**Positive Families Partnership MST/FFT**

**Screening guidance**

Prior to filling in the referral form, please complete this first section regarding inclusion/exclusion criteria drawn from the evidence base for the MST/FFT therapies. This exercise will determine if your referral is likely to be appropriate. Please call MST/FFT supervisors if you have any questions.

# Inclusion criteria: green boxes indicate likely eligible referral



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| **Criteria** | **Yes (Eligible)** | **No (Ineligible)** |
| The young person is aged 11-16 years (10 and 17 year olds will be considered by exception) |  |  |
| The young person has a risk of care, custody or residential school if current problems persist |  |  |
| The young person has some of the referral behaviours listed below at home, in school or in the community:* Physically or verbally aggressive
* Absconds/goes missing
* At risk of/experiencing child sexual exploitation
* Uses drugs or alcohol
* Makes threats of harm to others
* Parents/carers asking for child to go into care
* Commits crimes such as (not exhaustive):
	+ Theft/burglary/robbery
	+ Public order offences (affray, section 5 etc.)
	+ TWOC (taking without owner’s consent e.g. vehicles for joy riding)
	+ Assaults (GBH/ABH etc.)
	+ Possession/supply of drugs
	+ Breach of a court order
 |  |  |
| The young person is living at home with an agreed caregiver or, if in care, there is an agreed plan to return the young person home within three weeks of starting the service |  |  |

**Exclusionary criteria: red boxes indicate likely ineligible referral**

**Criteria**

**Yes**

**(Ineligible)**

**No**

**(Eligible)**

The young person lives independently, or a primary caregiver cannot

be identified.

There are concerns about the young person related to current

suicidal or homicidal behaviours.

The young person’s psychiatric problems are the primary reason

leading to referral, or the young person has severe and serious psychiatric problems such as psychosis.

The young person displays problem sexualised behaviour in the

absence of other antisocial behaviour.

The young person has severe difficulties with social communication,

social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism.

**What to do next?**

* Using the tick boxes above can you confirm that the young person appears eligible for these services? If in doubt, please contact the MST/FFT supervisors
* If you have determined that the case would be ok to make a referral, please fully complete every section of the referral form below.
* You should always seek consent from the family before making a referral. At referral stage, verbal consent is sufficient.
* If it is agreed that a referral should be made to PFP, please email this form to **referrals.Haringey@positivefamiliespartnership.com**
* Should you need a discussion in advance or are unsure of any section in the referral please call us on **0203 917 5440** or contact the relevant PFP e-mail addresses below.

PFP Supervisors:

* + [to be completed]

***\*\*Please note PFP will confirm the young person meets the eligibility criteria upon receipt of referral and again at the time of a space becoming available. Please let us know if the young person’s status changes or any further information comes to light which could impact on eligibility.\*\****

**POSITIVE FAMILIES PARTNERSHIP MST/FFT REFERRAL FORM – HARINGEY**

Referral Date: …………………… Mosaic ID ………………... ChildView ID: ...................

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| **Child/Young Person’s Details** |
| Surname: | First Name: |  |  |
| Nick name/previous names (if applicable): |  |
| Male |  | Female |  | Date of Birth: | Age: |
| Name of the primary Parent/Carer or other significant adult and their relationship to the young person: |
| Child’s Current Address:(including residential home if applicable)Family Address: | Parent Contact Tel. No: Parent Mobile Number: E-mail Address: |
| **Education, School and Employment** |
| School/Vocational Training/Employment Details: | Has the child remained on-roll at this school for the last 12 months? |
|  Education status, please tick any that apply: In school with no reported behavioural issues In school but <85% attendanceFixed-term exclusion Permanent exclusion EHCP/ SEN Support Alternative provisionPRU (Smart Centre) |  | Approximate number of agreed hours of education per week (if not full time): |
| GP:Tel No: | Address: |

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| **Child/Young Person’s Ethnicity** |
| Child’s Ethnicity (including Traveller status): |
| Child’s First Language | Second Language | Parent/Carer’s First Language |
| Are there any additional communication needs (e.g. an interpreter and for whom)? |
| **Social Care Details** |
| Is the young person in care? | Yes  No |
| **If Yes**, please provide date entered LAC (Looked After Children) care: | Please provide the approximate number of days in care over last 12 months (if applicable): |
| Is any family member subject to legal planning (e.g. PLO)? | Yes No, but has been previouslyNo, never |
| Is the young person on a Child Protection Plan? | Yes No, but has been previouslyNo, never  |
| Is the young person on a Child in Need plan? | Yes No, but has been previouslyNo, never  |
| **If yes** to any of the above, please give details: |
| **Medical Details** |
| Does the young person have any physical disability?Yes No | **If yes**, please specify: |
| Does the young person have any mental health diagnosis?Yes No  | **If yes**, please specify: |
| **Risk and Vulnerability Issues** |
| Sign of safety scale of safeguarding risk: 0 1 2 3 4 5 6 7 8 9 10*Please highlight accordingly. 0 = Very high risk 10 = No risk and no need for social care involvement* *If you have scored 5 or below, please provide details:* |
| Risk of family break-down: 0 1 2 3 4 5 6 7 8 9 10*Please highlight accordingly. 0 = Imminent risk of young person placed in care (crisis) 10 = No risk* *If you have scored 5 or below, please provide details:* |
| Do you or other agencies do home visits to the family as lone workers? | Yes No |
| Is there any additional risk information relating to the safety of workers visiting the family home? | Yes No |
| Is the young person safe at home? | Yes No |
| Is it safe to visit the young person at home? | Yes No |
| Is it safe to allow the young person & family into any PFP site? | Yes No |
| Is the neighbourhood safe at night? **If no,** please give details in this box: | Yes No |
| Does the family have any pets? **If yes,** please give details in this box:  | Yes No |
| Are there any other risk issues that we need to be aware of relating to the young person, the family or the environment? **If yes**, please give details in this box: | Yes No |

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| **Please detail who has legal/parental responsibility for the young person (if different from the primary carer above)** |
| **Name** | **D.O.B./****Age** | **Relationship** | **Address** | **Ethnicity** |
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| **Please detail below the family members who are currently living within the home and their relationship to young person.** |
| **Name** | **D.O.B./****Age** | **Relationship** | **Quality of relationship** | **Contact details** |
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| **Any other significant family members’ name** | **Quality and frequency of relationship with young person and family** |
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| **Please provide details of family members’ mental health, or physical problems and assessments where available:** |
| **Family Member** | **Mental/Physical health problem** | **Is adult mental health service involved?** |
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| Reason for referral:

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| --- | --- |
| Reason | Please tick all that apply |
| Poor School Attendance |  |
| Associating with Anti-Social Peers |  |
| Substance Misuse |  |
| Criminal Activity |  |
| Makes threats of harm to others |  |
| Parents or carers asking for child to go into care |  |
| Running away/curfew breaking |  |
| At risk of or engaging in child sexual exploitation |  |
| Other (such as self-harm, suicidal ideation, depression, anxiety). **If yes,** please specify |  |
|  | Home | School | Community |
| Verbal Aggression |  |  |  |
| Physical Aggression |  |  |  |

**Please provide more detailed information below, including details of behaviour or situation, that has prompted the referral.**  |
| **Give a summary of any family dynamics that are impacting on the young person’s behaviour including any current and past events of significance (e.g. Domestic Violence, Loss, Injury)** |

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| **Please note any previous interventions, including Youth Offending Services, that have been offered and/or accepted to assist the young person and family? Or if available, please attach a chronology.** |
| **Agency** | **Contact details** | **Year started****/duration** | **Work done & outcome** |
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| **Please note any current interventions, including Youth Offending Services, that have been offered and/or accepted to assist the young person and family?** |
| **Agency** | **Contact details** | **Start date** | **Nature of intervention** |
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| **MST/FFT** |
| **Has the young person or family been informed about MST or FFT therapies?** |
| **Have the young person or any family members agreed to be contacted by this programme? Please provide any useful information regarding this below, including any barriers you can foresee about engagement.** |

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| --- | --- | --- |
| **Referrer Name:** | **Agency & Address:** | **Tel No of Referrer:****Email of Referrer:** |
| **Signature of Referrer:** | Date: |

|  |  |  |
| --- | --- | --- |
| **Team of Referrer:** | **Line Manager Name:** |  **Tel No of Manager:** **Email of Manager:** |
| **Signature of Manager:** | Date: |

***If this form is being filled out electronically please ensure that the consent to share information as part of the referral is recorded within your own systems.***

**PLEASE ATTACH THE FOLLOWING TO YOUR REFERRAL, IF AVAILABLE**

* Summary of Prior Offending  Recent Mental Health Evaluation
* Recent Educational Evaluation
* Chronology
	+ Single Assessment  Child in Need Plan  Child Protection Plan  Risk Assessments