**Early Years Alliance** deliver a range of Therapeutic Parenting Programmes which support parents to meet their child’s needs and improve behaviour.

Our range of group and 1:1 sessions support parents to build a more positive relationship with their child and help them to understand their behaviour.

We work with parents who are concerned their child may have ADHD, or behaviours that make places and spaces unsafe to be in, or cause serious harm to themselves and others, or for children with:

* serious, high risk or distressing behaviours
* conduct disorders
* oppositional defiance disorder
* and where ADHD is suspected or diagnosed

These programmes include:

* **Incredible Years (IY) is a 12-week group programme** for parents of children aged 4-11 years delivered both online and in person. IY is delivered face-to-face termly over 12 weeks, often within a school setting to be targeted at the young people who the school identify as needing support. Spaces are offered to families outside of the school cohort as well. IY works with one or both parents to enable positive outcomes for the child/young person.
* **Therapeutic Parenting Support (TPP)**is a 6-week group programme for parents of children aged 4-11 years supporting parents to build a more positive relationship with their child.
* **Personalised Individual Parent Training (PIPT)** is an intensive 6-week 1-1 programme for parents of children aged 4-8 years.  This programme works with the child/young person as well as one or both parents. It is designed to use the IY strategies to promote a positive relationship between the child/young person and the parent by reducing the oppositional/emotional dysregulation behaviour and increasing pro-social behaviour and compliance.
* **Guided Self-Help (GSH)**is a 6-week 1-1in-depth support working with one or both parents and works on themed extracts from IY to fit the individual needs of the child/young person.
* *We are also currently developing****ASD programme modules****which will be available in 2025.*
* ***Systemic Family Practice****support will also be available in 2025.*

Please complete this referral form fully and email to [**Lewisham.Secure@eyalliance.org.uk**](mailto:Lewisham.Secure@eyalliance.org.uk)

**Please note - WE CAN ONLY PROCESS YOUR REFERRAL IF:**

* **The referral is typed and sent in WORD format**
* **SECTION D must be fully completed to comply with GDPR regulations**

**For urgent child protection referrals, contact the MASH on 020 8314 9181.**

**If you think a child or young person may be in immediate danger, call 999 or contact your local police on 101.**

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| --- | --- |
| **SECTION A:**  **REQUIRED INFORMATION ABOUT THE REFERRER and the FAMILY BEING REFERRED** | |
| **REFERRER’S DETAILS** | |
| Name of Professional making the referral |  |
| Organisation, Team & Role |  |
| Telephone Number |  |
| Email |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FAMILY DETAILS** | | | | | | | | | | |
|  | First Name | Surname | | Gender Identity | Relationship to child | DOB | School | CPP CIN | Ethnicity | Religion |
| Parent or Carer |  |  | |  |  |  |  |  |  |  |
| Parent or Carer |  |  | |  |  |  |  |  |  |  |
| **ANY OTHER SIGNIFICANT MEMBERS OF THE HOUSEHOLD OR FAMILY** | | | | | | | | | | |
|  |  |  | |  |  |  |  |  |  |  |
|  |  |  | |  |  |  |  |  |  |  |
| **CHILDREN (PLEASE LIST ALL CHILDREN IN FAMILY)** | | | | | | | | | | |
| Child |  |  | |  |  |  |  |  |  |  |
| Child |  |  | |  |  |  |  |  |  |  |
| Child |  |  | |  |  |  |  |  |  |  |
| Child |  |  | |  |  |  |  |  |  |  |
| Child |  |  | |  |  |  |  |  |  |  |
| Child |  |  | |  |  |  |  |  |  |  |
| **DO ANY MEMBERS OF THE FAMILY HAVE PHYSICAL OR MENTAL HEALTH NEEDS? Please state below** | | | | | | | | | | |
|  | | | | | | | | | | |
| **FAMILY CONTACT DETAILS** | | | | | | | | | | |
| Address and Postcode | | |  | | | | | | | |
| Landline and Mobile | | |  | | | | | | | |
| Email | | |  | | | | | | | |
| Is it safe to contact? | | |  | | | | | | | |

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| **ARE ANY OF THE FOLLOWING PROFESSIONALS INVOLVED WITH THIS FAMILY** | | | |
| Social Worker Name |  | | |
| Telephone: |  | Email: |  |
| Early Help/Family Thrive Practitioner Name |  | | |
| Telephone: |  | Email: |  |
| Health Visitor/Team Name |  | | |
| Telephone: |  | Email: |  |
| IDVA or IGVA Name |  | | |
| Telephone: |  | Email: |  |
| CAHMS Name |  | | |
| Telephone: |  | Email: |  |
| Please list any other professional currently involved in supporting this family | | | |

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| **SECTION B:**  **REFERRAL DETAILS** | | |
| **WHAT TYPE OF SERVICE ARE YOU REQUESTING?** | | |
| [INCREDIBLE YEARS PARENTING PROGRAMME](https://www.lewishamcfc.org.uk/wp-content/uploads/2022/03/Therapeutic-Parenting-Programmes-Info-Sheet.pdf)  OTHER SERVICE | | |
| **WHAT HAS HAPPENED RECENTLY TO THIS CHILD/FAMILY THAT HAS LED TO YOU MAKING THIS REFERRAL?** | | |
|  | | |
| **WHAT ARE YOU REQUESTING FROM OUR SERVICE?**  **PLEASE EXPLAIN WHY YOU CONSIDER US TO BE THE APPROPRIATE SERVICE FOR THIS FAMILY AT THIS TIME?** | | |
|  | | |
| **HAVE YOU OR OTHERS ALREADY PROVIDED ANY CONTACT, SUPPORT, OR INTERVENTION?** If YES please list details here: | | |
|  | | |
| **IS THERE ANY OTHER USEFUL INFORMATION YOU CAN GIVE US ABOUT THE FAMILY?** | | |
|  | | |
| **DOMESTIC ABUSE** | | |
| Have you explored historical or current domestic abuse with the family? | NO | YES |
| Is the family currently experiencing domestic abuse? | NO | YES |
| Has the family experienced domestic abuse historically? | NO | YES |
| If yes to the above, please give some details: |  |  |

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| **SECTION D:**  **FAIR PROCESSING AND CONSENT FROM PARENT** | | | |
| **IF THE PARENT HAS NOT SIGNED THIS FORM, PLEASE CONFIRM AT THE BOTTOM OF THIS SECTION**  **THAT THE PARENT HAS GIVEN VERBAL CONSENT FOR THIS REFERRAL AND TO DATA BEING PROCESSED AND RETAINED**  ***NOTE: WE offer consent-based services only, so a referral will NOT be accepted if verbal consent is not clearly shown.*** | | | |
| Here at Early Years Alliance we take your privacy very seriously, and with your consent we will process, retain and store your personal data in line with the General Data Protection Regulation (GDPR) (EU) 2016/679.  Your personal data and contact details will not be shared with any other third party but may be shared with other partnership organisations.  You have the following rights regarding your personal data:   * The right to withdraw consent at any time * The right to request your personal data is deleted * The right to access to your personal data   For more information regarding the use of your personal data please see [www.lewishamcfc.org.uk](http://www.lewishamcfc.org.uk) or make a request to: [Lewisham.Secure@eyalliance.org.uk](mailto:Lewisham.Secure@eyalliance.org.uk) or Early Years Alliance 50 Featherstone Street, London, EC1Y 8RT  and a copy of the policy will be sent to you.  **CONSENT: PLEASE TICK, SIGN AND DATE TO CONFIRM REGISTRATION**  I understand that by providing my consent I am confirming I understand how and why my personal data is used and give permission for Early Years Alliance to store and update my personal details.  I am a parent/legal guardian of a child/children under the age 16 and give consent for Early Years Alliance to store and use my child/children’s personal data for the purposes of the service.  I give permission to Early Years Alliance and any relevant partner organisation to contact me regarding services available and my access to them by: | | | |
|  | Telephone (including text messages)  Email  Post | | |
| PARENT SIGNATURE | | DATE | Click or tap to enter a date. |
| PRINT NAME | |  | |
| **IF THE PARENT HAS NOT SIGNED THIS FORM, PLEASE CONFIRM BELOW THAT THE PARENT HAS GIVEN**  **VERBAL CONSENT FOR THIS REFERRAL AND TO THEIR DATA BEING PROCESSED AND RETAINED.**  ***NOTE: WE offer consent-based services only, so a referral will NOT be accepted if verbal consent is not clearly shown.*** | | | |
| VERBAL CONSENT HAS BEEN GIVEN *(please put cross in box)* | | DATE CONSENT GIVEN | Click or tap to enter a date. |
| REFERRER’S SIGNATURE | | DATE | Click or tap to enter a date. |

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| ***EARLY YEARS ALLIANCE OFFICE USE ONLY:*** | |
| *Date Referral Received* | Click or tap to enter a date. |
| *NOTES/email trail*  *(e.g. contact with referrer before allocation)* |  |
| *Notes and/or pre-allocation contact with referrer or family to be added here* |  |
| *Reason referral is not appropriate for our service* |  |
| *Date referrer informed of rejection* |  |
| *Date of allocation and name of staff member allocated the case* |  |
| *Case number* |  |