setrust.hscni.net/	
Out ofHours Emergency Service (after 5pmeachevening atweekends,and public/bank holidays)	028 95049999	

Northern HSC Trust		
Telephone (for referral)	**03001234333**	
Areas	Antrim,Carrickfergus, Newtownabbey, Larne, Ballymena, Cookstown, Magherafelt, Ballycastle, Ballymoney, Portrush and Coleraine	
Further Contact Details (for ongoing professional liaison)	**Central Gateway Team** Unit 5A, Toome Business Park Hillhead Road Toomebridge, BT41 3SF Tel: 028 79651020	**South Eastern Gateway Team** The Beeches 76 Avondale Drive Ballyclare, BT39 9DB Tel: 028 94424377	**Northern Gateway Team** Coleraine Child Care Team 7A Castlerock Road Coleraine, BT51 3HP Tel: 028 7032 5462
Website	http://www.northerntrust.hscni.net/	
Out ofHours Emergency Service (after 5pmeachevening atweekends,and public/bank holidays)	028 94468833	

Southern HSC Trust			
Telephone (for referral)	**08007837745 (Free phone number from landlines only)/02837415285(Central number)**		
Areas	Craigavon, Banbridge,Dromore, Lurgan,Portadown,Gilford, Armagh,Coalisland,Dungannon,Fivemiletown, Markethill, Moy, Tandragee, Ballygawley,Newry City,Bessbrook,Annalong, Rathfriland,Warrenpoint,Crossmaglen,Kilkeel, Newtownhamilton		
Further Contact Details (for ongoing professional liaison)	**Craigavon/Banbridge Gateway Team** Brownlow H&SS Centre 1 Legahory Centre Craigavon , BT65 5BE Tel: **028 3834 3011**	**Newry/Mourne Gateway Team** Dromalane House Dromalane Road Newry,BT358AP Tel: **028 3082 5000, Option 1**	**Armagh/Dungannon Gateway Team** EFloor South Tyrone Hospital Carland Road Dungannon, BT71 4AU Tel: **028 8771 3506**	**Central Gateway Team** Lisnally House Lisnally Lane Armagh, BT61 7HW Tel: 028 37415285
Website	http://www.southerntrust.hscni.net/		
Out ofHours Emergency Service (after 5pmeachevening atweekends,and public/bank holidays)	028 95049999		

Western HSC Trust		
Telephone (for referral)	**028 71314090**	
Areas	Derry,Limavady, Strabane, Omagh andEnniskillen	
Further Contact Details (for ongoing professional liaison)	**Derry Gateway Team** Whitehill, 106 Irish Street Derry, BT47 2ND Tel: 028 71314090 Fax: 028 71314091	**Omagh Gateway Team** Tyrone and Fermanagh Hospital 1 Donaghanie Road Omagh, BT79 ONS Tel: 028 82835156 Fax: n/a	**Enniskillen Gateway Team** 2Coleshill Road Enniskillen BT747HG Tel: 028 66344103 Fax: n/a
Website	http://www.westerntrust.hscni.net/	
Out ofHours Emergency Service (after 5pmeachevening atweekends,and public/bank holidays)	028 95049999	

Update of May 2019

5. Forms

Referral
Self-Referral
Consent

Private and Confidential

Date of Referral:

Referral Form

Please Place a 'X'

1. Who Is Completing This Form?

	I am a pupil referring myself
	I am a parent/guardian or teacher/school contact

2. Pupil Name: | **3. Pupil Surname:**

4. Date of Birth: | **5. Gender:**

6. School: | **7. Year Group:**

8. Medical History/ Diagnosis (if any):

9. Please share why you wish to be referred?

10. Please Enter C2K Email Address:

11. Address: | **12. Postcode:**

13. Contact Number:

14. Parent/Guardian Name:

15. Parent/Guardian Contact Number:
We only need this in case of emergencies

Referrer Details:

Only complete this section if you are not a pupil

16. Referrer Name: | **17. Relationship to Pupil:**

18. Referrer Phone No: | **19. Pupil consented to counselling:**
Is a parental consent form required:
If yes, has this been received?

20. Has pupil attended counselling before: | **21. Are there any Safeguarding or risks that have been identified:**

22. If yes, please give details:

23. Any other services involved with this pupil:

24. Any other information:

Self-Referral Examples

My Name is _____

Today's Date is _____

My Teacher is _____

I want to talk to you about:

Family ☐   Friends ☐

School Work ☐   Something Else ☐

My Name is _____

Today's Date is _____

I want to:

Have a chat: ☐   Play an instrument: ☐

Listen to music: ☐   Write a song: ☐

Some time out: ☐   Something else: ☐

Consent Form

THE INFORMATION YOU SUPPLY ON THIS FORM WILL BE TREATED IN CONFIDENCE.

Please Place a 'X'

1. Who Is Completing This Form?

		I am a parent/guardian consenting for my child
		I am a teacher/school contact consenting for a pupil
Yes	No	If a teacher/school contact, have you gained consent from parent/guardian? *This is a requirement for counselling/therapy.*

2. Name and Surname:

3. Relationship to Pupil:

4. Pupil Name and Surname:

5. Pupil Date of Birth:

6. Pupil School:

What is Counselling?

Counselling provides pupils with a safe and confidential space to talk about their feelings, challenges, and mental health concerns with a trained professional. It aims to support their emotional well-being, helping them manage issues that may affect their academic performance and personal development.

What are the Arts Therapies?
The Arts Therapies consist of Music, Art, and Dramatherapy, each offering a safe, creative and confidential space for self-exploration, emotional expression and support. Often people find that the arts can bypass the use of words alone, and sessions are adapted to meet each person's interests and needs and may include music-making, art-work, dance and movement, singing, verbal conversation, music listening, & song writing.

By **signing**, you are **consenting** to the pupil **receiving counselling/therapy** with a Make A Melody counsellor/therapist. You are also agreeing to the terms and conditions found at:

www.makeamelody.co.uk/terms-and-conditions

www.makeamelody.co.uk/privacy-notice

Signed:
(Typed is okay)

Date:

R E T U R N I N G T H I S F O R M

Please return this form promptly to your school. Counselling/therapy cannot begin until this form has been returned

Contact & Resources

Emergency Support

- Emergency Services: 999
- Childline: 0800 1111
- Samaritans: 116 123
- Lifeline: 0808 808 8000
- CAMHS Referrals: Local trust contact numbers - see page 62

Make A Melody Support

- **Main Office:** 028 3881 0141
- **Clinical Director:** 07522 550275
- **Email:** stuartwatson@makeamelody.co.uk

- **Your Area Coordinator:** _____

- **External Supervisor:** _____

Need Support? We're Here for You

Remember, you're never alone in this work. Whether you need clinical guidance, professional support, or someone to talk through a challenging situation, we are here to support you every step of the way. For personal support needs, please don't hesitate to reach out - your wellbeing is so important to us.

As you embark on your journey with Make A Melody, remember that you are more than a practitioner - you are a safe space in times of uncertainty, a trusted professional on each client's path to healing, and a supporter of their own capacity for change. Trust in your training, lean on your colleagues, and never underestimate the profound impact of walking alongside someone as they discover their own capacity for growth and healing.

MAKE A MELODY
ARTS THERAPIES AND COUNSELLING