NEWS AND BEST PRACTICE IN SUPPORTING FAMILIES AFFECTED BY DRUGS AND ALCOHOL

families upfront

SEPT – NOV 2013 ISSUE 10

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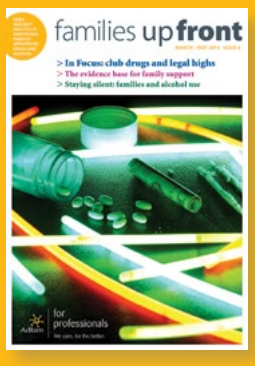

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Adfam, 25 Corsham Street, London, N1 6DR
Tel: 020 7553 7640 Fax: 020 7253 7991
Email: admin@adfam.org.uk
www.adfam.org.uk

Design and production by Sharon Crocker

SINCE the last issue of *Families UpFront*, we have held our conference *Hidden Harm: 10 years on*. It was a very successful event that triggered extensive debate, particularly around the issue of parental alcohol use. Many attendees thought that policy and practice on families and *alcohol* lags far behind the illegal drugs field. I have, therefore, started working with Alcohol Concern to create the Alcohol and Families Alliance. Our first meeting gathered together experts from both the voluntary and statutory sectors to explore the most pressing questions on children, parenting and alcohol use.

One topic of discussion was how we address parental drinking that sits within 'normal' limits – and isn't a child protection or 'troubled families' issue – but may still impact on everyday parenting practices. What's the difference between, say, a couple of glasses of wine or most of a bottle, in terms of parenting? As any parent knows, a drink or two after a long day can be just what you fancy; but how much is too much? Were the children's meals ready on time, and were they read a story before going to bed when they're meant to? Were they up and off to school in the morning? These are the kind of questions I think we have to be asking, rather than using over- over-the-top case studies of drunkenness at the school gates to try and make parents listen: I think this can alienate them and make them feel that the point is aimed at other people.

There are some precedents for previously 'normal' or widespread activities being made toxic and unacceptable by successful public information campaigns. Might there be an equivalent term to 'passive smoking', which has had such an impact on how parents see their behaviour? It's a difficult question, and the debate isn't black and white.

On another note, I'm sorry to say that this is the last issue of *Families UpFront*. See page 4 for details.

Vivienne Evans *OBE, Chief Executive, Adfam*

Adfam's services include:

- **Policy briefings** to help keep the sector better informed
- **Training** for families and professionals
- **Publications** for family members and people working with them
- **Consultancy** around providing the best possible services for families
- **Regional forums** for family support professionals

New Prison Family Support Alliance

The new Prison Family Support Alliance, a partnership of Pact, Nepacs, Pops and Jigsaw, has called for family support services to be made available in all 124 prisons and Young Offenders Institutions (YOIs) in England and Wales.

There are an estimated 95,000 children in England and Wales with a parent in prison, but their welfare is not automatically investigated when a parent is taken into custody. Breakdowns in family relationships are also linked to high rates of reoffending.

Andy Keen-Downs, Chief Executive of Pact, estimated that it would cost around £6million to place family support workers in all prisons and YOIs, but this would save £70million through reduced parental reoffending and fewer children being taken into care.

Meanwhile, the Government has announced plans to introduce 'resettlement prisons' so offenders can serve the last few months of custodial sentences closer to home.

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Uruguay first to legalise cannabis

In a move sure to cause controversy and curiosity in equal measure, the lower house of Uruguay's Parliament has voted to legalise the cultivation, sale and consumption of marijuana. The aim is to allow the sale of the drug in licensed pharmacies, to registered users, according to personal monthly limits. Individuals will also be able to grow up to 6 plants themselves.

The situation will be monitored closely across the world, not least the rest of South America, where increasingly bloody turf wars between drug cartels have led some to conclude that the prohibition regime is in need of urgent reform.

There were warnings from the United Nations, however, that such a move contravenes the international drug control treaties to which Uruguay is committed.

Minimum pricing mothballed

After months of deliberations, the Government has officially shelved plans to introduce a Minimum Unit Price (MUP) for alcohol. After a period of consultation on the proposals of the Alcohol Strategy, it was decided that there was insufficient evidence that MUP could reduce the problems of excessive drinking without penalising responsible drinkers. Multi-buy promotions on alcohol will also continue, despite previously announced plans to outlaw them.

The reversal was met with dismay by campaigners. Eric Appleby, Chief Executive of Alcohol Concern, described it as a "catastrophe for Britain's public health", and Prof Sir Ian Gilmore, Chair of the Alcohol Health Alliance, said that Government had "caved in to lobbying from big business".

In a similar move, plans for introducing plain cigarette packaging have also been dropped.

Spike in 'legal high' fatalities

Latest figures from the Office for National Statistics have shown that there were 2,597 deaths due to drug poisoning in 2011. The majority of these (1,706) were men, but the number of women has been rising since 2009.

Despite a fall in deaths due to heroin and morphine, these remain the substances most commonly involved in drug poisoning deaths.

Concerns have been raised over a significant rise in deaths involving new psychoactive substances, including mephedrone: these rose from 29 in 2011 to 52 in 2012. 20 deaths were linked to the ecstasy-like drug PMA, which led Martin Barnes, Chief Executive of DrugScope, to reason that effective harm reduction messages from the early 1990s are poorly understood by today's users: "when ecstasy was at the height of its popularity, there was a body of public health knowledge that helped protect people, for example not increasing dosage or allowing the body to get over-heated... [this] is less known to many of the current generation of club and festival goers". There has also been a rise in deaths linked to prescription pain killer tramadol.

ADFAM/DDN CONFERENCE

21 NOVEMBER

After the success of last year's inaugural *Families First* conference, Adfam and DDN will partner up again on 21 November in Birmingham.

Modelled on the highly successful service user conference held annually by DDN, this event is a chance for family members and the practitioners supporting them – and of course the people who are both – to gather and share with each other and learn about the latest practice in the field.

www.drinkanddrugsnews.com/families-first-conference-2013

Troubled Families programme extended

The Government's flagship Troubled Families programme has been boosted by a further £200 million in central funding. The money, to be released in 2015-16, is intended for work with 400,000 'high risk' families who do not currently qualify for the intensive Troubled Families programme. The Government money covers 40% of the cost of working with these families, with local authorities expected to contribute the remainder. Chief Secretary to the Treasury, Danny Alexander, said that the programme is "a radical example of how, by spending a bit more in certain areas, we can save much more in others".

Court victory for kinship carers

A kinship carer has won a long legal battle against her local authority for access to the same financial recognition as unrelated foster carers. 'Mrs X' gave up work to care for three of her nieces and nephews, all of whom were "severely neglected, demanding and exhausting", and whose parents had problems with addictions and mental health issues. In the London Borough of Tower Hamlets, the authority in question, foster carers received a weekly allowance of £334 for a child aged 11-15, compared with £163 for kinship foster carers.

The Court of Appeal upheld an earlier ruling by the High Court that kinship carers should not be paid less by the local authority than unrelated foster carers, purely on the basis of a familial relationship.

© ISTOCKPHOTO

The children had experienced a number of failed placements with other foster carers, and Mrs X was praised by Mr Justice Males as "one of the unsung heroines of our society". The ruling could set a precedent for other local authorities which discriminate against kinship carers, in contravention of existing statutory guidance.

DANOS under review

Skills for Health have begun a review of the current Drug and Alcohol National Occupational Standards (DANOS), to be completed in January 2014. DANOS were first developed in 2005 and have been used widely in the drug and alcohol sector as an important workforce development resource. They can be used as the basis for building role profiles, in recruitment and during the supervision and management process. As they are now eight years old they are considered in need of revision to ensure they reflect current, up-to-date practice.

The project initially used a working group of experts to revise the standards and get them to the current stage of public consultation. They can now be commented on until the end of September. You can see the draft standards and supporting documents at ***www.skillsforhealth.org.uk.***

Annual drug stats released

Each year, British Crime Survey figures set a benchmark for the use of illicit drugs in the UK. Around 1 in 12 adults took drugs in the last year (not including mephedrone), which equates to 2.7 million people; this was a fall from previous years. However, the rate of 16-24 year-olds having used drugs was 16.3%, which is almost double the figure for the whole adult population.

A separate report, *Smoking, drinking and drug use among young people*, found that all three are in long-term decline: 23% of school pupils aged 11-15 had ever smoked, compared with almost half in 1996; 10% had drunk alcohol in the last week, compared with 23% in 2003; and 17% had ever taken drugs, the lowest proportion since 2001.

Diary

● Working with the individual in a public health framework: how do we measure up?
This event is SMMGP's (Substance Misuse Management in General Practice) annual conference. Duncan Selbie, Chief Executive of Public Health England, has been confirmed as a speaker and workshops for delegates will look at topics including gambling addiction and delivering alcohol services.
www.smmgp.org.uk
24 October 2013, Manchester, £170/£180

● Game on: drug and alcohol services and the new local players
DrugScope's annual conference will this year focus on the new local landscape in the drug and alcohol world – Police and Crime Commissioners, Payment by Results, new drugs, the loss of the NTA and the creation of PHE and more.
www.drugscope.org.uk
6 November, London, £158 (members) / £204 (non-members).

● Alcohol Concern annual conference
This year's event will focus on the theme of 'conversations about alcohol': how we talk about it constantly but do not always address the important issues. Speakers will include Alistair Campbell and Professor Sir Ian Gilmore. The conference takes place during Alcohol Awareness Week 2013 (18-24 November), which will focus on the same theme.
www.alcoholconcern.org.uk
19 November, London, from £85.

We are sad to announce that this will be the last issue of Adfam's *Families UpFront*.

Like all charities, and especially in the current economic climate, we are always trying to find new ways to raise funds sustainably, and we had hoped that *Families UpFront* would help us to do this. However, despite full confidence in the magazine's quality and growing numbers of subscribers, we have been unable to fully cover the cost and staff time it takes to produce, and have decided to concentrate our limited resources on other projects. We hope that you have found *Families UpFront* useful during its lifetime, and will continue to engage with us in other ways.

IN FOCUS

Previous issues of *Families UpFront* will still be available to view on our website. Each edition featured an in-depth look at a key issue for family support providers and here's an overview:

01 Grandparent carers
02 Working with men
03 Criminal justice
04 Outcomes and evidence
05 Tackling stigma
06 The drug and alcohol workforce
07 Primary care
08 Club drugs and legal highs
09 Parental substance use
10 Residential rehab

FAMILY VOICES 2013

Each year Adfam runs a writing competition for families affected by drug and alcohol use, giving them the opportunity to tell their story in a creative and therapeutic way. Entries are always very powerful and demonstrate not only the struggles faced by families, but also the hope that they keep and the incredible value of seeking support. So please encourage your family members to take part – full details are on the back cover of this magazine.

There are cash prizes for winners, who will also be guests of honour at Adfam's annual Candlelit Carols fundraising event, where their work will be presented by celebrity guests. This will be held on 5 December in London.

BEREAVEMENT PROJECT

With funding from the Big Lottery and in partnership with the national organisation Cruse Bereavement Care (who will be leading the work), we are undertaking a new project to reach out to and support families affected by drug- or alcohol-related bereavement.

The aims will be to identify their specific needs, reduce their isolation and support them to become more active in their communities. We will design and develop training and information resources, and also work to establish peer support networks across the country to build a sustainable model which ensures that these families can be supported in the future.

RECOVERY FOR FAMILIES

With funding from Alcohol Research UK, we have been investigating the impact of recovery from alcohol use on families. Whilst 'recovery' has been a buzzword in the sector for some time, there is a gap in understanding of how it impacts on families: how do carers deal with lapse and relapse, for example? What is it like for families when a user takes the first steps into a recovery journey? And of course – what does the family's *own* recovery look like, and it is compatible with that of the substance user?

We have run focus groups with families, carers and children, and the findings so far have been extremely interesting. In particular, there seemed to be a gap between the optimism of the recovery movement generally, and the pragmatic view from families who have lived – often for many years – with the ups and downs of treatment, trips in and out of rehab, lapse and relapse. As ever, families were universally positive about accessing support for their own needs, and spoke passionately about how this support had given them the practical tools they need to cope with the ongoing challenges of supporting a loved one's recovery journey.

We will be writing up the focus groups with the hope of securing more funding for a nationwide study into the impact of recovery on families, so look out for further news from us.

Adfam's candlelit carols
Thursday 5th December 2013
St Bride's Church, Fleet Street, London

Every year, Adfam holds a Candlelit Carol Concert at St. Bride's Church on Fleet Street to help raise awareness of the difficulties families face, and to help raise funds to continue the important work of supporting families affected by drug or alcohol use. It is a very moving event featuring the personal stories of family members and as it is our only fundraiser, we aim to get as much support as possible. Eddie Mair, Adfam's Patron, hosts the event and celebrity guests present festive readings and the winning entries from our Family Voices writing competition.

For information about the event please visit www.adfam.org.uk.
We hope to see you there!

A challenging year for ESCAPE Family Support in Northumberland

When I wrote my Notes from the Community column in July last year, ESCAPE Family Support was a much larger organisation employing thirty people. However, we have spent the last six months downsizing and, due to the loss of three contracts and a significant grant, we now employ 15.

Last year, Northumberland's Drug and Alcohol Action Team (DAAT) amalgamated all of the contracts for the various modalities of the drug and alcohol treatment system into one large, all-encompassing contract. This meant that ESCAPE could no longer bid alone for the Tier 2 services, structured day-care or alcohol contracts we had successfully held but would instead need to bid as part of a partnership. We found national partners and submitted very strong bids but unfortunately lost the tendering process by a very tiny margin.

Simultaneously, the Ministry of Justice grant funding which had enabled us to provide an innovative empowerment service called SWAN (Supporting Women Around Northumberland) in partnership with Fourth Action, RELATE and Women's Health and Advice Centre, was devolved to the Probation Trust.

SWAN worked alongside women who needed help where there was a vulnerability of potential or persistent offending behaviour. In preference to the virtual one-stop service we had provided through SWAN, which took the services needed to the women throughout Northumberland's sprawling 2,000 square miles, the Probation Trust decided to commission women's hubs in the South East of the County. As a result this nationally acclaimed service was dismantled.

While ESCAPE continues to deliver services for drug and alcohol users, as a consequence of losing the contracts and grants, we have been forced to scale down delivery. We are now providing Tier 2 (advice, support, advocacy and information) and Tier 3 services (counselling, therapeutic and structured interventions) including 24-hour helpline support, brief interventions, SMART Recovery Groups, complementary therapies, diversionary activities, respite opportunities, social events and Parent Factor training for substance using parents, to a caseload of around ninety people with the support of our trusty volunteers and remaining staff.

Our DAAT has not provided funding to support carers of substance users since March 2011 – the majority has come from charitable trusts and foundations. This charitable funding was all due to end in March 2013. So at the same time as we were tendering for the drug and alcohol contracts for service users we were also writing an application to the Reaching Communities strand of BIG Lottery for our family support work.

> Reports continue to demonstrate the positive impact our family support services have on the lives of carers and family members

Now for the good news: thankfully March proved to be a hugely successful month for us!

Firstly, we were successful with our bid to BIG Lottery and secured £390,000, with Northern Rock Foundation providing match funding of £110,000. This sum will sustain the existing work of the family team in South East Northumberland and enable us to expand our family services, providing two new posts to provide robust family support in the rural North and West of the county. I am delighted for all of our carers and families that their service has been safeguarded. We could not have achieved this without the sterling support of those who attended our consultation events and steering group meetings to help us shape the service and inform our application.

Our Family Team works with family members whether their loved one is in treatment or not and now comprises a Manager, five Family Support Workers (two full-time and three part-time) and a part-time Administrator. Our Family Support Workers are trained and accredited in Community Reinforcement And Family Training (CRAFT), delivering this on a one-to-one basis and within group settings. We continue to deliver Parent Factor training to help support kinship carers, parents of substance users and substance using parents to develop their skills, which in turn, improves the lives of children experiencing 'hidden harm'.

Our carer drop-ins and support groups are expanding and continue to thrive and Carers Week events this year again included trips out and respite opportunities. We continue to support kinship carers – most group members are grandparents caring for grandchildren and are often attempting to continue supporting their adult substance-using son or daughter too.

The family team continues to use the Carer Support Outcome Profile (CSOP) developed by the Bridge Project in Bradford that tracks carer treatment and outcomes. Reports continue to demonstrate the positive impact our family support services have on the lives of carers and family members, showing that overall our service achieves improvement across all areas measured both in the early stages of support and across their entire time with us.

As you can tell, what a rollercoaster, bittersweet year this has been! We were very sad to see some long-serving staff lose their jobs. But yet again, despite the challenges faced, we have also had great achievements which continue to ensure that Northumberland's community-led response to drug and alcohol problems goes on.

With thanks and great appreciation to the dedication and commitment of our Trustees, staff, and growing team of volunteers, student placements and peer mentors.

We will continue to plan for the future and grasp all opportunities. Let's hope the coming year brings smoother waters.

Janet Murphy MBE
www.escapefamilysupport.co.uk

Keeping it in the family

Families UpFront looks at alcohol use by older people and the impact this can have on those around them.

FROM all of Adfam's work since 1984 it is clear that substance use affects families in multiple, complex ways. From stress and depression to the practicalities of care and support, from financial hardship to social stigma, families find drug and alcohol use a heavy burden to bear.

But within this wide arena of substance use there are many subtleties – specific patterns of behaviour which require different types of support, or cause particular types of stress. What, for instance, are the specific challenges presented to families which include an older drinker? Previous research by Adfam[1] has revealed a paucity of materials (both policy and research), statistics and general literature on how family members are affected by the drinking of a loved one. There is even less specific information on how older drinkers affect families.

However, there are some things we do know. The widespread presence, affordability and advertising of alcohol in our society; its social acceptance in many communities; and the lack of confidence families often have in identifying when moderate or heavy – but controllable – drinking has tipped over into a problem, all mean that harmful patterns of alcohol consumption can slip under the radar in a way which drug use may not, given the more widespread social opprobrium that surrounds it.

When family members do turn for help it's not always evident where to go. The available literature suggests that there is 'a lack of services specifically for children and families affected by alcohol misuse'[2]. There is of course a greater treatment focus on the individual themselves, but services 'historically tended to be very individualistic in their approach to treatment, viewing clients in a vacuum isolated from their families, friends, networks and communities[3]. Even within treatment services, research suggests that 'less than 1% of alcohol services in England provide a service specifically for older people.'[4] The same research notes that there is no specific evidence on whether specialist services for older people are superior to those that offer mixed age provision, but anecdotal evidence cited in the report suggests that older people prefer it.

So how does alcohol affect older people?

Firstly – what exactly is an 'older person'? There does not seem to be a universally accepted figure for the age when people become 'older'. Many statistics cited are for those aged 60 or 65 plus. The World Health Organisation suggests 65.

> A third of older people with drinking problems develop them in later life, especially women

Secondly – how do they drink and what are the risks? Older people tend to drink small amounts regularly. Those aged 65 and over report the highest levels of drinking five or more days per week (24% men and 13% women) of any age group; however, they reported the lowest rates of heavy drinking (consuming eight or more units on a single day) – 6% of men and 3% of women.[5] Average weekly alcohol consumption for the over 65s was 8.1 units compared to 13.1 for the 45-64 age group, 12.2 for people aged 25-44 and 11.1 for 16-24 year-olds.[6]

As people's bodies age they change. They lose muscle, gain fat and break down alcohol more slowly. This means they become physically more susceptible to the effects of alcohol. Alcohol may also interact unintentionally with prescribed medicines.

Age also brings non-physical challenges: insecure financial situations; lack of employment, activity and routine in the day; bereavement; social isolation; depression and stress brought about by any of these factors; or a loss of mobility and physical ill health.

A third of older people with drinking problems develop them in later life, especially women.[7] 'They tend to be highly educated and a stressful life event frequently precipitates or exacerbates their drinking…This group is more receptive to treatment and more likely to recover spontaneously from alcoholism.'[8]

Heavy drinking in older people is most common in more affluent and higher socio-economic groups. Generally, White British groups are more likely to drink heavily than Black or Asian ones.[9]

1 Adfam (2013) *Out of Focus: How families are affected by problem drinking, and how they look for help*

2 Zohadi et al (2004) *Service provision for the children and families of alcohol misusers: a qualitative study*, University of Bath

3 Templeton et al, (2005) *Working with the children and families of problem alcohol users: A toolkit* ('Planning the service' chapter)

4 Tilda Goldberg Centre/University of Bedforshire (2011) *Working with Older Drinkers*

5 Age UK (2013) *Later Life in the United Kingdom*

6 Office for National Statistics (2010) *General lifestyle survey*

7 Royal College of Psychiatrists (2012) *Alcohol and Older People* (web resource)

8 Dar, K., (2006) *Alcohol use disorders in elderly people: fact or fiction?* Advances in Psychiatric Treatment 12:3

9 Ibid.

How do older drinkers affect family members?

As we have seen, there is not a great deal of research available about how older people's problematic drinking affects family members. However by looking at the existing literature on how family members are affected generally, and how older people can be affected by alcohol, we can begin to make some deductions.

Perhaps the social and media views of alcohol consumption (often centred on young people's binge drinking and street-drinkers) make family members slow to realise that older people also can drink problematically. Families may have difficulties in identifying exactly how much older people are drinking – or perhaps are even happy for them to drink quite a lot if it 'keeps them happy' or occupied. The additional barrier of stigma around problematic alcohol consumption may be felt more keenly by older people due to generational attitudes and a reluctance to admit to weakness or a perceived social or even moral failing. This in turn makes it hard for family members to pick up that something is going wrong.

Some older people may be in financially insecure positions, and sustained ill health may necessitate expensive care. An alcohol problem could add pressure on top of this if a high percentage of limited funds is spent on purchasing it.

Attributing the effects of excessive alcohol consumption simply to the effects of old age is also a problem for families. 'Alcohol misuse may also lead to an increased likelihood of falls, incontinence, cognitive impairment, hypothermia and self-neglect. These sorts of problems may be regarded by health professionals and members of the family merely as signs of ageing.'[10]

Families are identified as a key means for support for older drinkers. We know the evidence suggests that families are invaluable in supporting all recovery journeys, but with the social isolation that some older people face, and the reduced social capital they may have, families are even more important. 'Emphasis needs to be placed on non-drinking social activities such as day centres and clubs in the context of the person's life circumstances and social support network – it may be necessary to work on redefining a social or family support mechanism.'[11] Research indicates that 'the concerns of family members and friends were the most common factor motivating older people to seek treatment for alcohol problems'[12] and that 'obtaining help from family members and friends has been shown to lower the likelihood of alcohol-related problems in older drinkers'.[13]

Family members can also play a role in reducing the possible harms of excessive alcohol consumption – by making sure prescribed medicines are taken correctly, for instance, and that the older drinker understands the suggested limits to consumption, and the reasons for not exceeding them. Older drinkers may also not be eating properly – if they have any kind of dementia or absent-mindedness this may be exacerbated by the alcohol. The drinker may become confused and not realise how much they have drunk and whether they've eaten or not. Families can support them, enhance their nutritional knowledge and understanding and explain how problematic drinking can lead to eating insufficiently or inappropriately.

Problem drinking amongst older people may place a strain on two particular types of relationships. Firstly, on the adult child who ends up caring for a parent: this parent may have lost a partner and/or friends, have nobody else caring for them and require quite a lot of support (financial, practical and/or emotional) from the child. This relationship would be hard for any person to manage; with problem drinking in the mix, it becomes even more challenging.

Secondly, on the grandchild who loses a treasured bond with their grandparent. An alcohol problem may impair the cognition and basic social functioning of the older person, and decrease their grandparenting capabilities – whether as occasional carers and babysitters, or simply as family members valued for their company and character.

Supporting an older drinker, then, is clearly a tricky proposition with many ramifications for family members or practitioners – some obvious, some less so. There is also a dearth of services supporting this particular client group which could advise family members, and a lack of awareness of this issue in general public understanding and discourse. Googling relevant phrases turns up little information on the subject. All these factors must contribute to a 'brick-wall effect' for worried family members. Hopefully some of the resources discussed in the article and listed below are therefore of use.

FURTHER READING

1. **Alcohol Concern (2012)** ***Trends in alcohol-related admissions for older people with mental health problems: 2002 to 2012***
2. **British Association of Social Workers (2012)** ***Alcohol and Older People – Essential Information for Social Workers***
3. **Royal College of Psychiatrists (2011)** ***Our Invisible Addicts***
4. **The Tilda Goldberg Centre, University of Bedfordshire (2011)** ***Working with Older Drinkers***
5. **Institute of Alcohol Studies (2013)** ***Older people and alcohol factsheet***

10 Institute of Alcohol Studies (2013) *Older people and alcohol factsheet*

11 Ibid.

12 Finlayson, Hurt et al. 1988, cited in Tilda Goldberg Centre/University of Bedforshire (2011) *Working with Older Drinkers*

13 (Moos, Schutte et al. 2004), cited in Ibid.

Doing it for ourselves

__Lindsay Henderson__ explains how to use peer-based research to examine the experiences of families affected by drugs and alcohol.

First Contact Clinical (FCC) is the Lead Organisation for the Carers' Drug and Alcohol Network (CDAN) in South of Tyne and Wear. A vital part of CDAN's vision is to influence local and national policy makers to challenge the stigma of substance misuse and highlight 'hidden carer' needs; this includes kinship carers, who care for other children in their family due to parental drug or alcohol use.

We wanted to establish a picture of kinship carer needs in South of Tyne and Wear and thought: why not use our expertise in peer-based research to do so? This is a model where people who have real-life experience of an issue – in this case grandparent carers themselves – undertake research in that area and within their own community. We also wanted to build on the success of the action research project *Breaking the vicious circle,* which used the participatory research model to identify the support needs of family and friends carers and was influential in the drafting of Sunderland's official Family and Friends Care policy[1].

So in 2012 we secured Big Lottery funding, with some help from the Voluntary Organisations' Network North East (VONNE), to explore the experiences of kinship carers in Gateshead and South Tyneside using peer-based research and make recommendations for meeting their needs.

THE TRAINING PROGRAMME

Participants FCC recruited and trained five carers from the drug and along network. Two, along with the lead peer researcher, went on to conduct the interviews, create the report and present the findings. "It was a really empowering experience," said Lesley, one of the participants: "when I reflect back and think 8 months ago where I was, I think wow! I feel so proud of myself that I've come so far and it's been an absolute joy to take part, I'm so happy I've done it".

Training We delivered eight half-day sessions using methods tailored to people who were not used to being in a research environment. It was a mixture of learning facts and new skills using quizzes, videos, games and other ways to make the learning fun in small groups, with lots of breaks.

The training programme equipped participants to undertake robust research and covered all stages of planning a research project, including how to be a 'safe researcher'. There is introductory information on the basics of research – defined as 'organised 'finding out' – and guidance on issues like planning the project, sampling, bias, conducting interviews, analysis and sharing findings. Another participant remarked, "it has been great to reflect on what I thought research was and what I now realise it is. I really enjoyed seeing everything we have worked towards coming together."

Putting learning into practice The researchers conducted 12 audio recorded interviews and two focus groups. They identified a number of challenges during the project, as explained in the table above. This provides a useful template for other services undertaking similar work.

Findings Again using learning from the training, the researchers transcribed and analysed the interviews. Overall, they found the main experiences to be dramatic life changes; complex family situations; financial problems and hardship; negative impacts on emotional health and general family relationships; and a lack of support, value and recognition of their needs, particularly from statutory agencies. These findings then informed the recommendations, including training for statutory and third sector organisations on the experiences and support needs of kinship carers, and a range of financial, practical and emotional supports for the carers themselves.

Key challenge	Response
Two researchers withdrew due to conflicts with their own caring roles	Three researchers increased their workload to meet demand
The sample of carers was smaller than anticipated and Social Services questioned methodology	There was a wide variation of kinship experience in each case, common themes were still identified and robust methodology was shown
Only one participant was signposted by statutory agencies	Existing networks signposted interviewees
Carers shared traumatic information	Researchers need the opportunity to debrief
Carers could be unwilling to talk candidly if orders are in process/place	Participant anonymity was ensured
Very large transcription content	Allowing for an initial, unrecorded discussion enabled a more concise and structured follow-up interview

Moving on Peer-based research is an important way of transferring power and skills, and families found it really empowering to explore in-depth an issue so close to their hearts. It was also a good way to mix the empathy and shared experience that families respond to so well with the more robust, systematic research approach that is needed to present arguments convincingly to more 'professional' audiences. We hope to use the report to access further funding to raise awareness of the needs of kinship carers both locally and nationally, and meet the needs of grandparents and the children they care for.

The final report, 'Nobody was listening', is available from __www.vonne.org.uk.__ For more information e-mail enquiries@firstcontactclinical.co.uk, telephone 0191 4274685, or visit __www.firstcontactclinical.co.uk.__

1 Available in Adfam's online resource library: www.adfam.org.uk/resource_library

Your organisation

Recently published resources on third sector issues and charity governance.

1 Show and tell: a best practice guide to portraying beneficiaries and service users

CharityComms

Using experiences and examples from across the charity sector, this best practice guide focuses on how to portray beneficiaries in photos, language and case studies. It suggests that charities have the challenge of creating a persuasive case for empathy and admiration rather than sympathy and pity, and that how society sees beneficiaries is often the responsibility of charities. The report splits the process into steps, including identifying your problems and sensitivities and agreeing your principles for how you will portray people, which includes looking at the language used and the impression it creates. The report recommends five key mechanics that are necessary to maintain a consistent portrayal of your beneficiaries, including the need for one person to have overall responsibility for the role (alongside a staff group to steer and review the process) and the completion of necessary paperwork. A user group is also recommended in order to offer advice and comment on their representation during the process and finally, an organisational database to store images and case studies for future use is advised.

www.charitycomms.org.uk

2 Taking your temperature: a brief organisational health check

Clinks

This tool is designed to help Voluntary and Community Sector organisations working in criminal justice to assess organisational strengths and weaknesses to flag up areas that require development. It acts as a 'health check', covering topics such as culture and values, income, fundraising and contracts, commissioning and procurement. Each topic contains a checklist of statements for organisations to tick off as appropriate: for example, under the topic of income are statements such as 'we rely on one or two sources for all our funding', 'our income is secure' and 'we have contracts from local authorities, NHS and some statutory criminal justice sector bodies.' The toolkit then provides a guide on how the answers reflect on an organisation using a colour chart, and offers advice on how to move forward.

www.clinks.org.uk

3 Charity awareness monitor

nfpSynergy

This report outlines the findings from a survey of over 1,000 people on the way charities spend their money. It asked participants whether they believed the different ways charities spend their money to be wasteful or worthwhile, and found that 3 in 4 people consider London-based offices to be 'somewhat' or 'very' wasteful; 72% of participants felt the same way about rebranding. Two-thirds however, felt that advertising and developing a website were 'fairly' or 'very' worthwhile uses of charities' money. 62% of respondents said they would feel confident that their donation would be spent well if charity staff did not travel first class, and over half suggested that they would feel confident if the organisation was run mostly by volunteers and no-one earned more than £50,000.

4 Small charity toolkits

Small Charity Week

Small Charity Week took place in June, and a number of resources were released to help organisations in key areas like building a volunteering programme, recruiting trustees, fundraising online and using social media, leading effectively and having a robust reserves policy.

www.smallcharityweek.com

5 Giving of time and money

Cabinet Office

This analysis of the 2012-13 Community Life Survey presents findings on the levels and nature of volunteering, charitable giving and social action. It shows that levels of both formal and informal volunteering have increased since 2010-11; the proportion of people giving to charity has also risen, but the amount donated has not changed in real terms; people who give time and money to charity are more likely to be older, with higher levels of education and actively practising a religion; and a 'central core' of one in seven people lead the way by getting involved in volunteering (formal and informal) and charitable giving.

http://communitylife.cabinetoffice.gov.uk

In Focus
Residential rehab

THERE has been disappointment in some camps that the 2010 Drug Strategy's focus on recovery has not brought the reorientation of treatment services that they had hoped for. Some residential rehab providers have felt marginalised by the strategic emphasis on 'treatment in the community' and complained that they are being starved of referrals for financial or political reasons. But rehab has an important role to play in any treatment system and it's important to know what it can provide, and for whom – especially as far as the family is concerned.

'It's very expensive, and it isn't right for everyone' isn't an ideal starting point for arguments taking place in times of tight budgets, but that is the challenge currently faced by rehabs. It's also an area Adfam has to engage in from a family perspective. Many families' first instinct is to 'get the user into rehab' and finding out about the realities of the treatment system can be a sobering experience: what they think their loved one needs may not match with what is available, accessible or affordable locally. Some may pay for rehab themselves, at great cost, without a guarantee of success.

Also, due to the more immersive recovery experience which rehabs pride themselves on, there may be room for much more work with families – as part of getting to the real roots of their behaviour – or much less, if the user is encouraged to make a brand new start away from their past and their home networks.

In this edition of *Families UpFront*, we want to debate (and celebrate) the role of rehab in promoting recovery and supporting families. Not all rehabs are the same, and we discuss different models like therapeutic communities *(p.18-19)* and mother-and-child rehab *(p.12-13)*. We also examine historical efforts to introduce some consistency into a sector which prides itself on independence *(p.14)*. And of course, we also seek the views of service users and families *(p.15-17)*. As ever, we hope you find it useful in your practice.

Joss Smith *Director of Policy and Regional Development*

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residential rehab has an important role to play in any treatment system

Setting the scene

A summary of the key facts on residential rehab.

What do we mean by 'rehab'?

Rehab may be used by people outside the drug and alcohol sector as a catch-all term to describe any kind of treatment for substance use. In this magazine we will be focusing purely on residential treatment, where clients stay overnight for a set time period. Other determining features of rehab include a focus on abstinence goals, highly personalised care plans, peer-led group work, psychosocial interventions and education on addiction. Overall they aim to provide a more immersive recovery experience than community treatment. However, rehabs are a diverse group and despite sharing a few key features, there is a huge variation in philosophy, intensity, access criteria and programme duration.

Rehabs are not statutory services, but are run by private or voluntary sector organisations. Some are funded, or part-funded, through local commissioning arrangements. Many are individual and independent, but some of the larger, national treatment providers, like Phoenix Futures and Action on Addiction, also run some residential services; private companies also run rehabs, including the 'idyllic' or 'isolated' overseas getaways often advertised in drug sector magazines. According to the NTA, there are around 100 rehabs in England being regularly commissioned by local authorities.

Although rehabs may encompass a varied group of providers, it is important to see them as part of the wider landscape of drug treatment, and not in isolation. People who access rehab will most likely have accessed other treatment services beforehand – indeed, the difficulty of achieving recovery in the community, even after several attempts, may be a reason why they access residential treatment in the first place – and they will still require support from other services after they leave.

How effective is it?

This is a topic of much debate: it can depend who you ask, or which client group is being referred to. The 2012 NTA report *The Role of Residential Rehab in an Integrated Treatment System* argued that residential services are most effective with more 'complex' service users for whom other kinds of treatment have been ineffective, and with alcohol users. The variety of approaches used in different rehabs, and a lack of official coordination between them, means that results can vary widely. The NTA report represented something of a challenge to the rehab sector to prove, and improve, its effectiveness, having found success rates (in terms of residents overcoming their dependence) from under 20% up to over 60%. Work is ongoing between the Government and treatment providers to create a set of quality standards specifically for residential rehab in order to increase the consistency and effectiveness of provision.

Who goes to rehab?

If a parent discovers their child is using drugs, the first reaction of many would be 'we need to get them into rehab'. But it is not that simple: rehab is not appropriate, effective (or affordable) for all substance users.

Only 2% of people in drug treatment are actually in rehab – a few thousand per year. It is much more expensive than community treatment, accounting for more like 10% of central drug treatment funding. Some have argued, however, that cost and political concerns keep the numbers accessing rehab artificially low: as other forms of treatment have become easier to access, more effective and cheaper, residential rehab providers have cried foul over being 'cut out' of commissioning cycles.

People in rehab are often at the 'complex' end of the substance using spectrum: community treatment may not have worked for them, they may have had longer substance using 'careers', they may use a variety of different drugs, and they could suffer from a wide range of related difficulties like poor physical and psychological health and housing problems. Commonly they will access funding for rehab through their local authority or the NHS, though they may also pay privately via their own resources or their family.

Rehab and families

The 'new start' or 'getting away from it all' ethos of residential rehab could cause some possible conflicts with family support, although this does not have to be the case. Contact with families may be sporadic or limited to certain times, or there may be initial bans on contact whilst residents 'settle in'.

Years of chaotic behaviour and relationships may make it a more difficult task to engage families positively, and previous 'failed' treatment attempts may hurt families' optimism. However, for those who identify family relationships as a key aim of recovery, there may also be increased capacity for intensive family work.

It's also important to remember that 'family' doesn't just refer to parents or partners coming on-site to visit. If the residents are older – as noted above, they may have had problems for many years before accessing rehab – they may be more likely to have children, who present very different challenges for visits, are likely to need support themselves and may be involved with social services.

Further reading

NTA (2012) *The Role of Residential Rehab in an Integrated Treatment System*

Service directory available from *Drink and Drugs News* magazine, www.drinkanddrugsnews.com/residential-directory

United we stand: keeping families together in rehab

***Hannah Shead** explains her work at Trevi House, a residential rehab for mothers and children in Plymouth.*

BEFORE joining the team at Trevi House, I had predominantly worked in adult-only services. Although, like many community drug services, these were commissioned primarily to treat the drug or alcohol user themselves, we did strive to include family members in some way, and much effort was made to ensure that interventions were available for 'affected others'.

Drug services have come a long way over the years, in terms of things like friends and family support groups and carers' drop-in; however the issue is one of philosophical approach as much as service design. You can initiate all the add-ons in the world, but unfortunately they are in danger of being simply that: 'add-ons'. Work involving family members – be they parents, partners or siblings – is frequently not considered integral to the work undertaken with the service user themselves. Unless the family member is literally in the room, they can all too easily become sidelined, and their potential impact upon a client's recovery, both positively and negatively, can be overlooked.

In terms of work with children, the change in approach has been more tangible: all adult drug users entering treatment are asked about their parenting responsibility, with drug teams notifying children's services as a matter of course. Practical measures have helped to support mutual understanding between children's and adult's services, such as multidisciplinary safeguarding training, and the increasing prevalence of drug workers and social workers located within one another's settings.

We can only hope that as time progresses, we continue to move in this direction of a more systemic way of thinking, enabling practitioners to not think about *either* the adult or the child, but rather the adult *and* the child.

Trevi House was set up 20 years ago this year. It was the brainchild of 3 local drug workers who felt frustrated at the limited treatment choices available for women with children, especially of the residential kind. By opening a residential rehab that allowed women to bring their children, the ethos was fairly simple: being a mother shouldn't stand in the way of recovery.

At Trevi, mother and child arrive and live here together. Mum attends the therapeutic group work programme during the day, whilst her child is cared for nearby within our on-site specialist nursery. We take women in pregnancy, and can cater for children up to eight years of age.

When we carry out our initial placement interview, we do this as a joint assessment with both a member of the counselling team and a staff member from the nursery. We ask mum a series of questions related to her child: not only does this help us build a better picture of her child's needs, but it also enables us to understand our potential new resident as a mother. What does bonding and attachment mean to her, why might children's services be concerned, and what has it been like to try and parent her child whilst in active addiction?

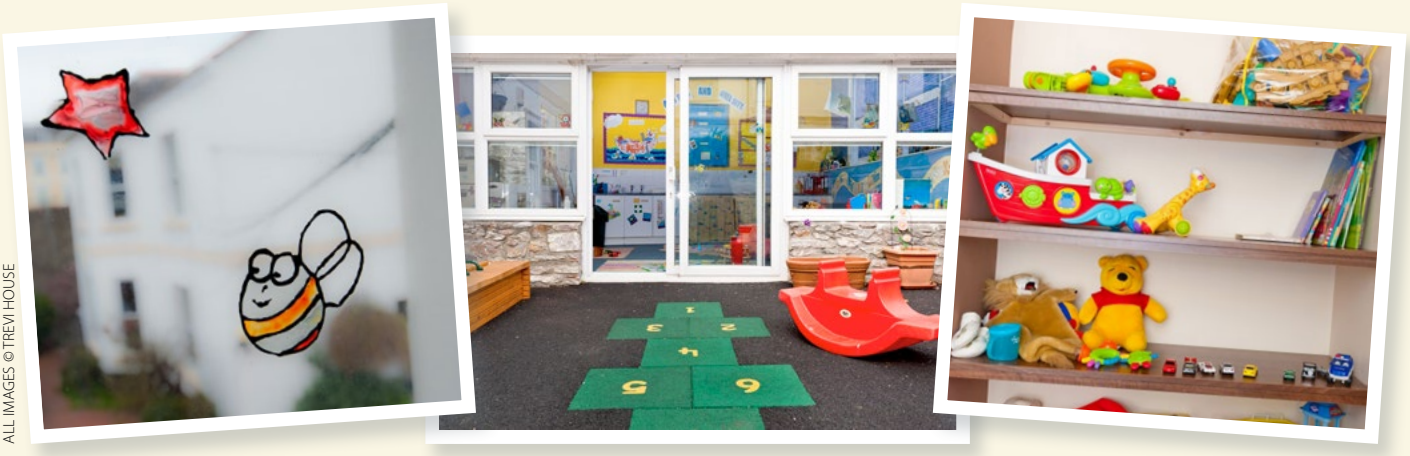
We recognise that to be a mother in recovery comes with additional challenges and prejudices to overcome. Recovery is not just about learning to live without drugs; it is about rebuilding healthy relationships. The Invisible Alcoholics by Marian Sandmaier (1980) offers a poignant reminder of the incredible struggle that women in recovery are undertaking:

'The [addicted] woman is attacked not only for her failure at motherhood, but for her abandonment of more general nurturing and caretaking functions that are at the core of the female role. 'Good' women are primarily concerned with the needs and welfare of others... and when women are no longer willing or able to serve – even for reasons beyond [their] control – the response is usually not support or sympathy'.

We often say at Trevi that the developments in the mum are reflected in her child, and vice versa – an almost symbiotic process. As mum begins to increase in confidence and strength, we will see her child develop and grow. Conversely, if mum is undertaking some challenging personal work or her child is teething or colicky, that is the point at which we are on hand to step in and ensure that both mother and infant get the necessary support. Mum's treatment goals and objectives become inextricably combined with her child's. An interesting phenomenon from working in a project such as this is that one learns to hold the needs of both mother and child in mind in parallel.

Thus, when considering when a resident and her child can go off the premises together for the first time unsupervised, we need to consider the safeguarding needs of the child alongside the need for maternal independence. Thankfully, in most cases the two are not at odds; on occasions however, it can be an interesting tension to manage and does undeniably affect the nature and scope of our work.

Adult-only residential treatment centres are able to deliver a much more



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intensive programme, often including groups in the evening. But at Trevi, we have pregnant women, who are ready to tumble into bed after dinner. We have mothers of newborns, who we try to encourage to 'sleep when baby sleeps'. All of our mums must be able to meet their children's needs (emotionally as well as basic care), both during lunch time and after groups. This can be fairly demanding, and we often say that our mums seem to have the emotional equivalent of the superhuman maternal strength that one hears about when a mother lifts a car from on top of her child.

Keeping the child in mind is key at Trevi House: yes, we are an adult treatment service, but our residents are all mums. This is a part of their identity that we want to celebrate with them, and support them to develop with confidence.

Like all treatment centres, our residents undertake 'lifeline' work, whereby they write or draw out their life so far, identifying key events such a childhood trauma or other significant early experiences. At Trevi, residents also do this piece of work on behalf of their children. Speaking from the child's perspective, mums will present an honest account of how it may have been to be their children, growing up. Women frequently minimise the effects of their drug use or abusive relationships before entering Trevi, often through the sheer terror of having their children removed. This can pose an extremely challenging piece of work as it demands confronting some painful home truths; but it can also prove to be one of the most effective in terms of sustaining change. Hearing the impact of your drug use from the 'voice' of your child is very powerful.

Having children on the premises brings many positives. There is nothing quite like a cheeky toddler to put a smile on people's faces, and what greater symbol of hope is there than the arrival of a newborn baby? Visitors to Trevi often remark on the family atmosphere; rarely will you hear raised voices or swearing.

I'm aware the focus here has so far been on mother and child. What about dad, and the wider family?

What greater symbol of hope is there than the arrival of a newborn baby?

Fortunately, we have been able to work with some fantastic fathers over the years, men who are committed to supporting their partner through treatment. We offer family contact (on and off site), couples work and parenting support. We have found that the sooner dads are engaged the better, and always welcome the opportunity for fathers to be part of the care plan.

In recognising the vital part that fathers play, we focus upon the importance of a positive role model and explore in depth with our residents the impact of domestic abuse upon children. We deliver a Freedom to Change programme, which covers the core elements of the acclaimed Freedom Programme[1], alongside some additional sessions that focus upon healthy relationships and assertiveness. This month we began delivering a group that centres on the impact of domestic abuse upon children, 'You and Me Mum'; we are excited by the prospect that our residents will be leaving us well equipped to protect both themselves and their children from violence and abuse.

At Trevi House we recognise the complexity of today's diverse and multicultural family structures, and as a result we are increasingly working with the wider family. It is not uncommon for our residents to already have children elsewhere within the family network, for example with grandparents or aunties and uncles, and we recognise the crucial role that the wider family may have both during and after treatment. We try to be as creative as possible, for example through use of Skype, and we are always looking for good practice ideas around how to best engage with the wider family network.

Being part of a service such as Trevi is a special thing. We are given the opportunity to get to know our residents holistically, to work with them as women and as mothers. We are thankful that our referrers can usually secure sufficient funding in order for their clients to complete the full six-month programme, thus ensuring a solid foundation is laid and the chance of long-term success is optimised.

Thus Trevi House is a place where women and their children can rebuild and learn vital life skills. Families move on from us in a place of strength, both as individuals within and as a family unit – stronger and more resilient to face the next step in their lives together.

I will finish with another favourite quote, one that for me, reflects the joy and optimism of parenthood: "You don't really understand human nature unless you know why a child on a merry-go-round will wave at his parents every time around – and why his parents will always wave back" (W.D. Tammeus).

To find out a little more about life at Trevi, please check out our blog www.treviproject.org. Please also follow us on Twitter @TreviHouse.

1 See www.freedomprogramme.co.uk

Keeping up the quality

Families UpFront sets out the history of inspection and monitoring in residential rehabs.

THE NEWS over the past few years has seen many stories about a lack of quality in hospitals and care homes around the country. Sometimes oversights in the inspection and monitoring of these institutions have also been suggested, and the worry that the inspecting bodies themselves – responsible as they are for maintaining quality in crucial services which care for some of our most vulnerable people – need to be better monitored has been much debated.

Like care homes and hospitals, residential rehabs work with and support people at a vulnerable point in their lives. Although clearly not a panacea for all serious drug use, rehab can lead to excellent outcomes and sustained recovery for some people. The 2012 NTA report *The Role of Residential Rehab in an Integrated Treatment System* highlighted a wide variety of outcomes for service users: 'Outcomes vary across the residential sector. The best performers see more than 60% of their residents go on to overcome dependence, while the poorest struggle to enable 20% or fewer to overcome addiction'. Positive results are dependent on an effective programme of, usually, a mix of group and one-to-one work (including a variety of psycho-social interventions), a secure living environment and a dedicated workforce. So how are these things ensured – or at least encouraged?

The first attempt to monitor or quality assure residential rehabs was in 1999 and developed by Alcohol Concern and DrugScope: QuADS (Quality in Alcohol and Drug Services). This took the form of a detailed manual[1].

It was developed for 'use by alcohol and drug treatment service providers as an assessment tool, to help with the development of quality in services. It [provided] an opportunity for services to audit comprehensively all aspects of their organisational practice and to determine areas of strength or areas where further development is required.'

This scheme was not mandatory, and since there were costs associated with inspection by an external body, its implementation was patchy. Certain Drug and Alcohol Action Teams (DAATs) which had commissioners keen to demonstrate the quality of their treatment services (and the funds to do so) commissioned QuADS, whilst the majority did not.

> *"We need to have more transparency in our part of the sector"*

After the National Treatment Agency came into existence in 2001 it took over performance management of the DAATs around the country and introduced the National Drug Treatment Monitoring System (NDTMS) and Models of Care. These three measures all helped to decrease the usage of QuADS, although there have been ongoing complaints from the residential rehab sector that NDTMS data does not accurately capture their work.

In 2004 the Commission for Social Care Inspection (CSCI) took on inspection of rehabs. Inspection was carried out against a generic national minimum standard for care homes without any specific reference to drug and alcohol rehabs. Since this standard covered all types of care homes – from old peoples' homes to sheltered accommodation for young people with learning difficulties – it was necessarily broad and lacking in some specific detail. However, CSCI did introduce training for inspectors which developed their understanding of the specific issues of residential drug and alcohol services.

In 2009 the Care Quality Commission (CQC) came into existence – formed from the merging of CSCI, the Healthcare Commission and the Mental Health Act Commission. It took on the inspection of residential rehab from CSCI and kept the generic model of inspection; however, it has recognised the need for greater insight into drug and alcohol treatment and is therefore training its inspectors. The CQC is also currently consulting on the regulation and inspection of rehabs.

The latest development in the area has come from the Recovery Partnership, which comprises the Skills Consortium, Recovery Group UK and DrugScope. It is working to establish a Quality Framework for residential rehabilitation services. This will build on and utilise existing service quality frameworks and benchmarks, to act as a resource for informing choices and decisions by service users and people in recovery, their families and carers, and commissioners and funders.

The project used a group of experts (chiefly in the form of people responsible for the day-to-day running and strategic direction of rehabs) to work towards a completed framework. The project is nearly complete, with drafts soon to be available for consultation.

Noreen Oliver, the Chief Executive of Recovery Group UK said: "I've worked in treatment for twenty years and although we have had standards before, they've never been truly adopted. We needed some energy to help bring up standards and improve the governance of rehabs. We need to have more transparency in our part of the sector to instil confidence in service users, family members, managers and commissioners. This framework will help the rehabs be accountable and the commissioners can measure effectiveness against them – we can then demonstrate that public money is being spent well."

1 Available at www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/quads.pdf

Rehab: expectations and realities

Key challenges for family members when a loved one enters residential treatment.

QUITE understandably, when a loved one develops a drug or alcohol problem, their family members are often desperate to find help. As well as those families who want to go immediately down the rehab route to 'cure' their loved one, there are others who may have seen other attempts at treatment prove unsuccessful, and for whom residential rehab may present an attractive option.

Here are some of the challenges that these families may face, along with some quotes from people who have had loved ones in rehab:

Managing expectations

Sometimes family members have unrealistic expectations of rehab and its potential for bringing about positive change. They may expect their loved one to return from rehab drug-free and well on their way to recovery. Whilst this does happen for some people accessing rehab, many unfortunately don't make it through the whole programme: being asked to leave for using drugs, for instance, or walking away because their commitment to the course wavers.

For those that do successfully complete rehab the risk of relapse is still fairly high. NTA figures suggest that one-fifth of those leaving rehab were back for specialist help within six months.

"I was so looking forward to the future. I saw this as life-changing for all of us for the good. For the first time in a long time I had peace of mind and freedom from worrying about her every single day from the moment I woke up until the moment I went to sleep. When I found out she had been told to leave rehab due to being found using drugs, I was shocked and devastated."

Visiting rights

A restriction on their visiting rights may surprise or upset family members. Usually when someone enters rehab they are not allowed visitors for the first week or so. This initial period is maintained for doing important preparatory work, getting some distance between the person entering rehab and their previous life and can yield excellent results.

"When we were allowed to visit him six weeks into the programme, we saw a glimpse of our old son. He had put weight on and was seeming very positive."

Travel and accommodation

Sometimes people will be resident in a rehab which is not close to their home or family; indeed, this can be part of the appeal. Family members, when they can visit, may therefore find it difficult financing travel and accommodation costs.

Adjusting to change

Once the person has entered rehab, family members may feel somewhat helpless and frustrated at not being able to support their loved one as they are so far away. They may have become so used to supporting their family member that it feels odd no longer having that focus, and the new independence may be uncomfortable.

"We were lost at first as our lives had become dependent on his addiction."

Child care

Parents of people entering rehab may end up with some additional child-rearing duties if their grandchildren are then left without a carer. This could bring additional social, financial and time-management challenges, as well as unexpected stress for those who may be looking forward to retirement.

Rehab fees

If a family contributes to the cost of rehab and the loved one leaves early, they may feel that the money has been wasted. They may also expect to receive a portion of their money back. This is not always the case, and is dependent on the exact nature of the contract.

Life after rehab

Once a person leaves rehab they are going to need a lot of help sustaining their progress and ongoing recovery. They may need a place to live, and practical, emotional and financial support. Families at this point will therefore play a key role, and form an important part of their loved one's recovery capital. Although this process may be very satisfying and worthwhile for some families, it will most likely present a set of challenges which won't always be easy to meet.

Alternatively the person may prefer to stay in the new area and make a new start, which could itself be problematic for the family.

"He decided to stay in the area where his rehab was and this was hard for us, but we realised that to allow him to continue to grow we had to let him go and become the person that he is today."

Conclusions

Although these challenges do exist it's important to remember what a positive place rehab can be. Every week the lives of people who have had serious issues with drug and alcohol use, as well as their lives of their children, parents and friends, are turned around and put on a completely new and positive trajectory. In the words of one parent:

"It's now 15 months since our son entered rehab. We meet up with him some weekends and talk on the phone often. We are so proud of the man that he has become, it's lovely to spend time with him and his new friends. His journey to recovery has also been our journey to living our lives, we are so happy that we all have our lives back."

A life in recovery

Michaela Jones shares a service user's perspective on rehab and families, and gives the thoughts of others in the recovery community.

ON this lifelong journey that goes under the name of recovery, it has become clear to me that there are three distinct areas that require different things – both from the person caught in the web of addiction and the people around them.

They are not linear – you don't finish one and immediately start the other – but they seem to me to be the foundations of living a life in recovery.

The first, **Healing Yourself**, is where many of the current treatment and rehabilitation services are focused. The growing understanding of the importance of mutual aid and connection to others in recovery – and that there are many pathways that people can follow – is helping people like me to sustain sobriety beyond the initial euphoria of the early years. There is still much to do, but there has been a step-change in the last five years that recognises that healing, rather than just putting the substance down, is the name of the game. And that, as addicts, we have to take responsibility for putting in a lot of the work ourselves.

Forgive me if I skip to the third of these areas, **Healing Your Community** – I said the process wasn't linear! Like Healing Yourself, there has been a great deal of development within this area in the last five years. Any self-respecting addict will talk about the importance of 'giving back', and for many the recovery process will include volunteering, peer mentoring, participating in mutual aid and using their creativity and passion within the burgeoning number of recovery communities.

And now to the second area, and the focus of this article: **Healing Your Family and Loved Ones**. Unlike the other two this remains a much neglected area, despite a greater recognition that addiction is a 'family illness' – and also an illness that runs in families.

This may be because it is just not as straightforward as the other two. It is messy and emotional and hard and complex. It may involve numerous agencies beyond the usual ambit of 'family life'. It could also be that today's definition of family and the web of relationships that may make up a family unit are diverse and intricate. But perhaps overarching all of this is that the vast majority of our health system continues to focus on pathology rather than the person and, when and if the individual behind the 'illness' is recognised, seeing them as part of a wider social unit – the family – is subject to a sort of collective blindness.

Residential rehabilitation presents its own particular set of challenges – not least that traditional models of rehab often involve the person having a complete break from their current circumstances and staying at a centre that is geographically distant from their home and family. Newer models of residential treatment are emerging across the country but they too can have their downsides.

David comments, "With getting clean in my home town I didn't have the worry of just appearing out of nowhere 'all fixed'. This can be a shock to a family and friends who last saw you when you were a mess and causing all kinds of harm and problems. And then you turn up all clean and well.

"My problems were mainly building trust with my mum and having to keep my distance from my brothers, who were both in active addiction at the time I cleaned up. I also had a new relationship to build with my son who I'd not had contact with for eight and a half years. Parenting was and is very hard for me."

Another challenge is family involvement while the individual is in rehab. Rehabs vary widely in terms of how much they seek to engage family members and loved ones and how much they focus on rebuilding relationships that have broken down. In this they are not significantly different from other treatment approaches. Overall, the effective involvement of families in addiction recovery is patchy across the UK and often what is available is unclear.

While some rehabs work very hard to integrate families into their programmes, very often 'family

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'Putting a face on recovery' as the Recovery Walk in 2011 weaves its way through Cardiff City centre.

involvement' simply means visiting. Given that the rehabilitation process itself can bring up some sticky family issues, visits can have unintended consequences. Reece talks about a visit from his parents where he "brought up things about the past that they didn't like hearing." This caused a major fall-out and his parents stopped visiting: "they didn't want to know". Now in long-term recovery, Reece realises that the timing wasn't right, but the withdrawal of their support was hard to deal with.

It is also fair to say that there can be a great deal of understandable reluctance for families themselves to get involved – particularly if relationships have irretrievably broken down. Sarah's dad, having seen her hit rock bottom, didn't want to get involved at all, although her mother supported her throughout. And even if relationships are still functioning, many family members according to Reece, "would rather bury their head in the sand and wait until the end when you are 'cured'. They don't realise that they need support, that they are struggling. And that you need support too."

That notion of rehab being a 'cure' persists and pervades what the general public, and therefore many family members, expect outcomes to be. This can be difficult for those exiting rehab who are increasingly aware that recovery is a process and requires substantial life changes. Both Sarah and Reece talk about the gap in understanding between the reality of living a life in recovery and family expectations.

But there is also a strange dichotomy here. The expectation of 'being cured' sits alongside the need for a person in recovery to prove that they are not the person they used to be. Trust needs to be re-established and broken relationships rebuilt. And this is where the good news begins. Despite all the problems and issues, many of which are not even touched on in this article, healing is happening. It just takes time.

Dave says, "My relationship with family is really good. From my twin brother following me into recovery – a big help to my own recovery – to my mum, who doesn't worry and live in shame like she used to. Also over the last four and a half years I've begun building a relationship with my son. It's hard but worth it. What's helped me the most with my life in recovery is the people I have met, be it at NA [Narcotics Anonymous] or other mutual aid places, walks and so on. Other addicts and their experiences have helped me with building relationships with family and friends today."

> *very often 'family involvement' simply means visiting*

Reece's relationship with his parents is "great now. They have seen the change and we are moving on. I see them every week and there is trust now." Sarah is three and a half years in recovery and now she has "proved herself" she and her dad are talking again. She also is close to having her children back after losing them when in active addiction.

I am loath to end this article with some homily like 'time heals all wounds' but as a person in recovery I am comfortable with the notion of healing as an ongoing, and sometimes tricky, process. I am also clear that treatment systems can be excellent, so-so or just a bit rubbish – but that they can only be a small part of a much bigger picture. Perhaps we all have a job of work to do to manage expectations and get a bit more real that all of this healing doesn't happen overnight, and that it is OK for things to take time. We live in a world that seems very target-driven – maybe we should resist imposing these targets on ourselves. We also need to understand that treatment doesn't equal cure.

Having said that, it simply isn't enough to just leave it there. What has been key for many of us addicts is the concept of recovery itself and the sense of purpose and community this has given us. Slowly but surely the landscape is changing and as the recovery advocacy movement grows we hope to put more pressure on governments (both local and national) to create the kind of services we need, but also to release funding for peer-led services within our own communities, moving resources away from the acute model to supporting longer-term recovery for everyone who has been affected by addiction. Things taking time is all very well, but support throughout that process is vital.

A paper by Bill White and Bob Savage called *All in the Family: Addiction, Recovery, Advocacy*[1] suggests a way forward:

"A vanguard of family members is needed to tell their story to legislators, policy makers, other family members and the community at large. Family members are needed to advocate for the support they need and for other family members still needing help. Telling their story will help provide a better understanding of the impact that addiction has on the family, help give permission for all families to speak about these issues, and help make it more acceptable for families to seek help."

Time to take the healing into our own hands.

1 Available from www.williamwhitepapers.com/pr/2005AllintheFamily.pdf

Therapeutic communities: what role for families?

*Families UpFront speaks to **Carrie-Ann Mills** from the Phoenix Futures Hampshire Residential Service about the daily challenges of managing a rehab and working with families.*

THE Hampshire Residential Service seems like what any family member would think of when they picture 'rehab': a large, Victorian house, miles away from the nearest town, set in several acres of countryside grounds and focused on abstinence-based recovery from drug and alcohol use.

But despite the peaceful exterior, inside it is a very busy place: there is room for 30 residents in the main house, plus five more in an outhouse cottage. The service is run according to the 'therapeutic community' model with a Cognitive Behavioural Therapy (CBT) programme, with support from a mixture of peer groups, staff-led meetings and keywork sessions.

Contact

The manager of the service, Carrie-Ann Mills, says that "family contact is strongly encouraged as we know that it can make a difference to treatment outcomes". Whilst some rehabs may place initial bans on outside contact while a resident settles in, this isn't the case here, and they are "encouraged to request visits even during 'Welcome House', our assessment and induction phase". In the main house, all residents have access to the internet for family contact within set times, and letters and parcels are permitted as long as they are opened in front of staff.

There are also facilities for contact with children for those residents with parental responsibilities – for example phone calls or Skype late in the afternoon so parents can speak to them before bedtime or read stories: "it's always good to encourage this", says Mills.

To facilitate family contact, she says, "we were very lucky to get grant funding for the NTA to build a dedicated family visit area, including a kids' play area, situated in the grounds of the service. It's a lovely space that allows some privacy in an otherwise busy service."

As well as supportive, interested family members and children, there may be certain concerned others who pose rather more of a challenge to the service – for instance residents' partners who use substances themselves. In these cases, Mills says, "[visits] would be dependent on risks...it isn't that we can't facilitate these visits but they need to be managed a little differently".

Involvement

Dealing with families in a rehab setting is not just a case of managing contact, however, and there can be a spectrum of family involvement in treatment. Although informal involvement is the most common, where families "just want to know how their loved one is doing", other family members may be more hands-on: "with consent from the resident, [families] can be involved in progress and care planning or three-way meetings to look at specific issues or incidents".

> *family contact is strongly encouraged as we know that it can make a difference to treatment outcomes*

Of course, facilitating contact and involvement is not always plain sailing. Whilst Adfam generally focuses on supportive families and the contribution they can make to positive outcomes, it is undeniable that some cases are more difficult than others and families are not always at a stage in where it is appropriate for them to be involved in the treatment of their loved one. On this point, Mills says, "each situation is unique, presenting different benefits and risks. For some it is appropriate to involve partners or parents in treatment, but other [residents] may not consent to it or the family might be unaware of certain situations. Whilst we encourage disclosure and honesty, it can't be forced."

One particularly interesting scenario, says Mills, is "managing the dynamic where a family privately funds an individual's treatment, which has potential conflicts, bearing in mind the professional and emotional relationships with the individual in our care and the family". With a 26-week stay costing up to £10,000, the importance of managing these relationships is hard to overestimate.

Differences in opinion between families, service users and practitioners can clearly make things challenging, even before treatment starts – or doesn't start, which can indeed be the problem. One of the bigger challenges, says Mills, is conversations with families where it becomes clear that the user is not ready for the changes that rehab tries to facilitate: "it's difficult when the motivation is only coming from the family and the individual isn't willing to engage: sometimes that's hard for the family to hear."

But this can also go the other way: Mills says that "one of the most common issues we encounter is when the individual in treatment changes but their family doesn't. It is hard watching someone do everything right when their family still can't trust that the change is real." So as well as managing sometimes unrealistic expectations of families regarding the suitability of rehab and its chances of success, there can also be resistance from families who can't quite believe that long-term changes are being made: after all, they may have suffered through their loved one making a number of unsuccessful attempts at treatment (residential or otherwise) before reaching this stage,

and "rebuilding trust is crucial from both sides". Mills explains that "rehab is essentially a massive journey of self-discovery and personal development, and it can be isolating for people when no-one else understands the significance of that journey and the changes to thinking and behaviour."

Some of this, she thinks, stems from misconceptions: "families can be very unrealistic and lack knowledge about how rehab works – though we have had families join us at 'virtual rehab' days, and these have been very positively received".

With many family enquiries relating to how to access funding or other support from their local area, it can also be part of the job to locate appropriate services elsewhere and direct families accordingly.

The community

We speak about the particular qualities of the therapeutic community model in use at the service, and how it affects families. The model, which dates back to the 1950s, is a system whereby residents take responsibility for the running of the house – with kitchen, garden, cleaning and maintenance teams, for example – and for supporting each other. It is designed to act as a stand-in for wider society – "the aim is to provide a microcosm of the real world" – and is structured so that everyone has a role to play in community life, including the staff. There is a hierarchy that residents move through as they progress, taking on greater responsibility and earning higher privileges.

"In many ways, the therapeutic community seeks to replicate a family environment with an emphasis on 'right living'", says Mills. "Some [residents] have not had that experience before or have lost those relationships in the course of their [drug] using journey, and it helps them develop skills that have a big influence on their external environment and family relationships". So perhaps more so than other modes of treatment, therapeutic communities can aim to equip residents with the social skills, as well as personal strength, necessary to build and manage a new life free of drugs in the community.

As well as managing contact and facilitating involvement, the Hampshire Residential Service also provides support for families themselves. Phoenix has recently begun the FLAMES programme (Families and Loved Ones Accessing Mutual Emotional Support), which involves educating family members on addiction and how the tools of the therapeutic community address this. As one family member who attended a FLAMES day in Sheffield said, "it was comforting to talk to other families, knowing we're all going through the same". So in rehab settings just as anywhere else, the simple benefit of having families share similar stories and experiences has clear value.

Implications

Of 175 services listed in the *Drink and Drugs News* residential treatment directory, 104 claim to offer family services, but without detailed research it is impossible to know what precisely this constitutes. Similarly, the therapeutic community model is only listed by 32 services in the directory (of which 21 claim to offer family services), so assessing the impact of this approach, as compared with others, is also difficult. And although Phoenix Futures is the largest single provider of residential treatment in the country, they still only run five services – yet more testament to the diverse nature of the sector.

Indeed, one of rehab's major advantages is that it rejects a 'one size fits all' approach to drug treatment; the fact that there is so much variety is generally cause for celebration rather than censure. But it does mean it is difficult to take the temperature of the rehab sector in general, let alone its approach to family work, so for now at least it seems the search for consistency in family support goes on.

www.phoenix-futures.org.uk/our-residential-services

Game on: drug and alcohol services and the new local players

Connaught Rooms, Great Queen Street, London WC2B 5DA

6th November 2013 9.45am – 4.30pm

It has been a long time coming, but now it is here. As the National Treatment Agency rides off into the sunset, over the hill comes Public Health England and with it a whole new landscape in which drug and alcohol services need to operate. So we have speakers that reflect the new dynamic as well as those reporting on developments in drug use which may well impact on services.

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- The changing scene from the perspective of local authorities, police and crime commissioners and public health
- The challenge to services of alcohol and new drugs
- Commissioning
- Payment by Results
- Update on new drugs/legal highs

Confirmed speakers and workshop leaders include:

- **Rosanna O'Connor**, Public Health England
- **Dr Andrew Howe**, Association of Directors of Public Health
- **Dr Owen Bowden-Jones**, Royal College of Psychiatrists
- **Sophie Howe**, Deputy Police and Crime Commissioner, South Wales
- **Dr Marcus Roberts**, Director of Policy, DrugScope
- **Dr John Ramsey**, St George's Hospital Medical School
- **Tom Woodcock**, Commissioning Lead for Lancashire
- **Debbie Holt**, Independent consultant on commissioning
- **Katy McLeod**, Crew 2000 Scotland
- **John Jolly** – CEO Blenheim/CDP
- **Steve Broome** – Director of Research, Royal Society of Arts
- **Local Government Association** (speaker TBC)

DrugScope/LDAN members £158.40 inc VAT.
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Booking form at:
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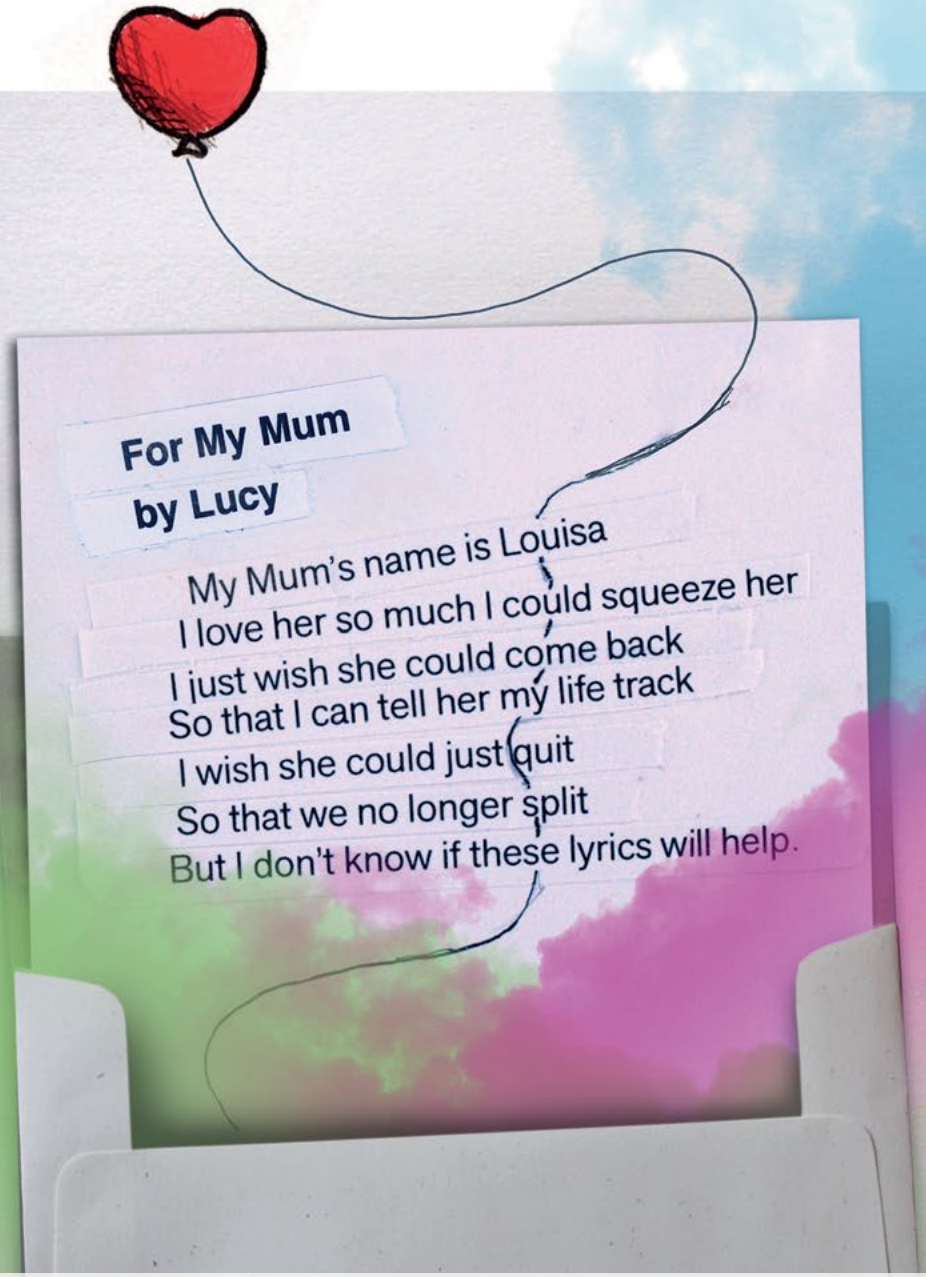

Prizes: First prize £150
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Plus an invitation as a guest of honour to Adfam's Candlelit Carol concert on 5th December 2013, where you will have the opportunity to meet celebrity guests and have your story read out. All travel to London and overnight accommodation costs for the winner and runners up are included in the prize.

What to enter

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How to enter

Please send your entries to Family Voices Competition: Adfam, 25 Corsham Street, London, N1 6DR or email to familyvoices@adfam.org.uk (please include your name and contact details).

Terms and conditions

1 All entries must be received by 31 October 2013 and winners will be notified by 8 November 2013 - the judges' decision is final.
2 All entries must be original and must not have been previously published or broadcast. All submissions become the property of Adfam.
3 Written entries must be a maximum of 500 words.
4 We regret that entries cannot be returned so please keep a copy of any original work.
5 Entries must include name, address, contact telephone number and/or email and where you heard about Family Voices.

Adfam reserves the right to use all entries it receives, in all and any activities, to raise awareness of our work. This may include reproducing entries in publications and on the Adfam website.
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