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| **Early Help Family Assessment** |

**Important: you must gain consent for this referral (see overleaf)**

When you start the assessment please register it by emailing the first page to earlyhelp@brighton-hove.gcsx.gov.uk You should then email the completed assessment within 35 working days

1. **Details of person undertaking the Early Help Family Assessment**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name |  | Role |  | Agency |  |
| Tel no |  | Email |  |

1. **Early Help Family Assessment ID**

|  |  |
| --- | --- |
| Early Help ID number:(to be generated by the Early Help Support Team) | Date Assessment started: |
| Date Assessment completed: |

1. **Family Contact Details**

|  |  |
| --- | --- |
| Home Address (including postcode) |  |
| Telephone numbers  |  |

1. **Family Member**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Name | Live in household(Yes/No) | Nursery / School / College | Family member, eg mother, son | Date of birth | Gender |
| Adult 1 |  |  |  |  |  |  |
| Adult 2 |  |  |  |  |  |  |
| Adult 3 |  |  |  |  |  |  |
| Child 1 |  |  |  |  |  |  |
| Child 2 |  |  |  |  |  |  |
| Child 3 |  |  |  |  |  |  |

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1. **Why are you undertaking an Early Help Family Assessment for this child/young person/family?**

|  |
| --- |
| What are the key difficulties for this child/young person/family? |

|  |
| --- |
| What additional help does this child/young person/family need? |

|  |  |
| --- | --- |
| Parent/carer comment |  |
| Child / young person comment |  |

1. **Indicators of Risk**Please tick where you know these to be factors. Leave blank if you are unsure

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Risk** | **Child 1** | **Child 2** | **Child 3** | **Child 4** | **Child 5** | **Child 6** | **Adult 1** | **Adult 2** | **Adult 3** |
| Carer |  |  |  |  |  |  |  |  |  |
| Crime / Anti-social behaviour |  |  |  |  |  |  |  |  |  |
| Domestic Violence (physical) |  |  |  |  |  |  |  |  |  |
| Domestic abuse (emotional) |  |  |  |  |  |  |  |  |  |
| Emotional wellbeing |  |  |  |  |  |  |  |  |  |
| Physical wellbeing |  |  |  |  |  |  |  |  |  |
| Homelessness |  |  |  |  |  |  |  |  |  |
| NEET |  |  |  |  |  |  |  |  |  |
| At risk of NEET |  |  |  |  |  |  |  |  |  |
| Poor school attendance  |  |  |  |  |  |  |  |  |  |
| School exclusions |  |  |  |  |  |  |  |  |  |
| Teenage pregnancy  |  |  |  |  |  |  |  |  |  |
| Relationship issues |  |  |  |  |  |  |  |  |  |
| Risk of sexual exploitation |  |  |  |  |  |  |  |  |  |
| Substance misuse  |  |  |  |  |  |  |  |  |  |
| Worklessness  |  |  |  |  |  |  |  |  |  |
| Special Educational Needs |  |  |  |  |  |  |  |  |  |

1. **Have you made any other referrals for this child/young person/family?**

|  |  |  |
| --- | --- | --- |
| Family Member | Date | Agency - main reason  |
|  |  |  |
|  |  |  |

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1. **Are there any other professionals involved?**

|  |  |  |
| --- | --- | --- |
| Name | Role | Contact details |
|  |  |  |
|  |  |  |

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1. **Any other assessments made for this child/young person/adult?**

Please ensure you attach with this referral any relevant assessment already made and supporting documents.

1. **Consent**

Ensure consent is obtained from the family for a referral and for sensitive information to be shared with professionals in the Early Help Hub. Please note anybody over 13 years, who is deemed competent, can give their own consent. This may be with or without parental consent.

I agree to this referral and to my information being shared with agencies who are part of the Early Help Hub response.

|  |  |  |
| --- | --- | --- |
| **Signed young person, parent/carer signature** | **Name** | **Date** |
|  |  |  |
|  |  |  |

**Consent withheld**

Any individual or service the family would **not** wish information to be shared with

|  |  |  |
| --- | --- | --- |
| **Name** | **Service / Relationship** | **Detail of information not to be shared** |
|  |  |  |
|  |  |  |

**Detailing where consent not required**

Consent is not required in the following circumstances:

* Alleged or proven criminal activity
* Child protection or safeguarding of children and vulnerable adults, in which case this would become an immediate Multi-Agency Safeguarding Hub (MASH) referral

If you have not gained consent, please detail below what of the two circumstances above applies to this referral and tell us why you have not made a referral to the (MASH).

|  |
| --- |
|  |

1. **Monitoring Information**

To be filled in by or with the child / young person / parent / carer

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Child 1** | **Child 2** | **Child 3** | **Child 4** | **Child 5** | **Child 6** | **Adult 1** | **Adult 2** | **Adult 3** |
| Ethnicity(please specify) |  |  |  |  |  |  |  |  |  |
| First language (please specify) |  |  |  |  |  |  |  |  |  |
| Religion or belief (if any)(pleasespecify) |  |  |  |  |  |  |  |  |  |
| Disability(pleasespecify) |  |  |  |  |  |  |  |  |  |
| Immigration Status(please specify) |  |  |  |  |  |  |  |  |  |
| Sexual orientation(please specify) |  |  |  |  |  |  |  |  |  |
| Gender identity(please specify) |  |  |  |  |  |  |  |  |  |
| Pregnancy / maternity(Yes/No) |  |  |  |  |  |  |  |  |  |
| Married / civil partnership(Yes/No) |  |  |  |  |  |  |  |  |  |
| Armed services(Yes/No) |  |  |  |  |  |  |  |  |  |

**Assessment details**

It is expected that professionals complete an holistic family assessment which complies with the **Early Help Assessment Practice Standards** available at [www.brighton-hove.gov.uk/early-help](http://www.brighton-hove.gov.uk/early-help)

Please use the template below to complete the assessment. If you have your own template which complies with the **Early Help Assessment Practice Standards** please use it instead.

Note: it is **not necessary** to complete all sections of the assessment if not applicable to an individual within the family or the family as a whole.

**Child 1 Name:**

Where there is more than one child with difficulties within the family please cut and paste this section and complete as appropriate. If a child within a family is not presenting with any difficulties please indicate this clearly in the summary at the end of this assessment.

**Health:** general health, nutrition, physical development, speech, language, sexual health, substance misuse

|  |  |
| --- | --- |
| **Strengths**:  | Immediate priority? **Y/N** |
| **Difficulties**:  |

**Emotional & Social:** mental health and attachment, including interpersonal skills, domestic violence, Child Sexual Exploitation

|  |  |
| --- | --- |
| **Strengths**:  | Immediate priority? **Y/N** |
| **Difficulties**:  |

**Behaviour:** self-care and independent skills, anti-social behaviour and any sanctions

|  |  |
| --- | --- |
| **Strengths**:  | Immediate priority? **Y/N** |
| **Difficulties**:  |

**Identity**: self-esteem, self-image, social presentation, sexuality, gender

|  |  |
| --- | --- |
| **Strengths**:  | Immediate priority? **Y/N** |
| **Difficulties**:  |

**Family Well Being:** family history, relationships, significant events/changes, culture

|  |  |
| --- | --- |
| **Strengths**:  | Immediate priority? **Y/N** |
| **Difficulties**:  |

**Learning & Education:** pre-school/school/college, employment, training and achievement

|  |  |
| --- | --- |
| **Strengths**:  | Immediate priority? **Y/N** |
| **Difficulties**:  |

**Housing, Employment & Finance:** housing, conditions, play and leisure opportunities, pets

|  |  |
| --- | --- |
| **Strengths**:  | Immediate priority? **Y/N** |
| **Difficulties**:  |

**Social & Community Relationships:** support, friendships, community connections, harassment//bullying

|  |  |
| --- | --- |
| **Strengths**:  | Immediate priority? **Y/N** |
| **Difficulties**:  |

**Now please complete the Adult(s) section.**

**Adult 1 Name:**

If an adult within a family is not presenting with any difficulties please indicate this clearly in the summary at the end of this assessment.

**Health:** illness, additional health needs, alcohol or substance misuse, domestic violence

|  |  |
| --- | --- |
| **Strengths**:  | Immediate priority? **Y/N** |
| **Difficulties**:  |

**Emotional &Social:** depression, anxiety, bereavement, loss, mental health issues

|  |  |
| --- | --- |
| **Strengths**:  | Immediate priority? **Y/N** |
| **Difficulties**:  |

**Behaviour:** anti-social behaviour, offending type, victim of crime or domestic violence

|  |  |
| --- | --- |
| **Strengths**:  | Immediate priority? **Y/N** |
| **Difficulties**:  |

**Identity:** sexuality, sexual orientation, culture**,** ethnicity

|  |  |
| --- | --- |
| **Strengths**:  | Immediate priority? **Y/N** |
| **Difficulties**:  |

**Family Well Being:** family history, relationships in family, separation, single parent, carer, family of prisoner

|  |  |
| --- | --- |
| **Strengths**:  | Immediate priority? **Y/N** |
| **Difficulties**:  |

**Learning & Education:** training, learning, aspiration

|  |  |
| --- | --- |
| **Strengths**:  | Immediate priority? **Y/N** |
| **Difficulties**:  |

**Housing, Employment & Finance:** financial hardship, debt, condition and type of housing, risk of eviction

|  |  |
| --- | --- |
| **Strengths**:  | Immediate priority? **Y/N** |
| **Difficulties**:  |

**Social & Community Relationships:** support, friendships, community connections, significant others

|  |  |
| --- | --- |
| **Strengths**:  | Immediate priority? **Y/N** |
| **Difficulties**:  |

**Parenting capacity**: basic care, ensuring safety, emotional warmth, guidance, boundaries and stimulation

|  |  |
| --- | --- |
| **Strengths**:  | Immediate priority? **Y/N** |
| **Difficulties**:  |

**Summary of the key priorities for individuals / the family?**

What has the assessment identified as the key difficulties to be addressed within the initial Early Help Plan? List in order of priority

|  |
| --- |
| 1. |
| 2. |
| 3. |
| 4. |

**Now please complete the Early Help Plan.**

**Early Help Plan & Review**

|  |  |
| --- | --- |
| Early Help ID:(generated by Early Help Support Team) | Date of Plan:  |
| Date of Review: |
| Date of next Review meeting: |

|  |
| --- |
| Family Surname |

|  |  |  |
| --- | --- | --- |
| Lead Professional Name | Role and Agency | Contact details |
|  |  |  |

NB: All other family members involved should be listed in the members of the TAF section below

**Main actions**

Complete this section if it is the initial Early Help Plan or skip to the Review of Existing Plan if you are conducting a review.

What has the assessment identified as the key difficulties to be addressed within the initial Early Help Plan? Please consider strengths within the assessment to inform proposed actions. List in order of priority.

|  |  |  |
| --- | --- | --- |
| **Difficulty**Please refer to baseline data from the Assessment/Referral form | **Action(s)** Include who is responsible for action and how and what will be done  | **Desired outcome or end result** (include timescales) |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |
| 5 |  |  |

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**Review of existing Early Help Plan**

The purpose of the Early Help Review is to evaluate the impact of the plan or agree to close the Early Help Plan as required.

|  |  |  |
| --- | --- | --- |
| **Difficulty** | **Action taken** | **Progress made/problems encountered**  |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |
| 5 |  |  |

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**Revised Early Help Plan**

Amendments as a result of the review of the existing Early Help Plan

|  |  |  |
| --- | --- | --- |
| **Difficulty** | **Action and how it will be achieved** | **Desired outcome/end result, within what time period?** |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |
| 5 |  |  |

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**Members of the TAF (Team Around the Family)**

A TAF meeting must include key family member(s). If they cannot attend it should be recorded as a professionals meeting and a subsequent TAF meeting should be arranged with the relevant family member(s).

|  |  |  |
| --- | --- | --- |
| **Name** | **Family member / Agency** | **Contact details** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

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|  |
| --- |
| Notes/Views/Comments: |

**Ending the intervention**

Please detail the key actins achieved, if the key actions are not achieved please give the reason why the intervention has ended

|  |  |  |
| --- | --- | --- |
| **Name of the professional who has ended the intervention / agency** | **Date** | **Actions Achieved?** |
|  |  |  |

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