

Family and Friends Assessment Form

For use assessing support for family and friends of substance misusers

Confidentiality and Child Protection Statement

This assessment is confidential; we will only share information about you to another service or agency with your informed consent. The 'consent to share' page is at the back of this assessment. Otherwise, we will only share information about you when we believe that you or someone else is at risk of harm.

Note to worker:

Please explain in more detail your service or agency's confidentiality and child protection policies.

Fields with prefix **N** indicate that clarification can be found in the guidance document.

N 1. Assessment date:

N 2. Name of assessor/agency:

N 3. Name of person being assessed (ie carer):

4. Date of birth:

5. Gender: male/female/transgender (please circle)

6. Status: (eg married/divorced/single etc)

7. Address:

8. Postcode:

9. Tel:

10. Mobile:

N 11. How is it best to contact you?

(Can we write to you or leave you a message on any of these phone numbers?) **Yes/No** (please circle)

12. GP name or surgery:

13. Address:

14. Tel:

N 15. Name of next of kin/significant other:

N 16. Relationship to you:

17. Address:

18. Tel:

N 19. Ethnicity: (of carer)

N 20. Nationality:

Group	Ethnicity	Tick one
White	White British	
	White Irish	
	Other White	
Mixed	White and Black Caribbean	
	White and Black African	
	White and Asian	
	Other Mixed	
Asian/Asian British	Indian	
	Pakistani	
	Bangladeshi	
	Other Asian	
Black/Black British	Caribbean	
	African	
	Other Black	
Other Ethnic	Chinese	
	Other	
	Not stated	

N 21. Do you have any cultural needs?

Prompt: Is Interpretation (INTRAN) required?

22. How can we help you?

23. What is your current family situation/or situation that brought you here?

N 24. Are you using any support networks already?

Prompt: eg social worker, community mental health nurse, friends, family

The following may have been answered in the last section

N 25. Do you have any concerns about your physical health?

Prompt: Does the person assessed have any diversity needs? eg mobility, disability etc

N 26. Have you any concerns about mental health/psychological issues?

(Now or previously? Any history of self-harm or suicide attempts?)

N 27. Do you use or misuse alcohol or drugs?

28. How best would you describe your current accommodation?

(Circle what best describes accommodation)

Stable Unstable Council/Housing Association

Rented Private Owner occupier

Squat Traveller Rough sleeper Other

N 29. Who do you live with?

N 30. Are there any issues with your housing situation?

N 31. Do you have any debt or finance issues?

N 32. Have you ever been affected by domestic violence?

(If so, how?)

N 33. Have you any legal concerns?

34. Do you have any criminal convictions?

N 35. Do you care for any children? Yes No
(This may be carer's own, or others)

36. Can you tell me their names and your relationship to them?
(Please use this table to add details)

Child's name	Date of birth	What is the carer's relation to child?	Who does this child live with?	School	GP	Other agencies involved? Which?	Child Protection issues? Y/N

N 37. Do any of the children have additional needs?

Prompt: Does this need a CAF assessment?

Remember, if any potential child protection needs are identified, please ensure that a referral is made

38. Are you looking after any other dependants eg elderly relatives?

Prompt: For any of the above, is information required for example on:

- Home Start
- Tax Credits/Working Tax Credits
- Carer's Allowance
- DLA
- Pension Credits
- Income Support
- Incapacity Benefit

Has the client been given a carer's booklet: **Who Cares?** (www.heron.nhs.uk)

39. Employment and training:

(Please circle as appropriate)

Full/part-time employment**Pupil/student****Full/part-time carer with benefits****Full/part-time carer without benefits****Retired****Other****Unemployed****40. If currently not in employment or training, would this be something you would be interested in?****N Please give brief details of the person you care for:****41. Name:****42. Address:****43. Postcode:****44. Gender: male/female/transgender** (please circle)**45. Date of birth/or age:****46. What is their relationship to you?**

(eg partner, other family member, friend)

N 47. Is the person you care for aware that you have made contact with us?**48. What are their substance/support issues?****Prompt:** This may include:

- type of substance
- amount used, route and frequency
- are they in treatment?

49. Do they have any physical or mental health issues?**Prompt:** Is any harm reduction information required for example on:

- needle use/needle exchange
- BBVs
- sexual health

N 50. Are there any other people affected by their substance misuse or support needs?

Summary section

N 51. Using a scale of 1- 4, how are you managing with the following areas of your life?

(1) = excellent

(2) = good

(3) = not very good

(4) = awful

Area of life	Score (circle)			
health	1	2	3	4
finances	1	2	3	4
relationships	1	2	3	4
work	1	2	3	4
legal	1	2	3	4
control	1	2	3	4
housing	1	2	3	4

Risk assessment

N 52. From the information discussed, please summarise any risk areas for the client:

- self-harm
- suicide
- substance misuse
- mental health
- physical health/disabilities
- accommodation
- neglect
- learning difficulties
- violence
- abuse/exploitation by others
- criminal convictions
- other

Initial care plan/Identified support needs

N

53. What is/are the goal(s) and support needs of the person assessed?

54. How will these be reached?

55. Who will help them reach these goals?

Prompt: State name of agency if it is necessary to refer on

N 56. Keyworker name if known:

Prompt: If the client provides regular and substantial care they may be entitled to a Carer's Assessment. For more information regarding Carer's Assessment - call Crossroads Norfolk Carers Helpline on 0808 808 9876

Is a full Carer's Assessment required? Yes / No

If yes, state who will carry this out

N **Consent to share information***This section must be filled in for all referrals*

I consent to the details contained in this form to be shared, where appropriate, with the agency/ agencies and individuals below, if this is required for my future care. I understand that I can withdraw consent at any time; these details will be checked with me at a maximum length of time of 3 months.

Organisation	Staff contact name	Client initial	Review date

Name of client:

Signature of client:

Date:

I understand that details without my name/address will be used to monitor service levels and quality and may be shared with N-DAP (Norfolk Drug and Alcohol Partnership)

Signature of client:

Date:

Signature of individual filling in this assessment: