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

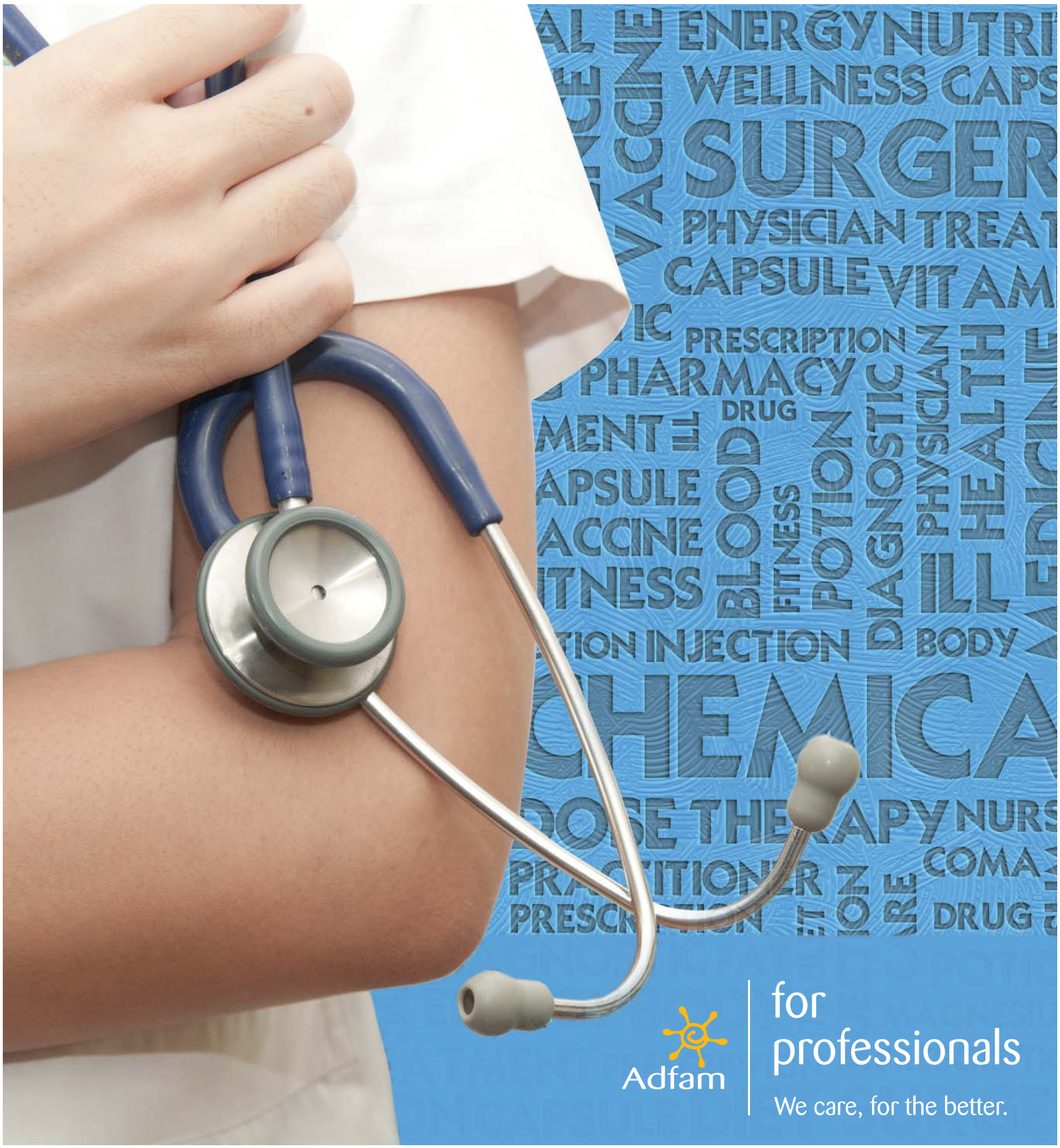
families upfront

DEC 2012 – FEB 2013 ISSUE 7

> In Focus: primary care

> Rhetoric and reality in prisons policy

> GPs and family support



families **upfront**

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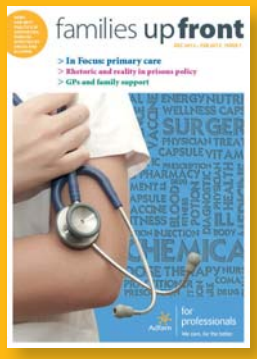

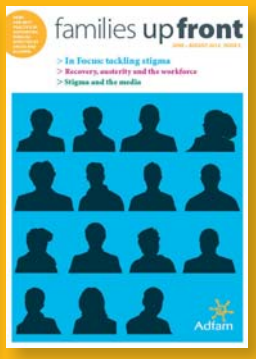

SUBSCRIBE *to Families UpFront* for hard copies and access to the online archive. See www.adfam.org.uk for details or call 020 7553 7640.

This November, we held our first ever *Families First* conference in partnership with *Drink and Drugs News*. This was an opportunity for families affected by drugs and alcohol to gather together and learn, and featured some of the most knowledgeable and inspirational advocates for family support.

It's not just family members themselves who can feel isolated – the services supporting them can too. We were proud to gather so many families and support providers under one roof: we've long argued that families need their own 'recovery agenda', so it was exciting to get such a positive response and we will be doing our best to drive on from here in a positive direction.

We have also just held our annual Christmas carol concert – some of you will have been there with us. The centrepiece of the night was the presentation of our *Family Voices* awards, which celebrate the work of family members who've used creative writing to tell their own stories of how drugs and alcohol have affected them. You can read this year's winner, *My Grandson*, on page four.

Both of these events showed that the simple ability to share and talk openly can be a key element of recovery for families. They also demonstrated that in all our discussion of important issues like training, good practice, policy and strategy, it's crucial that we don't lose sight of the real-life family stories which underpin every aspect of our work.

And a final note for our new subscribers – remember that you can access the *Families UpFront* archive online. That means our previous special issues on grandparent carers, offenders' families, stigma, workforce development and outcomes and evidence in family support are all available as a live reference library. Please do take advantage of this and let us know what you think.

It only remains for me to wish all our readers a very merry Christmas. We look forward to working together further in the New Year.

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

Domestic violence definition revised

Following a consultation process earlier this year, the Government has updated its definition of domestic violence, which will become official from March 2013.

The age range covered by the definition will be brought forward so that, for the first time, domestic violence will officially apply to 16 and 17 year-olds as both victims and perpetrators. The new definition will also acknowledge that domestic violence exists as a pattern of abusive and controlling behaviour – not simply as isolated incidents – and include 'coercive control', whereby perpetrators isolate victims, become their only channel of information and reduce their independent opportunities.

The change has been broadly welcomed by both the substance use and domestic violence sectors as going some way in more accurately describing the experiences of victims: Against Violence and Abuse (AVA) noted that 'young people aged 16 and over are able to get married and may well be parents themselves, yet until now their experiences of abuse have not been officially recognised'.

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UKDPC winding up; calls for reform

The UK Drug Policy Commission will wind up its activities at the end of 2012, having been set up in 2007 to provide independent, objective analysis of UK drug policy. As its final product, it has published *A Fresh Approach to Drugs*, arguing for a 'radical rethink of how we structure our response to drug problems'.

The report centres on several key misunderstandings which the UKDPC argue underpin current policy: seeing all drug use as problematic, when in reality it isn't; addressing drug use in isolation, rather than within a wider social and economic context; and separating illegal drug use from the relative harms of alcohol and tobacco.

The report's recommendations focus on supporting responsible behaviour and promoting recovery for people with entrenched problems. Key areas for improvement include developing early interventions with families and communities to build resilience; tackling stigma; reducing sanctions for drug possession; and providing more support for families.

www.ukdpc.org.uk/publication/a-fresh-approach

Donations 'down by 20%'

UK Giving 2012, the latest survey by the NCVO and Charities Aid Foundation, has revealed that fewer people are donating to charity and of those that do, they are donating less. John Low, Chief executive of CAF, described the findings as "deeply worrying". Earlier in 2012, the NCVO found that people over 60 now account for over half of all donations, and the 'generosity gap' between this group and the under-30s is widening.

See page 9 for a full summary.

Social justice: new Government framework

Iain Duncan Smith, Secretary of State for Work and Pensions, recently launched the Government's new *Social Justice Outcomes Framework*, outlining the five policy priorities of supporting families, keeping young people on track, stressing the importance of work, supporting the most disadvantaged adults and delivering social justice.

To track improvement in these key areas, the Government will look to measure indicators including children 'free from family breakdown', the educational attainment of disadvantaged children, and people engaged in drug treatment who do not return after leaving, find work and don't commit crime. The indicators are not explicit targets but rather aim to shape future policies. Launching the framework, Mr. Duncan Smith asserted that "when families are strong and stable, so are children" but was criticised by national single parent charity Gingerbread for 'reinforcing myths and stereotypes about single parent families'.

Cabinet reshuffled

David Cameron has undertaken his first major Cabinet reshuffle, and there have been changes in the ministers working on drugs, alcohol and family support.

At the **Ministry of Justice** Chris Grayling has replaced Kenneth Clarke. He is widely perceived to be to the political right of Clarke (see page 6), although in his previous role as Secretary of State for Work and Pensions, Grayling committed to engaging with the UK Drug Policy Commission to ensure that employment policy was accommodating to those with drug- or alcohol-related conditions.

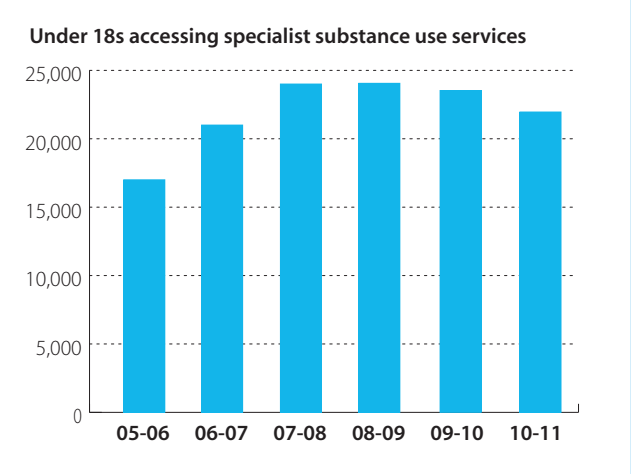
At the **Department of Health**, Andrew Lansley has been moved aside in favour of Jeremy Hunt, who was previously responsible for Culture, Media and Sport. Lansley had faced sustained and widespread criticism for his role as architect of the Health and Social Care Act. Anna Soubry has replaced Anne Milton as Parliamentary Under Secretary of State for Public Health and now covers the drugs brief.

At the **Department for Education**, Edward Timpson replaced Tim Loughton as Parliamentary Under Secretary of State (children and families). Timpson's family still owns and runs the high street retailer offering shoe repair and locksmith services, and they have a long-standing interest in adoption, fostering and employment opportunities for ex-offenders.

At the **Home Office**, Jeremy Browne has replaced Lord Henley as Minster of State with responsibility for the Drug and Alcohol Strategies. In his previous role as Minister for Latin America, he worked closely with the Bolivian government in attempts to stop drug trafficking.

NTA: fewer young people need help for drink and drug problems

The National Treatment Agency's latest research has found that the number of young people needing help for their substance use has gone down for the third consecutive year. Only 631 young people received treatment for Class A drug use in 2011-12, down from 1,979 in 2006-07, whilst the number accessing any type of specialist substance use service stands at 20,668 for 2011-12, down from 24,053 in 2008-09.



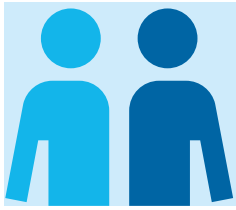
Alcohol and cannabis remain the main substances for which young people access services, and the number needing treatment for the latter rose despite an overall decrease in use. The NTA suggest that this increase (from 12,784 in 2010-11 to 13,200 in 2011-12) could be due to new, stronger strains of the drug or services acting more quickly.

The report also states that 'substance use is rarely an isolated issue for young people', and it is often accompanied by wider vulnerabilities including offending behaviour, pregnancy or self-harm.

The full report, *Substance Misuse Amongst Young People 2011-12,* is available from *www.nta.nhs.uk*

Government to appoint two Chief Social Workers

The *Munro Review of Child Protection* recommended the creation of a Chief Social Worker to advise ministers on social work issues and provide professional leadership to the sector. The Government accepted this recommendation and advertised the £110,000 post earlier this year, but found no suitable candidate; it has now been announced that two posts will be created, with split responsibilities for children's and adult's services. The Department for Education stressed that both will work closely together, but responses from the sector were mixed: Bridgett Robb, acting Chief Executive of the British Association of Social Workers, said that "the last thing the profession needs is more division", but Dave Hill, chair of the Association of Directors of Children's Services, said "two is better than none at all".



PCCs take office

On 15 November, Police and Crime Commissioners (PCCs) were elected throughout England, except London. They are now responsible for setting policing priorities in their local area, agreeing budgets and recruiting or dismissing Chief Constables.

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In what has been described as the biggest shake-up of policing in 50 years, the Government was accused by the opposition of overseeing a 'shambles' as concerns over low turnout and lack of public engagement grew – fears that were realized as an average of 15% of the electorate turned out to vote. Some Commissioners now hold office based on less than 10% of the eligible vote, and the Electoral Commission has launched an inquiry into what it called a "concern for democracy". There were also an unusually high number of spoilt ballots, suggesting a level of public hostility to the new post as well as widespread apathy.

Despite a strong emphasis on localism and a 'transfer of power' rhetoric from the Government, the major political parties had a strong presence. Sixteen Conservative candidates were elected, with Labour succeeding in a further thirteen areas. No Liberal Democrats will take office but there will be a dozen independent PCCs. Less than 15% of the new PCCs are women, compared with 22% of MPs in the House of Commons.

See page 8 for further information.

Diary

● Shared Voices: Reach Out conference 2013

The theme of this free, two-day conference is *Shared Voices*. The event will give an opportunity for families and carers to speak out about their experiences with others in similar situations and professionals providing support for them. There will be a keynote speech on child to parent domestic violence and abuse.

April 11-12, Bath, free.
www.dhi-online.org.uk

● Skills Consortium roadshow

The Skills Consortium is a sector-led initiative which aims to build the skills of the drug and alcohol workforce. This half-day event is aimed at anyone working for a treatment provider, membership body, Drug and Alcohol Action Team, HR or workforce team in the drug and alcohol sector. Attendees can join the Consortium and find out about its upcoming work.

February 1, Leeds, free.
Contact l.bowman@adfam.org.uk.

● Managing Drug and Alcohol Problems in Primary Care

This is the 18th annual event examining the critical role played by primary care in supporting drug users, their families and carers. There will be a variety of workshops, presentations and plenary sessions led by the top speakers in the field.

16-17 May 2013, Birmingham, from £96.
www.rcgp.org.uk/courses-and-events

ADFAM UPDATE

This autumn has seen Adfam busily launching reports, holding a great conference for families alongside *Drink and Drugs News* and running several national training programmes.

We have also secured funding for a new Regional Development Coordinator to work across the South West, and a new post in London working with Family Recovery Champions. All in all, the end of 2012 has been a hectic but productive time and we are really looking forward to working with you all again in 2013.

Next year heralds some long-discussed changes in the drug and alcohol sector landscape, and we hope that we can work together to ensure that these changes don't impact on the support that families receive.

DOMESTIC VIOLENCE

Building on research conducted with families by Adfam and our partner domestic violence Against Violence and Abuse (AVA), previously reported in *Families UpFront* 5, a programme of training is now under way across England. The 88 parents who took part in the research told us about their experiences of child-parent violence (CPV) from their drug and alcohol using children, and we have used this knowledge to inform our training, which is aimed at anyone who regularly works with families affected by this issue. The one-day course covers the background to CPV, compares it to partner violence and explores good practice in working with this group of parents and building local partnerships.

Four days of training took place in October and November 2012, with the remaining six days this December and in January 2013. Keep your eyes on the Adfam website for a set of good practice briefings for practitioners, commissioners and family members which will sum up these issues and the good practice content of the training into a series of handy resources.

REGIONAL DEVELOPMENT

By working with our regional forums and talking to organisations over the past year, it's become clear that a lot of people who work or volunteer in the field feel isolated, with often limited supervision and professional support. Peer support does not mitigate the need for good line management, but can help give a different, experienced viewpoint to help you identify a course of action that you're comfortable with, and increase your confidence. As well as the upcoming professionals' forum on our website we're developing two pilot projects:

Professionals Peer Support Database

An online database with the contact details of people who have been working in the field for a while, and who are willing to provide advice on specific areas of expertise. This is not intended to be a source of ongoing support but instead provides one-off guidance from someone who has experience in family support.

Professionals Peer Mentoring Scheme

A more extended and structured period of support and guidance from an experienced practitioner looking at whichever aspects of work or professional development are most important to the mentee. It will match people who are new to the field, or who are at a point professionally where some extra support would benefit them, with experienced practitioners with knowledge that they can share.

For more information on how to get involved, contact Kate Peake on k.peake@adfam.org.uk

Family Voices

This year saw a great response for our *Family Voices* competition, once again showing the courage, strength and resilience that families affected by drugs and alcohol can show. This year's winner is printed below.

My Grandson

A tiny baby wrapped up so tight
Crying helpless through the night
What's wrong? He looks fine to me
But his pain is deep where we cannot see.
A pain that was put there by his mummy
Because she took heroin while he was in her tummy
This tiny baby is growing up strong, looks around and thinks 'what's gone wrong'?
Why has my life been so sad when all I want is a mam and dad?
A mam and dad he needed most but instead he was passed from pillar to post
First his dad, then his mam, but he always had to go back to his gran.
His gran was the one who held him tight, kept him safe through the night
But he knew this wasn't how things should be, why could one of them not see?
They tried and tried but all in vain to rid themselves of all the pain
One would duck one would dive one would run one would hide.
One way out ..they had to split to rid themselves of all of it
They did the thing they thought was right
But one won the battle ...one lost the fight
Now 16 years and college bound that tiny baby won't look around
He's come through so much but he's not sad
Today he's happy… he lives with his DAD

Bridge Project Carer & Families service

a year of change and transformation

> Bridge has been focussing more and more intently on recovery as an achievable goal for all its clients, and that includes families

Looking back over the past year, it is hard to believe how much things have changed. A year ago, we had just run our first Family Nurturing Programmes, we were starting to use the CSOP (Carer Support Outcomes Profile) tool to report outcomes to our commissioners and we were waiting for Bridge's new abstinence service to open to see what links we could form. Now, it is coming up to Christmas, we've had the abstinence service for just over 10 months and things are changing once again in our service, and across the Bradford district.

Bridge, like many other services nationally, has been focussing more and more intently on recovery as an achievable goal for all its clients, and that includes families. We firmly believe that recovery is not just about the substance user, but is about the health and wellbeing of the family and the others who are affected by their behaviour. Indeed, the two are often inextricably linked. For our family and carers service, this increased focus on recovery is the next step in the journey we started last year where we began to look at outcomes for our carers for the first time.

Families and recovery

It's difficult to say what recovery means for families as it is different for everyone we've spoken to. There are some common themes – wanting to be able to live a life without fear, where it is not completely dominated by the substance use and related behaviours of the loved one, where things return to 'normal' – however that is defined. It is this quest for recovery for our carers that led us, along with the rest of the carer and family services in Bradford, to agree to join the new 'Concerned Others Pathway' proposed in the district. This is a new way of looking at the interventions we provide to our carers that takes the best of what we offered before and adds to it proven tools and interventions from the Parents and Carers Training (PACT) Programme. It has meant of a lot of work and training and a complete change to how things are done, but we believe it offers the best support we can possibly provide to everyone who needs help in Bradford.

It is now much clearer what support we can offer to people accessing our service. We do an in-depth assessment which teases out the issues that most concern our carers and allows us to address these in a focussed way to get the results the individual wants. We keep re-visiting the concerns identified at the first assessment, acknowledging that priorities change. We work closely with the carer to ensure they move forwards to recovery, sometimes independently of the work that is done with the user and sometimes not – it all depends on circumstance.

Other things have also moved on. Last year we offered our carers the chance to take part in the Family Nurturing Course designed by Barnardo's. This year we've gone a step further, opening this course to substance using parents, which has been a great step in improving their relationships with their families. This is held in the new abstinence service, as are many of our support groups, which lets us integrate more closely.

Use of CSOP continues to expand. Although times are hard financially and investment in training can be difficult, services continue to approach us to ask to get involved in using this tool – from as far away as Newcastle and London. The importance of proving value is becoming increasingly apparent and services are looking for ways to do this which are relevant and easy to use.

Looking forward to the year ahead, it is hard to see what the service will look like. We are constantly evolving and adapting to changes in the sector and there are definitely more changes to come. We continue to try and improve the service we offer and the outcomes we can achieve, and continue to use the CSOP tool to monitor our progress.

bridge
a way forward

www.bridge-bradford.org.uk

Prisons: rhetoric, reality and reform

Andrew Neilson, Director of Campaigns at the Howard League for Penal Reform, discusses the impact of new policies and leadership in the Ministry of Justice.

When David Cameron announced his September reshuffle few were taken by surprise. Not only had it been heavily trailed in the media, but the Prime Minister had probably gone for as long as he could without offering up-and-coming MPs the chance for promotion that a reshuffle brings. On paper at least, reshuffles are opportunities to reward loyalists and remove ineffective ministers; yet they can also bring instability, and all too often ministers embark on long-term reforms to find that they are booted out before their agenda can be seen through.

Such was the fate that befell the Secretary of State for Justice, Ken Clarke, and most of his ministerial team bar the Liberal Democrat minister of state Lord McNally. Clarke, with the help of his Prisons and Probation Minister Crispin Blunt, was pushing through the Government's 'rehabilitation revolution', testing a payment by results approach to pay providers to reduce reoffending. Alongside this, the Clarke approach to law and order involved characteristic blunt talking and a refreshing departure from the 'prison works' orthodoxy that had formed over almost two decades of both Labour and Conservative Governments.

Clarke's initial attack on the notion that 'prison works' was rooted in pragmatism. Firstly, the reoffending statistics – almost two-thirds of those serving sentences of a year or less go on to be reconvicted within two years of release – demonstrate that the revolving door between prison and the community is alive and well. Worse still, each spell in prison makes reoffending more likely. By contrast, the reoffending rate for much cheaper community orders is 37 per cent, falling to 34 per cent for those on intensive programmes tackling drug and alcohol misuse. When the Howard League interviewed prisoners as part of a research project into short sentences, many told us that they

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preferred spells in prison which ask little of them, compared to the challenges they would face completing community programmes that directly tackle the causes of offending.

Secondly, Clarke pointed out that there simply wasn't the money in public coffers to keep financing the ever-expanding prison population. Prison numbers

> almost two-thirds of those serving sentences of a year or less go on to be reconvicted within two years of release

have doubled since the mid-1990s and continue to increase, while the Ministry of Justice now faces 6 per cent cuts to its budget year on year until 2015. Indeed, in an age of austerity it is all the more important that expenditure on prisons is limited so that precious funds can be diverted to those public services with a far more meaningful impact on the prevention of crime such as education, social care or the treatment of physical and mental health.

Even if payment by results proves successful – and that in itself is a big 'if' – Clarke recognised that any efficiency savings produced by the reforms would not dramatically alter the potential spending gap if the Ministry of Justice continued to see prison numbers rise. He therefore proposed a number of bold sentencing reforms, only to drop these when political opposition hardened and Downing Street failed to come out fighting on behalf of its Justice Secretary. In recent months, the refreshing rhetoric of Clarke's early days in the job has seldom been heard.

Time then, perhaps, to see a new face at the Ministry of Justice. Yet the choice of former Work and Pensions minister Chris Grayling as the new Secretary of State for Justice worries many in the penal reform lobby. This is primarily because the new minister appears to have redoubled the rhetorical effort, but in the

opposite direction to his predecessor. Chris Grayling has described himself as a 'tough Justice Secretary' and has made it clear that he is not planning to 'reduce the number of prison places'. His first big initiative announced at the Conservative party conference involved making it easier to shoot burglars, which while not strictly relevant to penal policy, certainly underlined his desire to be seen as tough.

Yet scrape away this rhetoric and perhaps less has changed than some might fear. Yes, the new Justice Secretary has talked about seeing 'more of the right people going to prison' but at the same time he does 'not want to see them coming back'. Chris Grayling has talked of the importance of 'turning people's lives around' and while making it clear there will be a 'change in emphasis', he has also acknowledged that 'Ken [Clarke] put together some useful proposals and made some useful changes'. As for identifying himself as a 'tough' Justice Secretary, it's a brave minister who would characterise himself as 'soft'.

Whatever Mr. Grayling may say, the reality is that his hands are tied by the departmental finances he now oversees. For not only is the Ministry of Justice facing year on year cuts, but due to the collapse of Clarke's sentencing reforms, the department lost around £130 million of potential savings. A report by the National Audit Office into the restructuring of the National Offender Management Service (NOMS) found that the agency in charge of prisons and probation is already projected to spend £32 million more than its budget for 2012–13 due to lack of progress in reducing the prison population.

Chris Grayling has suggested in interviews that savings might otherwise be made through reducing prison budgets, as opposed to reducing prisoner numbers. Yet as the Chief Inspector of Prisons, Nick Hardwick, recently said, resources are already stretched very thinly and if a 'rehabilitation revolution is to be delivered, there is a clear choice for politicians and policy makers – reduce prison populations or increase prison budgets'.

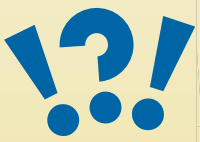
As the latter is not currently an option, the new Secretary of State for Justice may yet find himself converted to the cause of full-blooded penal reform.

For more infomation about the Howard League for Penal Reform visit
www.howardleague.org

The Howard League's top five hopes for the new Justice Secretary Chris Grayling

1 Temper the rhetoric

Tough talking may play well with the tabloids and on Tory backbenches, but it can also influence sentencers and lead to harsher decisions in court. With prisons overcrowded and no money to build new ones, the Government needs to avoid talking itself into a prison crisis.



2 Go slow with payment by results

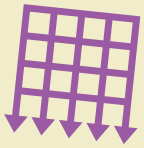
The Government is keen to roll out a payment by results approach in criminal justice, paying providers on whether they can reduce reoffending or not. There are many practical difficulties however, and it would be wise to pilot this new approach carefully rather than rush into costly mistakes.

3 If it ain't broke, don't fix it

Community sentences outperform short prison sentences for similar offences by eight percentage points in reducing reoffending. Yet Government wants to make punitive measures mandatory for all community sentences, despite the Ministry of Justice acknowledging that this may squeeze out rehabilitative requirements and lead to an increase in reoffending.

4 Review the indeterminate sentence for public protection

This sentence, otherwise known as the IPP, means that prisoners are kept in jail over their tariff if they are considered a danger. The sentence has proved unworkable as our overcrowded prisons are not able to provide the courses and support that prisoners need to progress through the sentence. While the Government is rightly abolishing the IPP, it is not addressing the plight of thousands of prisoners currently languishing in prison with no prospect of release. It is time to implement a system of review that fast tracks over-tariff IPP prisoners in order that more can be safely returned to the community.



5 Implement real work in prison

The Government is committed to offering more working opportunities to serving prisoners. The Howard League strongly supports this initiative as long as prisoners receive meaningful wages and can contribute to their families on the outside.

Family forces: reaching out to PCCs

Key pointers on engaging with new Police and Crime Commisioners

Elections to appoint local Police and Crime Commissioner (PCCs), a move described as the biggest change in policing in a generation, took place across the country on the 15th November, with the new PCCs taking office a week later. There were no elections in London, where the role is held by Mayor Boris Johnson and delegated to Kit Malthouse.

PCCs have been elected for a four year period and according to the Home Office, 'their job is to listen to the public and then respond to their needs, bringing more of a public voice to policing and giving the public a name and a face to complain to if they aren't satisfied.' PCCs will not affect the day-to-day operations of the police, but will fulfil their duties by holding the Chief Constable to account (including appointing and, where appropriate, dismissing them), designing and updating a police crime and plan, setting the force budget and regularly engaging with the public and communities. PCCs will be supported and held accountable by local Police and Crime Panels.

It is the budget-setting power which has piqued the interest of the voluntary sector, with many charitable organisations keen to ensure that their work remains prominent and well-resourced under the new administrations.

PCCs will also take control of the Community Safety Fund in April 2013, and some have expressed concern that newly elected commissioners will not have a sufficient understanding of the positive impact that Voluntary and Community Sector (VCS) organisations can have in reducing criminal activity. PCCs will also take control of approximately 40% of the Drug Intervention Programme (DIP) budget, which currently provides support to drug misusers within the criminal justice system. However, within the new system this portion of the DIP budget will no longer be ring-fenced specifically for drug- and alcohol-related issues.

There may, therefore, be legitimate fears that tackling substance use will be downgraded as a local spending priority, and given the PCCs' 'efficiency' remit, there will be increased competition for funding both within the VCS and outside it. However, this increased competition has led to many people suggesting that partnerships will be a way to thrive in the coming climate, as working alongside others will increase the likelihood of services being commissioned on account of their ability to reach more people. Working alongside others can also mean a sharing in knowledge, experience and contacts to ensure an efficient and effective service is delivered.

Influencing PCCs: making the case

Lobbying of the PCC candidates began before the elections, and will continue as action plans are drawn up in the coming months. Effective communication from the voluntary sector will be vital in securing the necessary funding to maintain stable and efficient VCS services.

To lobby effectively and ensure that family support services are able to retain their funding, it is important that they create a local strategy of who to target, when and how. Tips on this can be found in Adfam's *Surviving the transition: Local structures and networks* toolkit (www.adfam.org.uk/docs/adfam_transition_structures.pdf).

Ideally, PCCs need to be lobbied as quickly as possible to ensure that your service remains on the local action plan to reduce and prevent crime. PCCs are meant to be public figures with a responsibility to engage with their local community, so do not be afraid to approach them, including through social media. They need to be aware of what your service is providing and – crucially – how this helps their aims.

Try to find out what they support and believe in, and ensure that arguments highlight your involvement with criminal justice issues such as antisocial behaviour or community safety. Be sure to include information on any existing or past partnerships that you have built with the police. Some PCCs specifically mention drug and alcohol misuse in their priority areas, and many leant heavily on local history and experience in their campaigns – zoning in on these key issues seems a strong way forward. Present your PCC with data, statistics and case studies that prove the social and monetary value of your service wherever possible. Family support services also reach groups in the community who are often isolated or vulnerable, which could be an important selling point.

Of course, not all PCCs will react in the same way, and some will be more open than others: it remains to be seen how many will set out their stand as 'tough on drugs', or who are receptive to local 'not in my back yard' concerns over drug treatment services, for example. But PCCs are now a reality, and as they get to grips with their new role and try to communicate their messages to local people, family support providers need to be demonstrating their relevance and effectiveness to ensure they are a part of this new system.

Safer Future Communities

To help charities attract the funding they need, engage with PCCs and influence the commissioning landscape, the Safer Future Communities project has been funded by the Home Office to promote the role of the voluntary sector and provide guidance and support.

It is recommended that organisations make contact with their local Safer Future Communities lead as soon as possible in order to make the most impact – details are available from ***www.clinks.org/services/sfc.***

A full list of PCCs is available from the Home Office website at ***www.homeoffice.gov.uk/police/police-crime-commissioners***

Your organisation – top 5 resources

Recently published resources to help your organisation during this time of transition

1 Why Social Enterprise? A guide for charities

Social Enterprise UK

This guide is aimed at charity leaders, senior managers and trustees to help them understand what the transition to a social enterprise might mean for them. A social enterprise is a business that trades for a social and/or environmental purpose, generating an income by selling goods and services rather than through donations. The guide suggests that now is a good time to become a social enterprise as the UK is home to the world's fastest growing market for social investment, with the Government launching Big Social Capital to invest £600m in the social market earlier this year. A big part of the shift is a move from satisfying funders to satisfying customers, the report states, and it emphasizes that the ethos and values of organisations do not need to change, but the same social mission can be completed in a profitable and sustainable way.

www.socialenterprise.org.uk/advice-support

2 Making it easier to set up and run a charity, social enterprise or voluntary organisation: Progress update

Cabinet Office

This update aims to set out the measures being taken by Government to support the third sector, in order to 'unlock the huge potential of civil society to improve more lives'. The key areas identified are improving regulation and stripping down bureaucracy, for example by cutting 'red tape'; improving the support available for frontline civil society organisations, including support for infrastructure bodies and improving collaboration through the Transforming Local Infrastructure Programme; and developing skills across the civil society sector, especially in business matters.

www.cabinetoffice.gov.uk/resource-library

3 Writing a Fantastic Funding Bid

NCVO

This quick guide addresses the key difficulties in writing an effective funding bid, which the NCVO argues is doubly important in times of scarce resources. Chapters are devoted to finding the right funder by researching their priorities and seeing what they've funded in the past; identifying the key things funders look for, including demonstrating need, a realistic budget and an 'exit strategy' for when the money runs out; demonstrating impact; tips on style and tone (like avoiding jargon) and do's and don'ts; increasing chances of further funding; and a directory of further sources of advice.

www.ncvo-vol.org.uk/advice-support

4 Making an Impact

NPC

This report illustrates the charity sector's response to the challenge of impact measurement. Using the results from a survey of 1,000 charities with incomes over £10,000, it reports that 75% measure some or all of their work. However, nearly half of all charities with an income under £100,000 do not measure at all, with the greatest barrier seen to be financing the measurement process. A key finding was that whilst only 5% of charities said that improving services was the main motivation behind implementing impact measurement, improved strategy and services were in fact the main benefits they discovered. The report recommends that funders give clear messages about the importance of impact measurement; says charities should use their existing data, both positive and negative; and argues that Government should lead from the front by evaluating its own programmes.

www.thinknpc.org

5 UK Giving 2012

CAF/NCVO

The latest installment of this annual survey found that not only are fewer people giving, but those that still do are giving less – accounting for a £1.7bn drop in donations over the last year. The research also shows that 55% of people still give to charity in a typical month, and women are slightly more likely to give to charity than men. Medical research, hospitals and hospices, and children and young people are the most popular causes in terms of numbers of donors, but religious causes receive the highest average donation. The authors call on the public to support charities through regular giving, regardless of how much money they give each time; and ask the Government to ensure charities are not disproportionately affected by spending cuts at the local level.

www.cafonline.org/publications.aspx

In Focus **Primary care**

Much of Adfam's work is about bringing family support out into the open – or in from the cold, depending on how you see it. That means reaching audiences who come across families who might be affected by substance use, but either don't recognise the signs, aren't comfortable asking the right questions, or aren't confident of what to do with the answers. One of our key audiences in this mission is primary care – *primary* being the operative word, as the first port of call for all kinds of health concerns.

As you'll read in this special issue, the need for work in this area is quite clear – families going to their GP and needing anti-depressants, people visiting relatives with alcohol-related illnesses in hospital, and those trying to help a loved one navigate mental health services when they also have an addiction, for example.

We need to make sure that these professionals are attuned to the impact of drug and alcohol use on family life, and are also aware of what local specialist support services they might be able to refer families to. This sounds like a relatively simple task, but is much easier said than done – as many family support services have found out for themselves.

It's no longer enough just to drop off few leaflets at the local GP surgery listing a phone number or advertising a support group – what we need is a deeper *understanding* of family support in primary care settings, and more positive engagement between practitioners in different sectors who can really grasp how valuable a partnership can be.

As you'll read here, there are some fantastic, knowledgeable and dedicated practitioners leading work in this area and we hope we can help to replicate this elsewhere. But as changes to the health service kick in and routes of access to decision makers change, we may have to work even harder than before – and we will definitely need your support!

Joss Smith *Head of Policy and Regional Development, Adfam*

we need a deeper *understanding* of family support in primary care settings

Setting the scene

An overview of primary care and its links with drugs, alcohol and family support.

What is primary care?

Primary care is the first port of call health service provided by GPs and other health practitioners such as pharmacists, opticians and nurses, and accounts for 90% of the public's engagement with the NHS. It is defined in contrast to secondary care, which comprises the medical specialists (often located in hospitals) who practitioners in primary care may refer patients on to. GPs, as widely trusted general doctors, are often the first professional many people contact with a problem, whether for themselves or a family member.

How does primary care work and how is this changing?

Primary care services are currently managed by local Primary Care Trusts (PCTs), of which there are 151 in England. PCTs work with local authorities and other agencies to ensure that the needs of the local community are being met. They control 80% of the NHS budget*.

However, imminent reforms laid out in the Health and Social Care Act will affect how primary care is delivered, and create new challenges and opportunities for building links between primary care, the Voluntary and Community Sector (VCS) in general and family support groups in particular.

These changes will mean that PCTs are abolished and much of their power handed over to Clinical Commissioning Groups (CCGs), made up of GPs with some input from hospitals, other healthcare providers and schools. CCGs will have the power to commission primary care services and have a great deal of power in setting local health priorities. They will be able to commission from outside the established pool of NHS providers, with the potential for VCS organisations (including those working with substance users and their families) to be involved.

* From 'About the NHS', www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx

Health and Wellbeing Boards (HWBs) are also being created at a number of English top tier local authorities, with responsibility for creating wellbeing strategies which help set local priorities and impact on many areas – including drug and alcohol treatment, and support for families and carers. HWBs will include representatives from local CCGs.

Adfam's toolkit *Surviving the transition: local structures and networks* explains these new structures in more detail, and can be downloaded free from Adfam's website (www.adfam.org.uk/docs/adfam_transition_structures.pdf).

Primary care iand substance use

Sustained alcohol or drug use can lead to a number of long term health problems that require contact with primary care givers. People who drink problematically may be affected by cardiovascular disease, chronic pancreatitis and alcoholic liver disease, all of which will require them to keep in close contact with their GPs as well as more specialist consultants. Substance users may go to their GP for an initial diagnosis and referral on to a treatment agency if a negative impact on their health starts to be felt. Crack use, for instance, is associated with respiratory difficulties, mental health issues or heart problems, any of which may cause a user to consult a GP. Heroin users may be prescribed methadone by their doctor, as well as being affected by long term health issues including abscesses and blood-borne viruses such as HIV and hepatitis B and C spread by sharing needles. All of these things would keep them in regular contact with primary care givers. Drug and alcohol users who are worried about their substance use but not fully dependent may also consult their GP as a trusted source of information on decreasing their consumption.

Family support

Anecdotal evidence from Adfam's own work (such as recent domestic violence and stigma projects) indicates that many family members who are worried about their loved one's drug or alcohol use also turn to their GP in search of effective treatment for their family member. This means that those working in primary care have a good opportunity to signpost family members to support at a critical stage in their journey, and the relationship between family support and primary care can therefore be crucial. Parents often report consulting their GP for a 'stress-related issue' or tiredness and then eventually disclosing the true root of their problem when prompted.

There are therefore many points at which practitioners supporting families affected by substance use will interact with the primary care system. These might include families trying to engage the GPs of drug users so they can support their loved one through treatment; a family support group building links with a local general practice to help signpost family members to their services; a pharmacist who dispenses methadone to a recovering heroin user who works with the family to ensure the methadone is stored securely in the house away from children; or an alcohol liaison nurse who works with problematic drinkers and their families in hospital.

Glossary

CCGs Clinical Commissioning Groups

HWBs Health and Wellbeing Boards (taking on statuory functions from April 2013)

PCTs Primary Care Trusts (being abolished in April 2013)

VCS Voluntary and community sector

Doctor in the house

***Dr. Euan Lawson** gives a GP's perspective on family and carer support, drugs and alcohol.*

PRIMARY care and general practice are ideally placed to be a cornerstone of care for families who are affected by drugs and alcohol. I'd go further and say that general practice, and shared care, is the only place that can genuinely put families in the centre.

I was working as a locum in a local practice last week when I bumped into one of the GPs as he was popping out on a visit. It's a leafy rural practice with few patients who have substance misuse problems. The GP has never worked in drug or alcohol services and wouldn't regard himself as having much interest in the field. But he was on his way to undertake a bereavement visit to a family where the son, with a long history of substance misuse problems, had died of a suspected drugs overdose. Many GP practices still have a policy of routinely visiting a family after any death – it has long been recognised as an important time to offer support. It's old school general practice but it still goes on up and down the country, and it's a good example of how, without even realising they are doing it, GPs can and do engage with families affected by someone else's drug use.

It's worth making clear the link between primary care and families. From an academic perspective, they are almost indistinguishable. Take a look at the primary care medical journals: the one with the highest "Impact Factor" (the measure of how often its articles are cited) is the *Annals of Family Medicine. Family* Medicine. When you look down the list, you'll find that seven out of the top ten primary care journals in the world have the word 'family' in their title. *Family Practice, Family Medicine, American Family Physician.* It's a crucial idea to keep in mind when contemplating the role of GPs. It's what we're really about - we see the whole family, in true NHS tradition, from cradle to the grave. It means we can take into consideration the needs of children and the needs of carers, as well as the issues around the person with dependency. Of course, it can't all be done in a single consultation but over a period of time one GP can build up hours and hours of time with a single family. We know that there is evidence that suggests family members have their own particular needs and that when they are provided with support we achieve better outcomes.

> *for all the patients we see with substance misuse issues, there is a vast hinterland of other people affected too*

We all need to be aware of the challenges that face general practice if we are to see effective services. The Quality Outcomes Framework (QOF) has some notoriety in general practice. It is, at its simplest, a set of performance targets for GPs and they rely on it for a substantial portion of their income – but there are almost no substance misuse-related targets in the QOF. Practical experience, and to an extent common sense, suggests that the time-pressured GP will tend to concentrate on QOF areas. That isn't about avarice, it's a simple truth – GPs have to heat, light and maintain surgery premises; they have to pay their staff and they also need to earn a living. The pressure on GPs is ramping up as hospital stays get shorter and the push to avoid admissions and move services into the community is telling. Ultimately, when time is short, QOF will take priority. There are also no chronic disease registers for substance misuse issues. There is an increasing problem in the UK with general practice with continuity of care and that stands as an important barrier to ensure good care for families.

Working in a community drug team setting, I have got used to looking at a clinic list and seeing multiple family members affected. I've seen a father and son in adjacent appointments. I've seen brothers and sisters for years on end. There are extended families, cousins, and half-siblings galore. Many of them have substance misuse issues but I know this just the tip of the iceberg: for all the ones we see with thir own drug and alcohol issues, there is a vast hinterland of other people affected by it too. It's not challenging to see how the UK Drug Policy Commission could come to an estimate of a minimum of 1.5 million affected by someone else's drug use. But – and this is the rub – when I'm working in a substance misuse clinic I'm working in complete isolation. There's no link to anyone else affected. My only route to the families is through the individual. Worryingly, it's common that when I ask about families and children it's met with suspicion, particularly if the individuals have had difficult experiences with organisations like social services. It's possible to build systems that help to keep families involved but, for me, the best way to

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achieve this is to keep care as close to general practice as is possible. Shared care may have its critics, but you can be certain that families sit closer to that care than in any other system.

So, what can GPs do to improve their management of families? One recent example of family care has been the Swanswell Recovery Model*. They've been delivering shared care services in the Birmingham area for ten years and sessions are integrated into existing surgeries and systems. They showed some better outcomes for those with the substance misuse problem but I'd argue that the benefits are likely to go beyond that. It helps link the GPs in to the families with problems; it's hard to imagine a better way of bringing in some 'recovery capital'.

I work in both community drug team clinics and in general practice. Over the past few years, I've seen fragmentation of care and the tendering of specialist substance misuse services has fractured continuity. Substance misuse services have also been transformed, and changes in providers have meant that clinics have moved.

* http://www.swanswell.org/news/Swanswells-recovery-model-SMMGP.aspx

And it's likely that even when a new service is commissioned there is no guarantee that three years down the line they'll still be in existence. Sometimes it just means they are changing the name plate over the door but, more likely, there will also be changes in service configuration, key workers are different and the doctors move away. While efforts have to be made to ensure that family-orientated services are commissioned, it's difficult to see how continuity is going to be sustained in that system. In the three-year merry-go-round of substance misuse service commissioning, the long-term benefits of managing family issues are unlikely to be prioritised.

Some of the most upsetting consultations I've had have been with parents of those with addiction. They watch their children unravelling before their eyes. All GPs have had consultations where we've experienced something similar. We may face pressures from changes in healthcare systems but, when faced with that desperate parent, GPs still want to do the right thing. Yet, there is little training for them which concentrates on family issues in substance misuse – raising awareness and improving their understanding of how they can help is important but needs be carefully balanced. GPs cover the whole spectrum and there is a host of competing interests.

We should, and must, make community drug teams, in all their various guises, more family-orientated but we should remember that we already have healthcare with family at the centre. If we can push core addiction treatment into general practice then we open the doors to the genuine and meaningful involvement of families. General practice isn't immune from the future changes to the health services but it is relatively well insulated. And, don't forget, general practice *is* family care.

Dr. Euan Lawson is a GP with special interests in substance misuse, prison healthcare and medical education. He also writes a blog on his website, www.euanlawson.com.

"Think Carer!"

*Adfam speaks to **Lindsay Henderson**, Coordinator of the South of Tyne and Wear Carers' Drug and Alcohol Network (CDAN), about the importance of integrating GPs into local carer support.*

"We asked carers what our network's number one priority should be for the year ahead, and improving GPs' understanding was top of the list", Henderson begins. "Families felt that they would go to their GP with stress and anxiety problems, but what they really wanted was to be asked or prompted about how they were affected by someone else's drug and alcohol use." Families recognise that doctors are not support workers and that "their job is to identify and prescribe", but they want GPs to know where to signpost them and feel that "they're not asked certain things because of a lack of GP awareness of what family support is out there", she continues.

Single point of contact

CDAN developed a Single Point of Contact (SPOC) service for GPs in South of Tyne and Wear that aimed to smooth the process of referring someone to carer support. "GPs don't have to wade through service directories or have in-depth knowledge of carer services", Henderson states: "all we're asking them to do is 'think carer' and ring the SPOC if their patients have a caring role and want help.

"If their patient is the person who uses drugs or alcohol then we want GPs to ask them if their family or friends would benefit from advice and support. One phone call with the carer's name, telephone number and consent to contact them will signpost carers to the type of support best suited to their needs – it's that simple!"

Reaching out to GPs

Henderson stresses that "there are lots of demands on GPs' time and expertise – they get bombarded with information and some are more willing or able than others to embrace new initiatives". So she thinks it's imperative to "show that signposting is as easy as it can possibly be", and to emphasise the benefits to doctors and practice managers too: "it's about carers' access to support, which can reduce their own health harms and lead to less prescribing". Without an effective referral system, families may visit their GP again and again - getting repeat prescriptions for anti-depressants, for example - without ever being pointed towards the tailored carer support they would benefit from.

> *families affected by substance use are more likely to experience their own heath harms in the form of stress, anxiety and depression*

Henderson recalls one carer who suffered from depression for a long time, but subsequently benefitted from their GP's awareness: "once she disclosed that her partner was using alcohol, she was referred to carer support immediately". In this case the comfort of the family member in coming forward and the knowledge of available support by the GP combined for better outcomes, including a reduced need for the family member to keep attending GP sessions.

Understanding and integrating

Mutual awareness between practitioners is a key consideration for those working with vulnerable people, whether it's around domestic violence, mental health, children and family support or housing. Henderson's argument is that GPs need to be around this table too: a lot of the problems she has encountered seem to stem from families and professionals seeing GPs in standalone spheres of specialist clinical practice, rather than integrating them into local partnership responses.

Although CDAN itself is chaired by a doctor, the cultural differences between clinical methods of practice and ways of working in the voluntary sector have made integration hard, she thinks - "talking to each other is difficult when you speak different languages, and effective signposting can be the translator you need".

This is not to reduce a GP's role to one purely of referral effectiveness: families affected by substance use are, after all, more likely to experience their own heath harms in the form of stress, anxiety and depression*, for which they are entitled to medical help. But a GP's identity as first port of call for a variety of health and personal issues means they're a key point of access for other services: and if GPs routinely refer to different kinds of specialists – a psychiatrist, a dermatologist, or anyone else – then carers' services should be part of this conversation too. This means that GP practices will continue to be an integral part of the local support picture for families affected by substance use.

Future

Henderson is optimistic about the ongoing process of integration. "We haven't seen a lot of action with GPs yet but carer recognition is now a strategic priority in South of Tyne and Wear and the creation of Clinical Commissioning Groups (CCGs) may provide more opportunities to engage positively and influence practice". By raising the profile of the SPOC and educating GPs about the support available for carers, Henderson hopes to reduce stigma around substance misuse and ensure that more carers are signposted to vital support before they reach crisis point.

South of Tyne and Wear Carers' Drug and Alcohol Network (CDAN) is coordinated by First Contact Clinical (FCC), based in South Shields. www.firstcontactclinical.co.uk.

You can watch CDAN's video Think Carer! at www.adfam.org.uk/news/250.

* Ray et al (2007) *The excess medical cost and health problems of family members of persons diagnosed with alcohol or drug problems*, Medical Care 45:2

Tackling the 'secret disease'

*Adfam speaks to **Catrina Tranquille,** an Alcohol Liaison Nurse based in West Sussex, about the impact of alcohol use on families and engaging them in hospital settings.*

THERE were over a million alcohol-related hospital admissions in 2010-11, costing the taxpayer nearly £2 billion. These aren't all people getting drunk, falling over or getting into fights – drinking is related to a number of other serious and long-term conditions including liver disease, mental disorders, circulatory disease and cancer. Clearly, then, there is a role for alcohol specialists in hospitals.

The Government's Alcohol Strategy encourages all hospitals to employ Alcohol Liaison Nurses to manage patients with alcohol problems, connect with other specialist services in the community, educate other healthcare workers in the hospital and deliver Identification and Brief Advice (IBA) with key groups, including pregnant women.

The 'secret disease'

It is sometimes complained that alcoholism isn't taken as 'seriously' as drug addiction, and Tranquille describes it as the "secret disease". But as well as having an impact on practice – figures show that Primary Care Trusts spend just 0.1% of budgets commissioning alcohol services* – this lack of attention and openness can effect families too, who "haven't been able to share what's going on at home".

People can be afraid to even talk about alcoholism for a number of reasons – the legality of alcohol and its prevalence in our culture, confusion over how much is 'too much', an unwillingness to hold a mirror up to one's own drinking and, as pointed out by Alcohol Concern's Emily Robinson in *Families UpFront* 5, the serious stigma that remains attached to alcohol addiction despite the normality of its general use.

It's important, then, to tackle the issue head-on, Tranquille argues: she addresses alcohol directly with patients, asking about their drinking, what they would like to do about it and – crucially – whether families and friends have commented on it.

Her first contact with families themselves often comes with those who have stayed overnight with their relative in A&E and the Acute Medical Unit – the two busiest departments. When the family is not there, getting consent to initiate contact doesn't pose much of a problem, she says: "[patients] nearly always agree, as they're often at their peak of crisis". Contact can then be made in person, over the phone or through posting leaflets and information about support.

> *often relatives look at me as someone who can 'fix' or 'cure' the drinker, and they become frustrated when it doesn't seem like we're doing enough*

In terms of families' reactions, they seem similar to those of people affected by someone else's drug use: some are "very defensive and embarrassed, but others are desperate for support"; they tend to be "distraught" that their relative is in hospital, and "desperate for the drinker to stop". This can spill over into disappointment, however: "often relatives look at me as someone who can 'fix' or 'cure' the drinker, and they become frustrated when it doesn't seem like we're doing enough".

She has to explain to families that "it's up to the drinker to decide when to engage with support, but this doesn't mean that the relative's life can't improve even if the drinker continues to drink". This is where family support comes in. "Many [families] have no idea of the support services available to them", Tranquille continues, and she says they may also be unwilling to access them: "even though wonderful support exists in West Sussex, through the Families and Friends Network and Al-Anon, getting the relative to engage with them is challenging...often they don't think the service will do any good and have a 'what's the point?' attitude. But for those who are desperate enough and who can't see any other option, through my signposting and explaining what the services do, they might just go".

Tranquille finds that "a big challenge is when relatives can't see how they are affected by the illness – the stress, anxiety, tiredness and guilt". One of the most rewarding elements of the job, she says, is in helping families to see this light; and once she has explained what support they can get for themselves, "it's a great relief to them that they can share the illness with someone who will not judge, condemn or blame them".

Again, this evokes key features of support for families affected by drug use; as Tranquille notes, "the needs of the family of a drinker are often extremely complex and sensitive". There is nothing 'simple' about alcohol addiction and its impact compared to drugs, purely because of a difference in legal status. All of the presenting issues might not be identical - involvement in criminal activity is the obvious example – but the impact on family life and relationships can be much the same.

Alcohol-related hospital admissions are not all down to a phase of youth or an accidental overindulgence, but a symptom of a more serious and deep-rooted substance use problem which, when presenting in a hospital setting, has reached the point where it is causing significant, demonstrable harm to the drinker's health. The links between Alcohol Liaison Nurses and local family support groups, therefore, need to be built and maintained, and support services need to be equally equipped to work with alcohol users' families as they are with those affected by illicit drugs.

* National Audit Office (2008) *Reducing Alcohol Harm: Health services in England for alcohol misuse*

Healthy minds

***Marcus Roberts**, Director of Policy and Membership at DrugScope, explores what the Improving Access to Psychological Therapies (IAPT) programme means for families and carers.*

Depression and anxiety will affect many families in which one or more family member has a drug or alcohol problem. First, there is the direct impact of these mental health problems on family members with substance misuse issues. Back in 2002, the *Co-morbidity of Substance Misuse and Mental Illness Collaborative Study* – or COSMIC for short – found that 75 per cent of users of drug services and 85 per cent of users of alcohol services were experiencing mental health problems, largely anxiety, depression and trauma. Second, there is the impact on the family of supporting someone with a drug or alcohol problem. The UK Drug Policy Commission report *Adult family members and carers of dependent drug users* (2009) concluded that 'the feelings often associated with these experiences include anxiety, worry, depression, helplessness, anger and guilt'. Often these feelings will be sufficiently serious to benefit from therapeutic support.

It is encouraging, then, that in the Government's *Spending Review 2010* – in which the Treasury set out its spending priorities up to 2014-15 – the 'settlement' for the Department of Health included 'expanding access to psychological therapies'. In a four year action plan for talking therapies published in 2011, the then Minister for Care Services, Paul Burstow, explained that the expansion of psychological therapies was backed by investment of around £400 million over four years up to 2014-15, concluding that 'by then, every adult that requires it should have access to psychological therapies to treat anxiety disorders and depression'.

This builds on the Improving Access to Psychological Therapies programme (or IAPT) launched by Labour in May 2007. Initially, IAPT had a particular focus on working-aged adults and on supporting people on incapacity benefits because of mental health problems into employment. The influential Layard Report published by the London School of Economics in 2006 made a compelling cost-benefit case for Government investment in 'evidence-based psychological therapies', arguing

> *there is no evidence that substance misuse as such makes the usual psychological therapies less effective*

that if someone on incapacity benefits 'works just a month more as a result of the treatment, the treatment pays for itself'. In 2010, the IAPT programme was extended to all adults (not only those of working age), and from 2011 its scope has been broadened further. In particular, a new IAPT project is working to support children and young people. This programme is being expanded in 2012-13, with an additional £22 million of Government funding over the next three years.

So, what does this mean for people with drug and alcohol problems?

Some years ago, a number of DrugScope members approached us to express concerns that local IAPT services were turning away clients with drug or alcohol problems attempting to access psychological therapies for depression or anxiety. Some IAPT providers appeared to be operating what was effectively a 'blanket exclusion' policy against people in drug or alcohol treatment. At that point, we engaged proactively with the IAPT team nationally. We were able to highlight the conclusions of guidance from the National Institute of Clinical Excellence (NICE) on psychological therapies that clearly stated that substance misuse clients with mental health problems should have access to NICE-recommended psychological interventions, including CBT (Cognitive Behavioural Therapy) for depression and anxiety, and that there is no evidence that substance misuse as such makes the usual psychological therapies less effective.

Subsequently we worked with IAPT and the National Treatment Agency to produce an *IAPT positive practice guide for working with people who use drugs and alcohol*, which was published in January 2012 and is available on the IAPT website. The guide supports IAPT teams to work with people with common mental health and substance misuse problems. It sets out some simple assessment techniques and protocols for identifying IAPT clients with drink or drug problems and outlines criteria for determining whether they will be suitable for IAPT services. It also discusses how IAPT and substance misuse services can work together to improve outcomes for clients. We hope this is now improving access to, and engagement with, psychological therapies among users of drug and alcohol services.

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What about families?

Of course, individual family members can present to IAPT services where they are experiencing anxiety or depression in the same way that anyone else can (for example, through a GP referral), but that will not necessarily address their mental health issues as one aspect or dimension of caring for or coping with a family member with a drug or alcohol problem.

It may be encouraging, therefore, that the IAPT work stream for children and young people introduced in 2011 is now being referred to as 'Improving Access to Psychological Therapies for Children, Young People and Their Families'. The four year action plan for talking therapies published in 2011 to support the Government's national *No health without Mental Health* strategy highlights the importance of ensuring that the IAPT workforce has 'expertise and experience in engaging and working with young people and their families through to adolescence and young adulthood'.

A recent report from the group supporting this work stream states that 'all IAPT workers should have skills and competencies in working with adult patients who are also parents or carers' and that 'family-orientated IAPT services should be piloted to provide interventions which include meeting the needs of parents as adults in their own right, as well as identifying and meeting the needs of children, young people and families'. This could be an important source of support for families where the family member with a drug or alcohol problem is a child or young person, but perhaps less so in other situations.

Two final points. First, I have recently had discussions with colleagues working in the domestic violence sector who report similar issues to those that have affected drug and alcohol service users. Access to psychological therapies for domestic violence survivors appears to them to be patchy, with evidence that some IAPT services have excluded people who are in temporary accommodation such as refuges, or because they are not confident working with clients they view as at risk of harm. Second, the £400 million that the Government has announced to support IAPT services is no longer ring-fenced, which means that local commissioners could choose to spend it on other things. It is salutary to note that the Spending Review 2010 also pledged £6 billion for the Supporting People programme for housing-related support over the spending review period, but following the removal of ring-fencing much of this investment has not materialised locally. We will see if there are similar issues with IAPT.

The DrugScope, IAPT and NTA 'IAPT positive practice guide for working with people who use drugs and alcohol' is available on the IAPT website at www.iapt.nhs.uk

Details of the Children and Young People's programme are at www.iapt.nhs.uk/cyp-iapt/

The DrugScope website is www.drugscope.org.uk

Joining the dots

Lauren Lovatt from Solihull Integrated Addiction Services (SIAS) explains the process of implementing a local partnership for supporting substance users and their families, offering advice along the way.

The Metropolitan borough of Solihull has an estimated problematic drug using population of approximately 900 adults and an estimated 5,124 adults who drink harmfully. For every substance user, at least one significant other is affected.

Welcome was established in 2002, initially as an advice, information and signposting service for drug users. In 2004 it was commissioned to establish the Single Point of Contact (SPOC) system for residents of Solihull affected by substance misuse, which was designed to ensure there was a single point of entry to services. It aims to reduce duplication, improve care pathways and communication between services, provide initial assessments and maximise engagement. Since the introduction of the SPOC system, Welcome has grown substantially and now provides a range of structured psychosocial interventions for both service users and their families.

Designing the partnership

In 2009, needs assessment and service user feedback surveys were carried out by local services under the direction of the local commissioner and DAT coordinator.

Work closely with commissioners, find out what they want and keep them informed of progress and integration.

They highlighted the duplication of work amongst local organisations, and it was felt that service providers should work more closely together to create integrated pathways for service users and improve continuity of care.

Welcome then undertook this integration alongside five other organisations - Birmingham and Solihull Mental Health Foundation Trust, the Drug Intervention Programme, Aquarius, Solihull Young Persons Service (Str8 Up) and Changes UK. This partnership is now recognised as Solihull Integrated Addiction Services (SIAS).

The integration of services was managed through a number of operational working groups consisting of key people from each organisation. These focused on ways to enhance and improve current services, prevent duplication of practice, provide services in line with best practice guidelines and national policies and enhance and improve experiences for service users and their families.

Communication with the partner agencies is vital – it's best to set up regular working groups or meetings to facilitate effective communication and decision making. Appointing a lead in your organisation will make this easier. Social events and team away-days across the partnership can also be useful!

There were a number of challenges faced during the integration process, particularly issues regarding policy and system alignment and changing staff attitudes across the organisations.

Allow staff to have their say and be heard – working closer with other organisations may bring worries and concerns which should be listened to and answered.

Results

The creation of the SIAS Partnership has dramatically improved continuity of care, reduced duplication of work and prevented services working in isolation.

Don't duplicate work – there is nothing more frustrating for a family member. Ensure assessment documents are unified and meet the needs of families and services. We produced one single document that is recognised across all agencies within the partnership.

Feedback suggests it has improved overall experiences – three quarters of service users rate the level of communication 9 or 10 out of 10, for example – and the joining of the five organisations has increased access to shared resources and skillsets amongst the workforce.

Ensure staff are aware of the skill mix across the partnership to enable them to effectively use all the skills and resources available. We did a 'speed dating' session where everyone got to know each other and shared their experience and skills. You could also produce a handbook of the expertise available.

Solihull Integrated Addiction Services (SIAS)

Cuts to public spending are always a concern for recovery services. Working as part of the partnership ensures for Welcome that if budgetary cuts are announced, we can all work together to make sure that efficiency savings are made without sacrificing the priorities highlighted in the annual needs assessment.

If changes are being made to the design and delivery of your services then get the partners involved in this process.

A recent case study

Martin *(not his real name)*, 35, first accessed SIAS in August 2005 presenting with heroin and crack dependence. An initial presentation and a thorough assessment of the client's needs were undertaken, and a tailored and individualised recovery plan was designed in conjunction with the client. He was initially referred for specialist prescribing in order to stabilise and also accessed a range of structured psychosocial provision including 1-to-1, group work and psychotherapy. These were provided both at SIAS services and through outreach. Services were provided across the partnership and joint care planning was undertaken with all the agencies involved.

Educate your partners about your services – make it clear what benefits it could bring to their service users and make referral pathways clear.

In November 2005 the service user's social network was explored and his father, whom he lived with, was found to be struggling with his son's dependency. With the service user's consent the father was contacted via the family support worker who performed a home visit to establish the needs of the father. The father began attending the family support group and also accessed an information programme, Naloxone training, a respite trip, counselling and complementary therapies. Family interventions were delivered with the service user, the allocated practitioner, the client's father and the family support worker.

Get families involved in the design and delivery of your services, and consider appointing a family representative.

Martin became abstinent in late 2007 but realised the importance of ongoing relapse prevention interventions and peer support. He also suffered from a social anxiety disorder for which he continued to ask specialist services. He was discharged drug-free in late 2012, but his father continues to access the family support group and acts as a peer for other family members.

Before 2009, the partners were operating well but separately. Through the working group on joint care planning and staff meeting clients together more regularly, the recovery pathway has improved and we are seeing better results year on year.

Family support

SIAS adopts a whole family approach and recognises that, if and when appropriate, families can be a vital resource to support the recovery of their loved one: in our latest review, 60% of service users said their family was involved in their recovery. But we also recognise the need to support families in their own right and SIAS offers a wide range of interventions to address their needs. SIAS family services feature in the Annual Needs Assessment Planning and are seen by Solihull Commissioners and Partners as an essential part of recovery.

The Family Support Service is delivered across the Partnership, offering 1-to-1 sessions, support groups, an information programme, carer clinics, respite service and peer support, and these are tracked to see which are used the most. 90% of respondents to our latest family and friends survey felt their needs and expectations had been addressed completely.

The integration of services has had a positive impact on outcomes for service users and their families and has certainly increased the range of recovery interventions available and improved recovery pathways.

Ensure you have an effective outcomes measurement system – this will help demonstrate to commissioners or funders the effectiveness of your new partnership. For example, we have used Outcomes Stars and were the first service in the country to undertake an SROI (Social Return on Investment) evaluation.

Despite the challenges that SIAS has faced, the successes and the achievements that have been made would not have been possible without the dedication of its management team, staff and volunteers.

Find out more at www.freedomfromdrugs.org.uk

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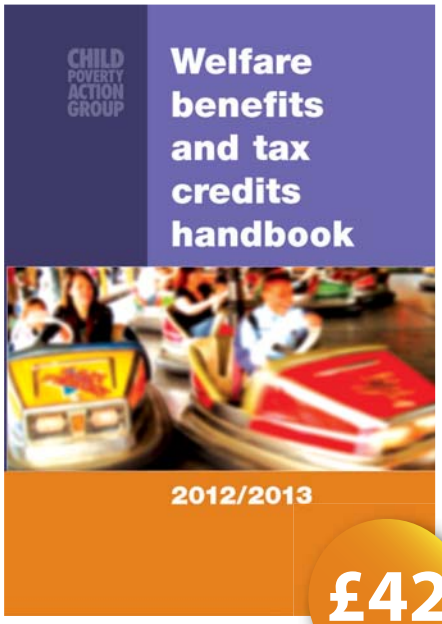

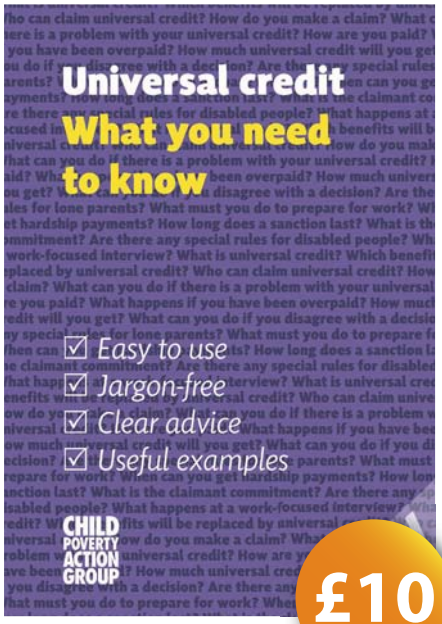

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- Dealing with debt (2 days)
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- Introduction to welfare rights (5 days)
  A course for people new to welfare rights advice. It explains how the benefit and tax credit system is organised, and helps you identify the issues that may affect your client's entitlement.