



Family Carers' Views on the
Future Provision of Family
Support Services
in Hertfordshire

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September 2005

Executive Summary

Carers in Hertfordshire was commissioned by the Hertfordshire Joint Commissioning Group to seek the views of family carers of people with drug or alcohol problems about their needs and the future provision of family carers support services in Hertfordshire.

This report, covering 18 months work, includes:

- Findings from a survey of current treatment services support to carers
- Discussions with the family carers reference group
- Site visits to good practice services in the UK and study of a literature review
- Discussions with a service advisory group
- Report of a consultation event attended by family carers, service staff and planners.

The report concludes that:

1. There is a pressing need to develop a range of family support services in Hertfordshire, separate from user services.
2. Identification, information, Carer assessments and signposting processes to support must be put in place. The report concludes that it is possible to build on some existing services, but that new service provision is also required.
3. Service development must involve family carers, and it may well be possible to develop capacity for support by collaboration and building on the informal mutual support currently provided by family carers.
4. A cultural shift is needed amongst user service providers to involve family carers in planning and at individual treatment level.
5. A series of recommendations are provided in a suggested action plan to develop family carers support in the short and medium term.

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Terminology

Family support

There is no single agreed definition of family support and there is a wide variation of views and experiences on the nature and purpose of working with families of substance misusers. This debate is referred to later in this report.

Interventions involving family members may be aimed at engaging the user in treatment and families often seek support for their substance misusing relative rather than for themselves.

There are amongst families and professional staff differences in perception about what constitutes an appropriate service to meet the needs of families.

Family support therefore covers a range of possible support activities.

For the purposes of this report, the overall aim of family support is assumed to be: to limit the harm to family members that can result from their relative's substance misuse.

There is much debate about the term "carer" as applied to family and friends caring for someone with substance misuse. The term is not one that many people initially easily identify with, family members involved often say that they do not see themselves as carers and as a result perceive that they have few rights. For some people, the term *carer* can be a useful way to gain recognition of the additional caring responsibility and the impact that substance misuse has on their lives and as result gain access to support services. As a result of our discussions with the family carers we have used the term family carer in this report.

Family carer includes:

- Family members (immediate and extended)
- Significant friends
- Those caring for a substance misuse or caring for dependents of substance misusing parents
- Dependent children of substance misusing parents /siblings

User

A person who uses drug and or alcohol assessment or treatment services as a result of problematic misuse of substance

Introduction

‘It is a simple and yet largely ignored truism that drug problems have a profound impact on families. Mothers, fathers, brothers and sisters are frequently caught in the maelstrom that drug problems almost inevitably create. If the effects on families have been ignored it is because of a preoccupation to perceive and treat drug problems as the preserve of the individual rather than having wider ramifications for close relatives’ Drugs in the family – the impact on parents and siblings, **Joseph Rowntree Foundation 2005.**

‘Families of problem drinkers are families in distress. Children of problem drinkers are often children in need. These are fragile families who teeter on the verge of collapse.....’ **Families, Children and Significant Others, Alcohol Concern, 2000. Background**

Carers in Hertfordshire were commissioned by the Hertfordshire joint commissioning group to seek the views of family carers about the provision of future family support services in Hertfordshire. There was recognition at that stage that there was little if any involvement of family carers in planning in Hertfordshire. (DAT Grid 8) and report into dual diagnosis acknowledged the need for information for family carers.

The organisation received two one-year grants during 2003-2005, and has undertaken the following exercises:

1. A survey of service providers in Hertfordshire in 2003 to find out what family support service exists
2. The formation of a Family Carers Reference Group and consultation to seek their views and experiences
3. Investigation of examples of successful services, commended as good practice in a Home Office Audit, and others from internet research
4. Study of a literature review (Effective Interventions Unit, Scottish Office)
5. The formation of a service provider’s Advisory Group-to share information and perspectives and to discuss issues regarding the provision of family support. The group advised on the planning of the carers consultation event
6. A Family Carers consultation event in July 2005, attended by family carers and service staff.

Existing Service Provision

This section of the report is based on:

- *The results of a service mapping exercise (September 2003) to find out what family support services existed and*
- *The comments and feedback from service providers contacted since then including discussions from the Service Advisory Group*

The results of the service mapping exercise

From thirty-eight (38) agencies contacted, fourteen (14) local service providers completed a questionnaire. The list of agencies that took part in the survey is show in Chart A overleaf.

The main findings from the analysis of their responses revealed:

1. In Hertfordshire, there were services that provided support to family carers, but these were limited in range, availability and accessibility.
2. There appeared to be significantly more family carer awareness amongst voluntary sector services than statutory services.
3. Statutory services were not positive about encouraging carer contact and saw themselves as primarily there for the service user. The main reasons for this position appeared to be:
 - a. Difficulty in managing concept of confidentiality
 - b. Lack of resources
 - c. A service culture that had the belief that the primary focus was for individual with the problem of substance misuse, to the exclusion of other family members
 - d. Lack of structure, and tools to work with carers e.g. carers assessment tool
 - e. Lack of training
 - f. Shortage of services to which family carers could be referred, or lack of knowledge about what is available
 - g. Different aims and expectations between the agency and families
 - h. Mistrust and negative attitudes
4. There was scope in particular for enhancing and further promotion of existing, but patchily provided services; in particular carers commended those that provided information and advice, telephone support and family support groups.

Chart A

Alcohol/Drugs Both/Other	Dacorum	Hertsmere	RBBS	SE Herts	St Albans & Harpenden	N Herts & Stevenage	Wel/Hat	Watford & 3 Rivers	Countywide	Out of County
Drug & Alcohol	Yes									
Alcohol Services in Tring										Yes
Drug & Alcohol										Yes
Alcohol Services in Royston										Yes
Drug & Alcohol							Yes			
Drugs				Yes						
Drug & Alcohol	Yes									
Drug & Alcohol					Yes					
Drug & Alcohol						Yes				
Drug & Alcohol								Yes		
Drugs (runs Alcohol Services Consortium from same premises)					Yes					
Drug & Alcohol	Yes									
Drug & Alcohol				Yes						
Drug & Alcohol										Yes
Alcohol									Yes	
Drug, Alcohol & other						Yes			Yes - but accessibility may be an issue for Family Carers who are not local	
Drugs						Yes				
Drug, Alcohol & other									Yes - but accessibility may be an issue for Family Carers who are not local	

Chart B

Agencies Contacted	Participated in Survey	Alcohol/Drugs Both/Other	Statutory	Non-Statutory	Area Covered	Family Carer Support								Other
						Group	Info and Advice	Education and Presentation	Carer Training	Counselling	Advocacy	Practical including Respite	Telephone Helpline	
Adfam	No	Drug & Alcohol		Yes	National		Yes	Yes	Yes		Yes			Support in prison visitor centres & community development work
Al-Anon Family Group Hemel Hempstead	No	Alcohol		Yes	Dacorum	Yes								
Al-Anon Family Group Watford	No	Alcohol		Yes	Watford & 3 Rivers	Yes								
Alcohol Advice Centre	Yes	Drug & Alcohol		Yes	West Herts									Refers to 3rd party services
The Cedar Project	Yes	Drug & Alcohol	Yes		Wel/Hat									
Clouds Families Plus	No	Drug & Alcohol		Yes	Out of County	Yes	Yes			Yes		Yes		
CRI PATCHED	No	Drugs		Yes	Out of County		Yes	Yes						
Famanon	No	Drugs		Yes	Nherts & Stevenage	Yes								
Family & Friends Project (West Sussex)	No	Drug & Alcohol	Yes		Out of County	Yes	Yes	Yes		Yes			Yes	
Focus Project	No	Drug & Alcohol		Yes	Dacorum		Yes			Yes				Acupuncture & Drop-In Service
FRANK	No	Drugs	Yes		National		Yes	Yes - website					Yes	
GASPED	No	Drugs		Yes	Out of County	Yes								
Herts Alcohol Problems Advisory Service	Yes	Alcohol		Yes	Countywide			Yes		Yes				
Hetty's & WAM	No	Drugs		Yes	Out of County	Yes	Yes			Yes			Yes	

Agencies Contacted	Participated in Survey	Alcohol/Drugs Both/Others	Statutory	Non-Statutory	Area Covered	Family Carer Support								
						Group	Info and Advice	Education and Presentation	Carer Training	Counselling	Advocacy	Practical including Respite	Telephone Helpline	Other
Jewish Care	No	Drug, Alcohol & other		Yes	Countywide	Yes	Yes	Yes		Yes				
National Treatment Agency	No			Yes	National									Involvement
Newcastle PROPS	No	Drugs		Yes	Out of County	Yes	Yes			Yes	Yes		Yes	Outreach
Oasis	No	Drug & Alcohol		Yes	Out of County	Yes	Yes						Yes	Bereavement Support
Parental Drug Awareness Service	No	Drug, Alcohol & other		Yes	Countywide	Yes	Yes	Yes		Yes				Befriending
The Living Room	Yes	Drug, Alcohol & other		Yes	Countywide but accessibility issues for Family Carers out of Nherts & Stevenage	Yes				Yes		Yes - Creche Facilities		
The Sheffield Family & Friends Alliance	No	Drugs	Yes		Out of County	Yes	Yes	Yes		Yes				
SPODA	No	Drugs		Yes	Out of County	Yes	Yes			Yes	Yes		Yes	Outreach
Stevenage & North Herts Drugsline	Yes	Drugs		Yes	Nherts & Stevenage	Yes	Yes			Yes				
Support, Nottingham	No	Drug & Alcohol		Yes	Out of County	Yes	Yes						Yes	Text messaging service & outreach
Turning - Point Short Breaks for Carers	No	Drug & Alcohol		Yes	Countywide							Yes		
Vale House Stabilisation Services	Yes	Drug, Alcohol & other		Yes	Countywide but accessibility issues for Family Carers out of Eherts	Yes								

Feedback and Discussions with Agencies

Subsequently we have had more contact with agencies and have continued to “discover” services. The agencies contacted in the course of this work are listed in Chart B (page 5), with a breakdown of their service and catchments.

It is significant to note that, even with the resources at our disposal; information about family support services was not easy to come by and rather like a well kept secret. There were probably other informal and formal support services in existence but they were not easy to find. Carers commented on the stress for them, and the amount of persistence, time and effort involved, to find out about any support.

“You find out things by accident, or through your own efforts or from other carers. I’ve got quite good at finding things out now but it’s taken me years on top of caring for her (daughter). Why can’t they (service staff) tell you what help is out there?”

“No information or support has caused my health to worsen over stress”

Those services that offered some family carer support were not always clear about the service aims and objectives. For example, it was not always clear if the aim of a family carer support group was primarily for the family carer’s needs or as an adjunct to the user services, with the aim of improving the treatment outcome for the user. Carers appreciated the clarity of clear information when it was available. Services also had different and sometimes contradictory philosophies, which were not always apparent to the carer.

We found generally that Hertfordshire agencies did not necessarily know what each other offered by way of family support service or what services were available to family carers outside of the county. If there were links between agencies, then there was little evidence of **systematic** links between them, indicated for example, by the existence of cross referral protocols. There was a need to streamline and pool information in order that services could help to ensure carers had a choice of service and received the appropriate service for them.

Carers in Hertfordshire were included in the picture described above. The charity had followed a pattern amongst carers organisations, in that it had not until this time, considered the specific needs of carers of people with substance misuse. The organisation had therefore made little, if any links with other services in this field, before undertaking this work.

There appeared to be scope for greater networking around carer issues amongst service providers, so that they could share information and enhance service development and take up. One service was particularly keen to see the continuance of the Service Advisory Group that developed during the course of this work, because of its potential to perform this function.

We considered the level of promotion of family carers support services and possible explanation for why they were not easy to identify. This appeared to be because:

- The service was an adjunct to the user service and not the core concern.
- There was not an open access to the service, i.e. entry was actually, or perceived as, linked to the user being in treatment.
- Some services said they were not funded to provide the service –i.e. they raised funds themselves and therefore there were under financial constraints and had capacity issues.
- It was a response to the issue of stigma and the wish to preserve the anonymity of family carers

Funding and lack of resources were barriers to supporting family carers, mentioned by both voluntary and statutory sector services. Two family support groups that have been commended by carers reported that they were not commissioned to provide the service and do so from their own funding sources. This created a climate of insecurity, instability and “short term-ism” in service provision.

Of serious concern in Hertfordshire was the lack of information available to carers about their right to carers assessments. If some CDATS performed this service, it was patchy and there was evidence of an apparent inability of some of the CDATs to undertake them. The reasons for this seemed to be in part cultural: the ethos of the service was that it really wasn't their role: they had to concentrate on the user, and families were eclipsed in the battle to care for users. The argument was also a financial one: it was suggested that CDATS were not sufficiently resourced to undertake carers assessments and to do so would be at the cost of user services.

Community mental health teams were able to undertake assessments, but not all families came under their remit and the relevance of the assessment tool used by CMHTs was questioned by staff and carers alike.

This is a thorny issue and one that strategists and commissioners must resolve with the CDATs. In our view, it is both a failure of legal responsibility and short-sighted in terms of outcomes, to provide an inadequate assessment response to family carers. Cultural change, resources, training, process and tools are needed to make a change. Such change has been managed in some statutory services, for example by additional funding for carers co-ordinator posts in Adult Care Services (EPD teams) and carers assessor posts in Community Mental Health Teams.

Different approaches were used by each of these departments, but both approaches appeared to have had a positive effect on raising the awareness of the service teams of the needs of carers and their service's legal and policy obligations.

The evidence from our work showed that the local authority was failing its duties under the Carers Equal Opportunities Act, 2005 and therefore risked legal action by family carers as a result.

From the advisory group and the addiction event held in July 2005, it was clear that organisational/cultural issues prevented family carers accessing support from agencies.

“I have been totally excluded and made to feel that I was the reason for my son’s addiction” (carer)

“Not being invited to visit her son in rehab left his mother feeling very dejected, ostracised and rejected”

Some staff in services described feeling unsupported by their agency’s position in relation to family carers. They reported feelings of stress, arising from their inability to provide a service to meet family carer needs, which were only too visible to them in the course of their work with the user.

The particular gaps and complexities of service provision for dual diagnosis had an additional impact on their family carers, who felt washed along in the slipstream of the passage of the service user between one service and another. Family carers were unable to find support specific to these circumstances. (COSMIC survey 2001, demonstrated the significant scale of dual diagnosis: prevalence of severe depression 27 % of the using population and 75-80% of the alcohol using population drug). Hertfordshire services have also reported on the need for better information for family carers in these circumstances (Report by Dual diagnosis project steering group, 9 December 2004).

Carers Experiences

This section of report draws upon:

- *Information from the carers reference group*
- *Consultation at the addiction event*
- *Good practise sites and literature review effective interventions Unit (Scottish Executive).*

We contacted carers through an invitation disseminated by service providers. In total nine carers responded and agreed to form a group to consider their experiences, examples of good practice and to give us their views about future provision of family support services in Hertfordshire.

Carers in the group had each between five and fifteen years of caring experience. There were both male and female members of the group and a mix of caring circumstances: drug misuse, alcohol misuse or both and dual diagnosis: substance misuse and mental ill health.

Limitations

The reference group was small and there were specific areas of need which were not reflected within the group (see below). All the group members were caring for an adult son or daughter. The group presented a vivid picture of their experiences, which we found were corroborated by our findings from the good practise sites we contacted and from the study of the literature review produced by the Scottish Executive, Effective Interventions Unit (EIU)

Estimates vary but Velleman(2002) quoted in the EIU report makes the conservative assumption that every substance misuser will negatively affect at least two close family members “to a sufficient extent that they will require primary health care services” .

Sheffield drug and alcohol services work on the assumption that there will be at least four family members affected and Al Anon suggests eight people will be affected.

The precise number in Hertfordshire cannot be identified but it is clear that the impact can spread widely within close family friends and the wider community. It is clear that further assessments of specific family carer needs are necessary:

- Families coping with HIV/Aids or Hep C
- Grandparents
- Young carers
- Carers from black and minority ethnic communities (We have made contact with the service “Aspect” as this report was finalised, and therefore this work is progressing for this group of carers in one part of the county.
- Bereaved carers

Initially members of the group used the sessions to talk about the services for their relative, but with encouragement and growing confidence in each other and the facilitators they talked about their own experiences and revealed the impact of substance misuse on their lives. The aims of the group were clear and not those of a support group. However, family members did provide each other with emotional support throughout the process. Families wrote up their experiences in the form of case studies and provided them to HCC for training purposes. (Contained in Appendix 2).

Carers Experiences of Agencies in Hertfordshire

In one session we drew up an extensive chart of all the agencies with which carers had contact, and asked carers to rate their “supportiveness” from their experience. Two agencies were reported as helpful, and one carer’s contact with a second GP was reported as helpful, but for the vast spread of agencies on the chart, family carers had received no support. They expressed feelings of anger and mistrust. They reported feeling, at best, ignored, and at worst, rejected or blamed by agencies.

*“I have been blamed and made to feel that I was the reason for my son’s addiction.”
(Carer)*

“Attempts to get professional to help our daughter have been futile so we have had to become social worker, crisis intervention and benefits agency to our daughter” (Carer)

For the most part family carers reported that, in their experience, services were there for the user and offered no support to the family. Carers voiced the common experience that their knowledge and understanding of the user and their condition was not welcomed or valued. They were not involved in the treatment or given assistance and advice about how to cope with their relative's behaviour.

“Client confidentiality is constantly used as a way of excluding us from our daughter’s care” (carer)

“Not only have I been excluded from the treatment process, my daughter has been disregarded and disempowered” (carer)

Family carers spoke about lack of information about drugs, their effects and various treatments. They knew of two family support groups that could provide emotional support and did not know of any practical assistance for themselves or other family members. The support was welcomed when it was offered:

“Our circumstances have changed dramatically and has saved our marriage. This service has provided more support, education and “tools” to enable us to make our recoveries-more than any other, i.e. GPs psychiatric unit etc and we look forward to a brighter future ... “(carer).

It was important to carers to have full knowledge of a service, easily available to them, with clear aims and objectives, so that they could exercise choice and find the service that was right for them. There were reports from carers of contradictory recommendations and advice from different agencies, which left carers feeling angry and confused.

Carers recorded their personal stories and experiences -see case studies. Family carers described feeling isolated stigmatised, shocked and distressed and felt abandoned to cope as best they could. Many spoke of huge efforts, practically and financially to obtain service for their relative and of how difficult it was to support their relative through treatment and relapses and to still maintain jobs, their own health and family life. They alluded to relationship pressures in their relationships with other family members, as impact strained family life sometimes to breaking point.

Unsurprisingly given the service findings recorded earlier in this report, initially none of the group members had knowledge of carers' rights and no-one had been informed about carers' assessments –despite the level and range of contacts with agencies in Hertfordshire. This highlighted the need for information; for statutory carers assessments and the need for agencies to know what each other can offer and be able to signpost family carers to support.

Carers Assessments

During the process one member of the group asked for a carers assessment from a CDAT. The response was inadequate and inappropriate and without any beneficial outcome for the carer.

Later another carer requested assessment from the CMHT which is resourced to undertake carers assessments. She reported on a favourable experience: the emotional support and being recognised and listened to was a positive experience at the time, even though outcome in the form of practical assistance wasn't forthcoming.

At the event others commented on the lack of services so even if there is an a assessment there may be no services and one person described having a year of support suddenly and abruptly stopped.

Involvement and Confidentiality

“Generally my experiences with CDATs have been positive. However, policies seem to vary significantly between different teams-some appear more lenient in their approach. This can be quite confusing for the carer. Also as the main carer it would be useful to have a copy of the care plan so that treatment objectives are known” (carer).

On an individual planning level, carers stressed the need to be involved. They wanted their knowledge of their relative to be considered and they wanted advice on how best to manage bizarre and inconsistent behaviour, or threatening behaviour, within their family

“Client confidentiality is constantly used as a way of excluding us from our daughter’s care” (carer).

Carers reported that confidentiality was in their experience used as a smokescreen so that staff could avoid listening and sharing any information with them. People understood the right to privacy but felt that the issue was not well managed. Their relatives were not routinely asked for permission for family carer involvement when they were well and family carers were not given general information that would have helped them to take care of their relative with a greater understanding and better response. There was also much disagreement between family carers and agencies about the management of risk and appropriate interventions to minimise harm.

Despite their feelings of being ignored and rejected sometimes for long periods of caring, members of the family carer group and family carers at the event demonstrated that some family carers were willing to be involved and were prepared to give credibility to joint work with planners and commissioners.

One carer at the event said *“we need more meetings like this one so that we can say what we know and help you people to improve services”*.

Financial

People spoke of money problems as a result of theft by their relative, or bailing them out of trouble and debt or the cost of treatment –one paid £1000 for a week treatment at the Priory.

One grandmother gave her example of eligibility for payment when she was at home caring for her grandchild, but caring for her daughter wasn’t counted for benefits purposes and she now had no choice but to work. Balancing work and caring for her daughter-a drug user and caring for grandchildren was creating high levels of stress, but she couldn’t afford to stop work.

Break from caring

Family carers did not feel they got a break from caring. They described always “living on the knife edge”. Some described work as the only break from caring and that work kept them sane and made them feel normal.

The discussions with carers in the group and at the event are consistent with **the key findings contained in EIU 2003**

- The stress that families endure can have a direct impact on their physical and psychological health.
- Relationships are affected a stability within the family becomes more difficult to maintain.
- Families face financial hardship whether through caring for the children of the drug user, helping with drug debts, or even through theft or violence.
- Social lives are restricted either as a result of fear of leaving the house, embarrassment or sheer lack of energy to do something for ones' self.
- Family members will be affected differently, respond differently and have individual needs.

There are significant differences between alcohol and drugs in the stress and strain experienced by families coping with drug use because of illegality and associated criminality, level of stigma and level of guilt and shame felt by parents.

The Needs of Family Carers

Coping with stigma Family carers talked about how this can stop them seeking help; their efforts, particularly early on, to conceal the problem. Sometimes the stigma is very real, e.g. when family are excluded from primary care services (Adfam).

Accessing treatment service and be involved in it: family carers were angry and frustrated by their experiences of trying to get support. They felt that even in extreme conditions e.g. attempted suicide it was difficult and one person reported being left to cope on her own in such circumstances.

They reported that they were often told that the user had to be off the drugs or alcohol before they could be treated, which appeared to them to a contradiction in terms. It was particularly difficult for family members when their relative relapsed after treatment. This demonstrated the need for family carers to be more informed and more involved in treatments.

Assistance with how best to help their relative: The families we worked with had clearly adopted different ways of coping. It was difficult for family carers to understand how they could both help and hinder recovery, without assistance to discuss and analyse their circumstances. An example occurred at the addiction event when a service provider responded in the discussion by providing information to family carers of the health

dangers of suddenly withdrawing alcohol from an addict. Families need information of this kind and to know what might be helpful to do instead of sudden withdrawal.

Access to information and training Families described the barriers they encountered if they asked for information and advice. Carers reported that “confidentiality” was frequently cited by service providers as a reason for not providing information about drugs, their effects and the nature and course of dependency. Family carers spoke of their frustration at not getting information and of simply not knowing what to do to manage their relative’s behaviour: to safeguard the user and to minimise the impact of their behaviour on their family.

A range of support options: from the group’s discussions it was clear that family carers reacted differently and have different needs. It is essential that there is a range of support options available. They need to know what support exists and how to access it.

Emotional Support

“We feel like victims ourselves” (carer.)

Amongst other examples of research, *The Carers Health Survey, 2003 Princess Royal Trust for Carers* revealed high levels of GP diagnosed depression, stress and anxiety amongst family carers. The highest incidence was amongst carers coping with bizarre and inconsistent behaviour and after, “a good nights sleep”, this was cited by carers as the second highest factor in affecting their lives.

“You can cope with the stress of caring, but the stress put on by outside people makes the breaking point” (Carer).

Family carers identified the following as meeting their emotional support needs to deal with the commonly experienced frustration, stress and anxiety.

- Availability of local family support groups
- Counselling services
- Telephone helpline service

Practical support family carers described the impact of drug and alcohol use on the family and their struggle to maintain "normal" family life. They had to cope with detox, withdrawal, going missing, and crime and suicide attempts. They need

- Advocacy
- Methods of coping with stress such as complementary therapies
- Befriending
- Assistance with child care, particularly for those caring for dependent children of drug users

Financial assistance families reported that their caring roles were invisible, in part because of stigma and resulting concealment. They spoke of the difficulty in maintaining their jobs, given all that was happening in their personal lives. For some work was a haven; another family carer would have preferred to receive benefits assistance so that they could fully care for grandchildren (of drug abusing parents). She didn't qualify for assistance and her caring role was not recognised by the benefits system. The 2005 carers' legislation places specific duties upon Local authorities to ensure family carers have equal opportunity, as anyone else, to access work, leisure and education. Without proper recognition and assessment of need, substance misuse family carers are denied access to existing Hertfordshire carers services designed to implement the legislation.

Health information "it is imperative that family carers receive accurate health information especially about intravenous drug use and the associated health risks such as HIV/Aids and hepatitis C Without such information, they may be unable to take the necessary precautions to prevent the risk of cross infection.

What will help family carers?

- Access to a support group to help overcome shame and stigma
- Knowledge about the diseases
- Knowledge about current treatments and drugs
- Training on managing stress
- Greater access to counselling and bereavement counselling
- Assistance with supporting other family members
- Aftercare support to family
- Greater respite opportunities
- More childcare support
- Emergency fund to help families financially when required

Summary

1. Self blame amongst family carers can sometimes act as a barrier to accessing support. However the evidence from our work both with family carers and with service providers, revealed the logical, if unintended outcome for family carers of the current service provision in Hertfordshire: **Agencies do not on the whole offer support to families and many family carers are unsupported and ignored.**
2. The statutory role of informing and assessing substance misuse family carers is not being undertaken sufficiently and must be improved and outcomes monitored.
3. Historically, voluntary sector provision for family carer support has been under developed. There is a real opportunity now with the tendering process and additional funding for drug services to commission and develop services in line with the assessment of need.
4. Substance misuse carers must be included and cross referenced in strategies in Hertfordshire, e.g. Hertfordshire carers strategy; HPT carers strategy and drug and alcohol strategies. Commissioning linked to these strategies would then develop family carers support incrementally over time.

Findings

The main findings we concluded from our work were:

- It is important to provide family carers services with a prime focus of harm reduction to family carers, not simply service as an adjunct to those provided to users.
- It is necessary to provide a range of services and service provision separate from treatment agencies, in order to meet diverse needs and perspectives .
- It is possible to build capacity for family support services by training and empowering family carers
- The model of carer focussed, carer- led services ensures services are provided according to carers own views of their needs not the views of professionals
- Family carer involvement is possible to achieve given the right environment, which would be developed with improved provision of family carer support services.
- The formation of networks amongst support services strengthens capacity and pace of development

Recommendations

What is needed to develop family support in Hertfordshire?

From our discussions with carers with service providers locally and nationally and from the literature review, we recommend:

1. Drug and alcohol strategies must set clear objectives to develop family carers support alongside user services and thus address the tension between the confusion of perspectives that exist currently.
2. Fund a 3-year development post to:
 - Oversee the development of family carers services
 - To continue the work with the carer advisory group and service advisory group
 - To develop a carers assessment tool with carers and service staff involvement
 - To develop family carers support networks amongst communities throughout Hertfordshire in collaboration with existing service providers and family carers
 - Involvement of family carers –to hold regular forums maybe quadrant based, along the lines of the consultation/dialogue event held during this work
 - To network with other authorities and service providers in the UK to develop best practise in Hertfordshire
3. Ensure stable funding exists for existing information and support groups and use EIU good practise checklists to ensure a common direction of travel
4. Increase the capacity of county wide information providers. Make it a requirement of the commissioning process that services must provide written information for family and friends about what they can and cannot provide
5. Develop identification and signposting of family carers through primary care NHS-cross- link to Hertfordshire carers strategy and enhanced medical services
6. CDATs to develop carer assessment service, consistently throughout the county. This cultural shift will necessitate staff training (which should make use of carer trainers) , development of policy, a good assessment tool (developed with family carers) and process within the teams, and better signposting to support services. This is a significant task and in the light of other Hertfordshire experience, we recommend that additional financial resource is used to support the CDATs in this task.

7. The development of an effective protocol for family carers between CMHTs and CDATs in cases of dual diagnosis. Ensure the production of clear carer information, in line with Hertfordshire's findings.
8. We recommend that tendering and commissioning processes use the EIU Agency checklist to develop a culture of "carer- friendly" user services. This will provide a systematic baseline assessment of carer friendliness and comparative picture over next 3 years. The checklist is re-printed in Appendix 3
9. Generally needs are known and are consistent with the review. However the specifics in Hertfordshire have yet to be assessed for grandparents, young carers, carers from black and minority ethnic communities (link with Aspect) and bereaved carers and for the differences in impact on the family between drugs and alcohol.
10. Improve promotion and knowledge of help line services in Hertfordshire, particularly relevant to the needs of rural carers
11. Address confidentiality issues and the evident differences in approach between agencies in Hertfordshire. We recommend that a shared protocol is developed between agencies, based on the recent work by the Royal College of Psychiatrists, which was done with family carer involvement.

Sources and References

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Acknowledgements

Carers in Hertfordshire would like to thank

The family carer reference group:

Carole Beard
Eric Beard
Helene Paulson
Kevin Walter
Barbara Walter
Lou Wilson

The project steering group:

Sonia Douek, Jewish Care
Janis Rogers, The Living Room
Gil Alcock, Parental Drug Awareness Service
Mike Stilwell, HAPAS
Jo Plosajzski, North Herts. & Stevenage CDAT
Julie Pratt, The Cedar Project
Tina Haines, The Cedar Project
Teresa Mattingly, North Herts. & Stevenage Drugline
Ruth Gatenby, The Focus Project
Rebecca Plater, Turning Point, Short Breaks for Carers
Elaine Kelly, Turning Point, Short Breaks for Carers

All the family carers and professionals who attended the event 'Addiction: families coping together'

Adfam, Rachel Nicholson

The Sheffield Family & Friends Alliance, Tracey Ford

The West Sussex Family & Friends Project, Jane Brown

Support, Nottingham

Jewish Care, Sonia Douek

Hertfordshire Drug Arrest Referral Service

Gasped

Hetty's

WAM

The National Treatment Agency

Newcastle PROPS

SPODA

South Yorkshire Parents against Drugs

Clouds – families plus

Support, Nottingham

Appendix 1

Research of literature and good practice examples locally and nationally: *Carers in Hertfordshire* and the family care group have researched notable carer organisations recommended by the Audit Commission for their support and involvement of family carers. Through site visits and investigation of websites the group has gathered examples of good practice in supporting family carers. This research has enabled the group to:

- Decide what services they want to see in Hertfordshire
- Determine how existing Hertfordshire services might be developed
- Determine what new services need to be developed.

Local Services

Alcohol Services:

HAPAS provides confidential counselling on a one-to-one basis for **people who abuse alcohol** and their **family and friends**

Drug Services:

Drugline (Stevenage & North Herts) also has centres in Hitchin and Royston offering advice, information, support, alternative therapies and counselling for **drug users** and their **families and friends**. *Drugline (Stevenage & North Herts)* runs a family support group on Wednesday 2.00pm – 3.30pm

Drug & Alcohol Services

Parental Drug Awareness Service provides a free, confidential service to **parents and carers** who may be concerned about their children and drug, alcohol and solvent use or misuse. *Parental Drug Awareness Service* aims to:

- Raise awareness about drug, alcohol and solvent use/misuse within the community and the home
- Provide appropriate support and information for parents, carers and others who are faced with having to cope with problems related to drug, alcohol or solvent use/misuse

Parental Drug Awareness Service offers:

- Advice
- Support
- Befriending
- Counselling
- Support groups
- Presentation

Drug, Alcohol & Addiction Services

Jewish Care provides an Addiction Disorders Support Service to **families** affected by someone else's addiction. *Jewish Care* work in South East England – their services cover Hertfordshire. The service is evaluated by *Drugscope* and offers:

- One-to-one support – exploring emotions, helping families to set boundaries, providing information on drug and alcohol issues
- Support group run by families – held weekly
- Educational events – providing additional information on addiction issues.

Carers in Hertfordshire has a list of all **The Sheffield Family & Friends Alliance** support projects and details of **The Family & Friends Project** support groups. We also have available a copy of 'We Count Too'.

The Living Room works with **addicts and their families and friends**; recognising that addiction affects the whole family and as such offers support to family members and friends regardless of whether their relative or friend is receiving treatment. *The Living Room* provides a family support group which runs all day on a Thursday.

Out of County Drug and Alcohol Services:

CRI PATCHED SERVICE provides advice and support to the **families** of substance misusers or anyone experiencing the effects of someone else's drug problem. The aim of the project is to support and empower. *CRI PATCHED* provides the following services and are hoping to develop these in **Hertfordshire** (Watford).

- Advice & information
- Health & social care
- Training & education

GASPED is a **family** support service based in West Yorkshire that runs a number of support groups and has produced a comprehensive guide: **A Guide to Setting up a Support Group**.

Hetty's is a support network for **parents, carers, family and friends** of illicit drug users. Services include:

- Confidential telephone support
- Individually prepared information packs as and when required
- One-to-one support
- Group self-help meetings
-

What about me? Or WAM is part of the *Hetty's* project and has a specialist worker providing support, help and advice for **young people under the age of 18** who are

affected by someone else's illicit drug use. *WAM* has a dedicated helpline and also offers face to face listening service. *WAM* has produced a video which examines the impact on family life of illegal drug use.

The National Treatment Agency recognises that drug treatment **service users** and their **families and friends** have a unique and vital role to play in improving treatment and are working on producing a strategy on how the *NTA* will involve service users and their families and friends.

Newcastle PROPS provides support groups, one-to-one support, outreach and advocacy services to **families** affected by drug misuse.

The Sheffield Family and Friends Alliance is a city wide membership group for any **parent, carer or family member** whose life is affected by someone else's drug misuse. It is co-ordinated by the Family and Friends Development Worker who provides members with newsletters, information about drug services and relevant organisations. The alliance group has full support and involvement from family support groups, drug services and relevant organisations. The overall aims of the group are:

- To provide information and advice to anyone whose life is, or has been affected by someone else's drug misuse
- To ask families what they think, what they need for themselves and the user
- To Create a bigger voice for anyone affected by someone else's drug misuse
- To keep families informed of local and national events
- To promote the different types of support available within the Sheffield area.

The alliance group has also taken part in national initiatives, such as being consulted on *Adfam's* work to develop a set of quality standards/codes of practice, 'We Count Too', for family support groups.

SPODA (Derbyshire) provides services including a **family** support helpline, support groups, one-to-one support, outreach and advocacy to **families and friends** affected by someone else's drug misuse

Drug & Alcohol Services

Adfam works for and with the **families and friends** of drug and alcohol users. The *Adfam* vision is that ***no family affected by someone else's drug or alcohol misuse should go without support, information, advocacy and advice.*** Meeting families' needs and addressing their concerns are main priorities of *Adfam* which provides the following:

- Support for families in prison visitor centres
- Training for families and friends of drug and alcohol users to enable them to set up structures that support one another
- Community development work
- Advocacy

Clouds – Families Plus is devoted to **family** members and others who want help in understanding and coming to terms with the substance misuse of others. *Families Plus* offers:

- Brief residential family programmes
- Therapy for individuals, couples or families

Support, Nottingham are funded by the Drug Action Team and provide the following services to **families and friends** of people who misuse drugs or alcohol:

- Telephone helpline
- Three outreach services
- One-to-one support
- Group support meetings
- Text messaging service
- Online support.

Oasis is based in Lincolnshire and supports **families** affected by a family members drug or alcohol use. Services include:

- Confidential telephone support
- Group self-help meetings
- Weekly open access
- Bereavement support

The West Sussex Family and Friends Project is located in the DAT and is funded by the seven local Crime and Disorder Reduction Partnerships. The Family and Friends Project provides **relatives**, and anyone else who may be affected by someone's substance misuse, with:

- Information about drugs and alcohol
- Advice about where to go and what to do
- Meetings with other people in similar situations
- Individual support
- Training and workshops

The project recognises that family and friends can play an important role in helping someone to recover from their addiction. The project aims to tackle the discrimination and stigma families and friends have to face and ensure there is support available when they need it.

Appendix 2

FAMILY CARER CASE STUDIES

1. Introduction

This series of anonymous case studies have been put together from interviews with family Carers about their experiences and contact with drug and alcohol services.

2. The Case Studies

a) Tony

Tony is the sole carer for his son, who has been diagnosed with drug and alcohol addiction and depression. Tony believes that the problems started three years ago, when his wife died.

Tony knew of the existence of a local service through the community and newspaper, and when his son asked for help he attended this service initially for day services and then for a six month period of rehab as inpatient. During rehab his son had sessions of group and one-to-one counselling. Tony feels that the rehab did help the alcohol addiction but the depression was not treated, even though Tony was of the opinion that it was the depression that had caused the addiction. Tony felt that the service did not consider his thoughts as carer and at no point during the rehab was Tony informed of the care plan.

Since his son's period of rehab, he and Tony have a new GP. This GP will see Tony alone and keep him up-to-date as far as possible with what is going on with his son. His son is now on "lots of drugs" both for the alcoholism and depression and the GP is currently considering a further period of rehab.

Tony has not had a carer's assessment; until recently he was not even aware that he was entitled to one. He was visited by a worker from the elderly and physical disability team, who recorded the information provided by Tony on a single assessment form. Tony has heard nothing since.

Tony's own life has been restricted considerably by his full time caring responsibilities. Tony gets no quality time to himself and if he is out he is worried what he may come home to, and if his son is out he is worried about what he is doing. Tony has become isolated from his grandchildren, as his daughter-in-law will not bring them to visit because of his caring responsibilities.

Tony provides a lot of care and has a lot to offer but feels he has not been involved and that his input has been unwanted. Tony does understand

confidentiality but feels that this has been used as an excuse not to involve him in the care of his son.

b) Sue & Mike

Sue and Mike have been caring for Sue's two sons for twelve years. Both sons have misused drugs and are on methadone replacement programmes but continue to use heroine. The elder son has also misused alcohol and suffers from depression.

Sue advised that the services her sons have received have been quite good. Both are currently under the care of the local community drug and alcohol team (CDAT) and one is part of a shared care scheme organised by the GP. Sue says that the CDAT services have been good and that both her sons see that it is important. However, Sue did say that last year there had been some problems with regard to rehab for her younger son who, having achieved set targets to enter rehab, found that the "goalposts were moved" and that he needed to do more before going into rehab.

Sue said that on occasions she has attended GP and key worker appointments with her younger son when he has been happy for her to do so.

Sue discovered services for herself quite by accident when looking for help for her sons. On contacting local drug services, Sue was asked how she was feeling about the situation and was consequently offered counselling. She has found this counselling very helpful and says that without it she may have "gone under".

Whilst Sue believes that services provided to her sons have been good, she felt it would have been useful to have had more knowledge of the care plan, perhaps with an explicit agreement within this about how she would be involved. One of her sons, who works full time, would have found it helpful to be able to access CDAT services outside normal office hours. She has also found it very difficult to get hold of relevant information.

c) Martin & Anna

Martin and Anna are carers for their daughter, who has a dual diagnosis of serious mental illness, combined with drug and alcohol abuse. Their daughter has been ill since 1999 and since that time there have been a number of different diagnosis of mental illness.

When their daughter first became ill their GP felt there was nothing wrong. However, several months later, when her condition had deteriorated considerably, an emergency GP did involve the crisis team. Following the intervention of the crisis team their daughter was admitted to a local service under section of the Mental Health Act. Upon discharge she came under the care of the local

community mental health team (CMHT). A suicide attempt in 2003 resulted in the involvement of the Assertive Outreach Team, which continues to date.

Anna and Martin feel that nothing has helped their daughter and that support from some specialist services has come too late to make a difference to their daughter's future. Services have not responded quickly enough and information has not been forthcoming from any of the agencies. Information they have obtained has been obtained through their own research via the internet and through contact with organisations such as Sane Line.

Martin and Anna feel that staffing difficulties in the local CMHT have compounded their daughter's problems as there has been a lack of continuity of staff, which has been distressing and frustrating for them and their daughter; this included nine changes of consultant in just over a year. They feel that client confidentiality is used as a way of excluding them from their daughter's care; at meetings, professionals make it clear that carers are there by invitation and they feel sidelined and that information they provide is ignored.

Whilst their daughter is receiving support in relation to her mental health needs, Anna and Martin feel that too little emphasis has been placed on the drug use, and it has been stated by staff that if she does have a drug problem it would not be their responsibility. It seems as though services will either treat the mental health problem or the drug use but what their daughter really needs is support to tackle both at the same time.

Martin and Anna feel that attempts to get professional help for their daughter have been futile and that in their caring role they have had to become social worker, crisis intervention and benefits agency for their daughter.

The strain on the family has been immense and the support provided to them as carers has not been the right support. The Assertive Outreach Team has recently put family visits in place, which they say they were originally told was to gather information, assess themselves and then "dovetail" things, so that their daughter would have maximum input. They have now been told that the visits are strictly for carers support and that discussing their daughter is not on the agenda. The current objective of these visits is to teach the family "how to problem solve". Anna and Martin feel that this is an insult, as this is exactly what they have been doing for the last 5½ years. They have had a carer's assessment but did not receive services as a result of it, although Martin did say that he and his wife do at least have each other and there are carers out there who are in more need of support.

d) Tony & Maria

Tony and Maria are joint carers for Maria's son, who is a (recovering) alcoholic, who also suffers from mental ill health. Maria advises that her son's problems

with alcohol began some twenty years ago but is of the opinion that signs of mental illness were there in his early teens.

In the first instance Maria made contact with various voluntary organisations, eg alcohol help lines and MIND. Her son also attended a day service and Maria attended for counselling. The family had heard about local services from the community, GP notice board and the newspapers.

Late 2001 Maria's son lost his job and was admitted to a rehab service. He was there for a year and according to Maria, she feels that the last six months were a "waste of time" and that his problems were not being sorted. She feels that the rehab service worked with regard to the alcohol addiction but says that they did not treat or acknowledge the mental ill health that the family believes caused the addiction. The family feel that a mental health assessment should have been undertaken and that this would have assured that treatment and the right support were put in place.

Maria advises that she and her husband were not involved in her son's care, even though they made it clear they wanted to be. For the first four months of his treatment Maria and her husband were not allowed to visit with no explanation given for this decision. Contact with a key worker was also stopped without explanation and their letters requesting updates went unanswered (though they have since received a written apology with regard to this). When they approached the rehab service in person they report that they were treated with hostility and their request for family counselling was refused on the basis that the service was too busy. Maria and Tony find the current situation quite intolerable and at present they do not have any contact with her son.

Maria and Tony have not had a carer's assessment. They did ask for one recently but Maria advises that this was refused by the local CDAT, who told the family to contact Carers in Hertfordshire.

3. What would have helped

The individual circumstances described in these case studies were all very different, but there are some common themes and messages about what carers feel would be helpful in their individual circumstances.

- Information: About different types of services, different types of treatment, what to expect, eg purpose and possible side effects of different types of treatment. There was some suggestion that an information pack for carers would be helpful.
- Involvement: Taking the family history and family's experiences into account. Input of carers into drawing up care plans and keeping them informed. Issues of confidentiality are recognised and one carer suggested

that a written statement about how the carer would be involved in the care and treatment as part of the care plan would be helpful.

- Closer Involvement between Mental Health and Drug & Alcohol Services: The experience of some carers is that particular services will focus on the mental health issue or the addiction issue, rather than tackling the “dual diagnosis”.
- Support for Carers in their own right: Basic essentials of carer’s assessment need to be in place with clear information for carers about the outcome of that assessment, what support is available for them, etc. For some carers access to counselling has been helpful. Named point of contact or a mentor to act as a link between families and the services would also be helpful.

Appendix 3

CHECK LIST FOR AGENCIES AND SERVICE PROVIDERS OFFERING SUPPORT TO FAMILIES

- | |
|--|
| <ul style="list-style-type: none">• Is your agency/service clear on what support they can offer to families and carers and what support they can’t?• Are there any training implications for staff?• Are there any boundaries such as confidentiality that need to be established?• Do any existing policies need to be reviewed such as assessment procedures for drug users to establish if and to what extent they may wish families and carers to be involved in joint working?• Are there any resource implications to offering support and how can these best be met?• Has your agency got good knowledge of other support that may be available locally and how to refer people onto that support?• Can working with other support providers strengthen the support you offer?• Are there any barriers that may prevent people accessing support and can these be minimised?• Has your agency/service developed a method of evaluating the support they offer to families and carers? |
|--|

Appendix 4

Determining where family support fits into a DAT's responsibilities and commissioning structure	Needs assessment	Taking into account diversity of needs	Seeing the needs of family members as distinct from the needs of users	Capacity building to support the development of services	Commissioning flexible services, tailored to fit local circumstances	Consultation & involvement	Funding	Monitoring & evaluation
							Yes	
				Yes				
	Yes	Yes						
								Yes
						Yes		
Yes			Yes					
		Yes						
					Yes			
							Yes	
Yes								Yes
							Yes	
					Yes			
		Yes						
						Yes		
				Yes				
	Yes							
			Yes					

Appendix 4 (cont/d)

Research of good practice examples by Drug Action Teams:

Following are nine areas for attention by commissioners of family support services as recommended in 'We Count Too' (Adfam, PADA and FamFed 2005) and examples of action by Drug Action Teams:-

1. Determining where family support fits into a DAT's responsibilities and commissioning structure

- **Nottinghamshire DAAT** commissions Hetty's a dedicated county-wide family support service, and What About Me? (WAM), a support service for children and young people affected by the drug and alcohol use of parents, siblings or friends. Both services are seen by the DAAT as key to the delivery of their treatment, prevention and education strategy, and receive core funding from DAAT Pooled Treatment Budget and Young People's Partnership Grant, supplemented by funding from DAAT partner agencies. The DAAT has recently appointed part-time advocacy posts for both service users and families/carers.
- **Gloucestershire DAAT's** Community Support Officer leads on this area of work and works closely with the district Crime and Disorder Reduction Partnerships in the county, including access to funding
- **Gateshead DAT's Co-ordinator** has ensured that the needs of family members affected by drug use are included in their local carers strategy, and has applied to the Carers' Support Grant for funding to support work in this field.

2. Needs assessment

- **Coventry DAT** commissioned an external consultant to conduct a Review of Services for Parents and Carers that led to a list of action points to further determine need. This includes stipulating that treatment provider services record all contacts with parents and carers as part of their monitoring, in order to determine the level of hidden demand for family support services.
- **West Sussex DAAT** recently organised a consultation day entitled 'Voices of Families and Carers'. This was publicised through local services and groups, and also via press releases to local papers and adverts on local radio. Forty-five people from a wide range of backgrounds attended, and a list of recommendations for action was agreed, including which types of services family members felt would be most useful to them. Further consultation is currently being carried out, and from this the DAAT lead worker is drawing up an action plan for the development of services in the future. *A copy of the event report is attached.*

3. Taking into account diversity of needs

- **Havering DAT** commissions a range of services including a Family Support Counsellor at their local adult treatment service who runs separate support

groups for parents and partners and provides one-to-one support. The DAT Family, Young People's and Community Development Worker runs specific Workshops for Foster Carers to help them respond to drug use and its impact on their families, with a view to developing an indication pack for newly recruited foster parents. She also works with local services to ensure that they take account of different family structures

- **Coventry DAT's** recent Review of Services for Parents and Carers made efforts to assess needs in local Black and minority ethnic communities, but found it difficult to access this information within the scope of that piece of work. They have decided to provide funding to support a local Black community drugs education project to expand its remit to explore further the needs of parents and carers within local Black and minority ethnic communities
- **Sheffield DAT's** Family and Friends Advisory Group recently identified that specific services for grandparents was a gap local provision. Their Development Worker has gathered information about services elsewhere and brought together a group including Social Services, local family support services and family members with relevant experience to plan how to address this gap. They are currently developing an Action Plan

4. Seeing the needs of family members as distinct from the needs of users

- **Wirral DAT** commission their local voluntary sector treatment agency to provide a separate service to families affected by drug use, including advice, information, one-to-one and group support
- **Gloucestershire DAAT** has involved PADA in providing specific support and advice to local groups who have experienced difficulties trying to include family members and users in one support group

5. Capacity building to support the development of services

- **Stoke DAAT** secured a grant from DrugScope on behalf of their local support group for a year, which enabled the group to complete training, employ a part-time facilitator and become constituted. Once it was clear that there was significant demand for family support in the area, they initially provided funding from the CAD initiative. The service has now been mainstreamed through the Pooled Treatment Budget with recruitment of a full-time worker and the launch of a dedicated telephone helpline service
- **Blackpool DAT** piloted work with families in a deprived ward of the town, using DAT, CAD and Sure Start funding. They commissioned UNITY, a local parents and carers support group run by qualified counsellors to run two 13 weeks courses for parents and carers with the aim of setting up a self-help group in the area. The success of this has led to an increase in provision and allocation of funding from the Pooled Treatment Budget to run the course in all priority areas of Blackpool, as well as a central location for those families that prefer not to attend a course in their local community. There is now a dedicated helpline, and one-to-one counselling available for families who are not comfortable attending group meetings.

6. Commissioning flexible services, tailored to local circumstances

- **Kingston DAT** has had difficulties accessing families requiring support. To address this, they are planning a Family Day for drug misusing parents and their children, with whom they are already in contact. This will include activities for the children and an opportunity to talk. The day is intended to launch a pilot project working with these parents and their children, with the aim of improving outcomes for the latter. The DAT has also recently compiled a resource pack including information on running a group and useful national and local contacts. They are training local voluntary sector organisations providing general family support to use this pack. The aim is to equip these organisations to identify needs, provide support and signpost or refer where appropriate.
- **Rotherham Drug Strategy Team (DST)** recently commissioned the lead worker from the county-wide (South Yorkshire) family support helpline service on a part-time basis to carry out development work and build family support services in the borough. Her post has been backfilled by funding from the DAT and she is focussing on making contact with family members and exploring how their needs can be addressed and how they can be involved in DST consultation in order to influence the development of services

7. Consultation and involvement

- **Gateshead DAT** is working towards having carer representatives on their Joint Commissioning Group who will be elected from CASA, their local Carers' Support Group. This group is already well represented on their Needs Assessment Steering Group
- **Stockton DAT** has user and carer representation on the DAT itself and on their commissioning group. A carer representative chairs their Reality Check Group. This group gives users, carers and community-based workers a voice in service provision, i.e. a quality circle for DAT planning. It has been well received by the NTA and Government Office North East

8. Funding

- **Kirklees DAT** have been working with local family support groups for five years to successfully access Carers Special Grant Funding. They have been able to broaden the definition of 'respite' to encompass support group meetings, as well as breaks away, which has proved useful. They have supported group applications to Social Services for this funding, discouraging individual applications. They have used some of the funding allocated creatively to enhance other local family-focussed services by providing a respite budget. They are in the process of identifying the best ways to use some of this to support work with Asian families, in partnership with their targeted service, 'Making Things Equal', and with families themselves. They are currently pushing hard for carers of drug users to get carers' assessments more routinely.

- **Barnsley DAT** has recently been allocated a proportion of their borough council's Carers' Support Grant. This is being used to provide respite services, holiday support and training for carers of drug and alcohol users. The DAT have organised a families and carers consultation day to agree the best use of the funding across the borough. There are two family and carer groups for substance misusers in Barnsley at present, both of which are fully involved in this consultation
- **Plymouth DAT** commissions a comprehensive service from Hamoaze House. They provide a structured day care programme for the treatment of drug users, but also therapeutic whole family work with affected family members. They also facilitate self-help focussed family support groups and one-to-one work for family members affected by drug use, whether or not the users is accessing treatment, and run a programme for vulnerable young people, many of whom have parents who are using drugs. The DAT has agreed clear boundaries between support for users and that for family members.

9. Monitoring and evaluation

- **Derbyshire DAT** commission a local service, SPODA, to provide support to family members, including children. They have a detailed service specification and are in the process of agreeing specific targets, outputs and outcomes for monitoring and evaluation purposes
- **Nottinghamshire County DAAT** have detailed Service Level Agreements for their local adult and children's support services. These include clear monitoring requirements, performance indicators and target outcomes. Many of the requirements mirror those required of treatment providers, such as compliance with QuADS standards, adherence to Hidden Harm and Every Child Matters, and increasing the numbers of families engaging with the service. Monitoring information is collected via a customised database provided and implemented by the DAAT. An important part of the performance management of the services is through regular structures service reviews.