bringing evidence
and analysis together
to inform UK drug policy

UKDPC
UK DRUG POLICY COMMISSION

Adult Family Members Affected by a Relative's Substance Misuse:

Qualitative Interviews with Commissioners and Service Providers in England and Scotland

Alex Copello, Lorna Templeton, Gagandeep Chohan and Trevor McCarthy

March 2012

Published by:
The UK Drug Policy Commission (UKDPC)
Kings Place
90 York Way
London N1 9AG
Tel: +44 (0)20 7812 3790
Email: info@ukdpc.org.uk
Web: www.ukdpc.org.uk

This publication is available online at
http://www.ukdpc.org.uk/publications.shtml#Families_report

ISBN: 978-1-906246-37-2

© UKDPC March 2012

The UK Drug Policy Commission (UKDPC) is an independent body providing objective analysis of evidence related to UK drug policy. It aims to improve political, media and public understanding of drug policy issues and the options for achieving an effective, evidence-led response to the problems caused by illegal drugs.

The views, interpretations and conclusions set out in this publication are those of the authors and are not necessarily those of the UK Drug Policy Commission.

UKDPC brings together senior figures from policing, public policy and the media along with leading experts from the drug treatment and medical research fields:

John Varley (President)
Dame Ruth Runciman (Chair)
Professor Baroness Haleh Afshar OBE
Tracey Brown
Professor Colin Blakemore FRS
David Blakey CBE QPM
Annette Dale-Perera
Baroness Finlay of Llandaff
Jeremy Hardie CBE
Professor Alan Maynard OBE
Vivienne Parry OBE
Adam Sampson
Professor John Strang
UKDPC Chief Executive: Roger Howard

UKDPC is a company limited by guarantee registered in England and Wales No. 5823583 and is a charity registered in England No. 1118203. UKDPC is grateful to the Esmée Fairbairn Foundation for its support.

Contents

1 Introduction 4

2 Methods used 7

2.1 Sample selection in England and Scotland 7

2.2 Interviews 11

2.3 Interview team 11

2.4 Treatment Plan Review 11

3 Review of treatment plans and strategies in study areas 12

3.1 England: Local treatment plans 12

3.2 Scotland: ADP treatment strategies 13

4 Analysis of commissioner interviews 15

4.1 Knowing and understanding the problem 15

4.2 Commissioning processes 19

4.3 Challenges/barriers to engaging families 25

4.4 Service delivery 28

4.5 Other issues identified in Scotland 31

5 Analysis of complete interview sets for areas in England and Scotland 34

5.1 A comparison of areas in England 35

5.2 A comparison of areas in Scotland 44

6 Comparison of service provision with a template for service provision 52

7 Conclusions and Discussion 56

8 References 59

Appendix 1: Commissioner interview guide 60

Appendix 2: Service provider interview guide 61

Appendix 3: Areas used for qualitative analysis in England and Scotland 62

Appendix 4: Review of Adult Treatment Plans/Strategies 63

Appendix 5: Extracts from UKDPC report on Phase 1- Template for service provision 68

Appendix 6: Comparison of 16 areas with levels of provision from Copelloet al (2009) 70

Acknowledgements

We are very grateful to the Pilgrim Trust, Scottish Families Affected by Drugs, Adfam and the Esmee Fairbairn Foundation for their support for the research.

We would also like to express our thanks to all the members of the Project Advisory Group, the UK Drug Policy Commission and in particular to Nicola Singleton for her extremely valuable advice and support throughout this project.

Organisations represented on the Project Advisory Group included:

- Adfam
- Scottish Families Affected by Drugs (SFAD)
- Action on Addiction
- SPODA, Derbyshire
- Families, Partners and Friends Service, CASA, Islington
- The Princess Royal Trust for Carers
- DrugScope
- Centre for Drug Misuse Research, University of Glasgow
- Scottish Government
- Welsh Assembly Government
- National Treatment Agency for Substance Misuse
- DHSSPS, Northern Ireland

1. Introduction

The impact of drug (and alcohol) misuse on families is now widely recognised and accepted. However, less is known about the extent and nature of responses to the issue. This report forms part of the second phase of a two part project commissioned by the UK Drug Policy Commission (UKDPC). The first phase of the project considered the prevalence of adult family members with a relative with an illegal drug problem and the cost of the harms experienced by these family members and also reviewed the evidence concerning the specific support needs for this group (Copello et al, 2009; UKDPC, 2009)[1]. The second phase includes a review of policy and other guidance across the UK and a detailed survey and mapping exercise of the local response to families affected by drug misuse.

This report focuses specifically on the analyses of in-depth qualitative interviews with commissioners and service providers in a number of areas of England and Scotland that were conducted as part of a mapping exercise. The findings of the policy and guidance review and the web survey are covered by separate reports.[2]

The aim of this part of the project was to obtain in-depth data from a range of areas in England and Scotland in order to complement the findings from the quantitative web survey. Whilst the national web survey provided a picture of what is delivered across the UK based on the responses obtained, the data from this part of the study allowed the exploration of commissioners' perceptions of the impact of drug problems on adult family members and the services delivered as well as gathering more detail of what is delivered across specific treatment areas.

ANALYSES INCLUDED IN THIS REPORT

This report covers the results of four sets of analyses. First, the treatment plans/strategies for the areas selected were explored in terms of the amount of reference made to 'carers' and 'family members' and the issues outlined. Next, a qualitative analysis was conducted on commissioner interviews from the English and Scottish areas.

Finally, analyses were conducted looking at full sets of interviews (commissioner and service providers) obtained for 8 areas in England and 8 ADP areas in Scotland. This was done in two ways. First we compared the areas in terms of key themes that

---

[1] See http://www.ukdpc.org.uk to access these reports from the first phase of this project.
[2] Copello & Templeton (2012) *Adult Family Members Affected by a Relative's Substance Misuse: A UK-wide survey of services for adult family members*. London: UKDPC and Templeton & Copello (2012) *Adult Family Members Affected by a Relative's Substance Misuse: A Review of Policy and Guidance Documents across the UK.* London: UKDPC.

emerged from the interview material and some of the themes that emerged from the analysis of commissioner interviews and these are described in more depth later in the report. Secondly the service provision in each area was compared with the template of comprehensive provision that was developed as part of the review of evidence based approaches conducted as part of the UKDPC phase 1 study (Copello, Templeton and Powell, 2009; see Appendix 5 for template).

RESULTS REPORTED

(i) Result of review of treatment plans/strategies

(ii) Qualitative analysis of commissioner/ADP coordinator interviews

(iii) Analysis of all interviews in 8 areas in each of England and Scotland

(iv) Comparison of the provision in these 16 areas with the template of service provision form UKDPC phase1.

2. Methods used

2.1 Sample selection in England and Scotland

Areas for in-depth study were selected, as far as it was feasible within the resources of the project, in order to represent a wide geographical spread as well as to include inner city, city, town, rural and semi-rural areas in both England and Scotland.

The areas that were surveyed in England were selected from five regions that included: East Midlands; West Midlands; London; South West and North East. Four Drug (and Alcohol) Action Team areas were selected at random from each of the 5 regions, giving a total of 20 areas for inclusion in the study.

The main drug service commissioner was identified for each of the 20 areas and a semi-structured qualitative interview was arranged and conducted. All interviews except for one were conducted by telephone and recorded with the interviewees consent. One area was not able to take part in the project due to pressures resulting from reorganisation and change at the local level. This area was replaced with another from the same region. All commissioners were interviewed except from one area where no contact was established during the project timescale. In another area there were two commissioners resulting in a total sample of 20 commissioner interviews.

Towards the end of each interview, the key commissioner was asked to identify key informants from all the services in their area that provided support to adult family members/carers of people with drug problems and contacts for these were obtained. Service providers were then contacted and telephone interviews were arranged. In some cases interviews were also conducted with carers and/or service user representatives. A total of 43 interviews were completed. In most areas all services identified were interviewed but in a few cases it was not possible to make contact with the service within the project timescale and, as a result, in three areas no service provider interviews were carried out. For a more detailed description of the full set of service provider interviews conducted in England see Table 1.

In Scotland a number of areas were identified in consultation with key informants and chosen to represent a range of different types of area. The final sample included: three cities, two semi-rural and three rural areas. The initial key informant for each area in Scotland was the Alcohol and Drug Partnership (ADP) coordinator. For each area the ADP coordinator was identified, approached and interviewed by telephone. As in England, towards the end of the interview, the ADP coordinator was asked to identify key informants from the service providers in the area and contacts for these were obtained. Service providers were then contacted and telephone interviews were organised. All eight ADP coordinators were interviewed. A total of 29 service provider interviews were conducted, which represented all but three of the

services identified. For a detailed description of the full set of service provider interviews conducted in Scotland see Table 2.

Therefore, the full interview set for each area in both England and Scotland included (i) the key commissioner/ADP coordinator, (ii) the service providers identified and in some cases (iii) carer/family member or service user representatives.

Given the absence of any definitive listing of services for family members of people with drug problems, it was not possible to establish whether we managed to elicit a full coverage of all services that came into contact or provided support for adult family members for each area. However, our commissioner interviews sought to prompt the area/ADP key informants in such a way as to elicit all of the range of services for adult family members within each area known to that key informant and also where possible we looked at web survey responses to identify any services that had not been identified through key informant interviews in the areas. In some instances, additional services were identified as part of the service provider interview process but this varied between areas. It is a fair assumption that the main services were covered with this method and difficulty identifying other services may reflect the fact that the latter may not be clearly visible also for people potentially needing access to these services in the area.

Table 1: Breakdown of Service Provider Interviews in England

Area Region	Family service	Carers service	Drug treatment		Other (details)
			Stat/NHS	**Non-stat**	
SW	1			2	1 (Children serv.) (1)[1] (carer)
SW	1		1	1	1 (DHI)
SW	1	1	(1)[1]	2	1 (Service user org)
SW				2	1 (SU Forum)
L			(1)[1]	1	1 (SU rep)
L		1	1	2	1 (SU rep)
L	No service provider interviews – no details obtained despite attempts				
L			1	1	1 (carer)
WM			1	1	1 (carer)
WM			(1)[1]	(1)[1]	
WM			2	1	
WM	Current decommissioning of existing service and new service commissioned but not started				
EM	(1)[1]				
EM	1		1		1 (criminal justice)
EM	1		1		
EM					
NE		1	1	(1)[1]	1 (social enterprise org.)
NE	1			1	
NE		1			
NE	No service provider interviews – no details obtained despite attempts				
Totals interviews completed: 43 (8)	**6 (1)**	**4**	**9 (4)**	**14 (2)**	**10 (1)**

Table 2: Breakdown of Service Provider Interviews in Scotland

Area Region	Family service	Carers service	Drug treatment		Other (details)
			Stat/NHS	Non-stat	
S		1	1	1	
S	2	2		1	
S	1	(1)[1]	1		
S	1	2			1 (Generic counselling)
S	1	1	1		
S				3 (1)[1]	
S	1	1 (1)[1]		2	1 (Generic counselling)
S			1	1	1 (relationship counselling) 1 (women's service)
Totals interviews completed 29 (3)	**6**	**7 (2)**	**4**	**8 (1)**	**4**

[1] Numbers in brackets indicate services that were identified but were not interviewed for a number of reasons. Most common reasons were lack of available contact details or in some areas contact had not been established by the time field work had to be completed.

2.2 INTERVIEWS

Two interview schedules were developed one for commissioners and one for service providers. The full semi-structured interview schedules for commissioners and service providers can be seen in Appendices 1 and 2 of this report respectively. Once an area was selected the initial contact was made by a member of the study team with the key commissioner in England and the ADP coordinator in Scotland. The method varied as we progressed incorporating the most successful strategies to identify, make initial contact and organise telephone interviews. In England most contacts were made via e-mail. In Scotland an initial contact was made via e-mail which was followed-up after a day or two with a telephone call.

Commissioner/ ADP coordinator interviews were transcribed in full whilst service provider interviews were written up in report form. Reports were produced shortly after the interview was conducted and followed a set of rules/parameters that involved the inclusion of verbatim quotes as well as a comprehensive description of the contents of the discussion.

2.3 INTERVIEW TEAM

The interviewers included 4 members of the study team. In England the bulk on interviews were organised and conducted by Lorna Templeton (LT) and Trevor McCarthy (TM), with some limited help from Alex Copello (AC). In Scotland interviews were organised and conducted by Gagandeep Chohan (GC).

2.4 TREATMENT PLAN REVIEW

In England, all Part One adult treatment plans for the 20 areas selected for in-depth qualitative study were reviewed. In Scotland, all strategies for the Alcohol and Drug Partnerships in the 8 areas selected for in-depth study were also reviewed. The methodology adopted involved using the 'find' function to establish the number of times the words 'carer'(s) and 'fam' (family, families, family members, familial) were used. The plans were then scrutinised more closely to consider the extent to which they considered adult family members of drug misusers.

3. Review of treatment plans and strategies in study areas

Some discussion of the key points that arose from this review is included here but more detailed information in the form of a brief summary review of each plan/strategy is included as Appendix 4 of this report.

3.1 England: Local treatment plans

Overall, the majority of the plans reflected national drivers such as the Drugs Strategy and the recovery agenda and, as part of that, expressed commitment to developing services for families and carers. Often, however, this commitment was expressed in broad terms with little detail given beyond this (even where clear priorities were identified), and many plans indicated that this was an area of work which continued to need attention. The overall picture was therefore of increased recognition that families are important but a lack of precision in what is meant by families and whether the discussion was about children affected by parental substance use, families in general in the role of supporting recovery of drug users or adult family members needs in their own right. Where adult family members were mentioned there was little detail about the prevalence of the problem or the types of family members affected that were being discussed, e.g. parents, partners, grandparents. Some areas included families within their priorities but sometimes this was expressed in very general terms or using, for example, the term 'services for drug users and their families' which did not link to any specific actions for adult family member services.

In many cases the need to support families was couched within the broader 'Think Family' agenda, and hence in terms of issues such as parental substance misuse (and supporting children, parents and families as part of that), safeguarding and supporting troubled families. Little specific attention is given within the plans to supporting adult family members in their own right, although as stated several indicated the importance of families in facilitating engagement of users in treatment.

There were, however, some more specific issues which were covered a few times across the dataset, which perhaps indicates the approach which commissioners are taking at a local level. This most often included: involving carers, both in developing treatment plans and in commissioning more generally, and overdose training. Carers' involvement was mentioned in most plans although there was much variation in terms of how and to what extent. This ranged from family members being involved in the developments of the plans as was evident in some cases, or helping with needs assessments in others, or was part of a more formal on-going arrangement of service review and monitoring. One plan mentioned grandparents, while a few mentioned carers assessments, a couple indicated the need for Tier 1 i.e. those

services involving non-specific generic services such as general practice, probation, housing (GPs, for example were mentioned specifically in one plan) to do more to identify and engage families and support their access to more specialist services. A small number of plans mentioned specific services which existed in their area, but there was little mention of specific approaches or the need to implement evidence based interventions to support families or the need to develop these further.

3.2 SCOTLAND: ADP TREATMENT STRATEGIES

Overall, the vision set out in the majority of the strategies reflected national outcomes outlined in the 'Road to Recovery' and Changing Scotland's Relationship with Alcohol; where there is recognition of the need to support and improve the outcomes of families affected by substance misuse. Little detail was provided in most cases on the level or type of support to be provided, e.g. will adult family members receive services in their own right? If so, where will this be delivered? Furthermore, no strategies identified specific services (for affected family members) which existed in their area.

Most strategies expressed a commitment to improve identification, assessment and monitoring outcomes of affected adult family members, however, only a few provided or referred to a detailed action plan of how this would be achieved. In most areas there was a clear commitment to work with Scottish Families Affected by Drugs to help establish or improve accessibility (in cases where groups are already available) to self-help or recovery groups. At the local level, which in some cases had been informed through a local needs assessment, there was strong recognition of the importance of engaging with family members; having family member representatives or forums to better develop services and inform future priorities of the ADP. Furthermore, some strategies mentioned delivering overdose prevention training to family members.

In summary, the overall picture was one of recognition of the issue of families, although the main emphasis was on children of drug users. There was much variation between plans and strategies with lack of consistent approaches in terms of identifying need, specific detail of adult family members and discussing a range of responses including General Practice, Tier 1 responses. Little consideration is given to the development of a workforce that can deliver evidence based approaches to adult family members.

KEY POINTS – TREATMENT PLAN REVIEW

- While there is fairly widespread recognition of the issue of families in the area treatment plans/strategies the main emphasis was on children of drug users rather than adult family members.
- Most plans/strategies considered involvement of family members in service planning and needs assessment but to varying degrees. The role of GPs and Tier 1 services in identifying family members and their needs was only occasionally mentioned.
- There was significant variation between plans/strategies but in general there was less focus on meeting the needs of adult family members in their own right and a lack of specific detail about how their needs might be met.
- The plans included little consideration of need for the development of a workforce that can deliver evidence based approaches to adult family members.

4. Analysis of commissioner interviews

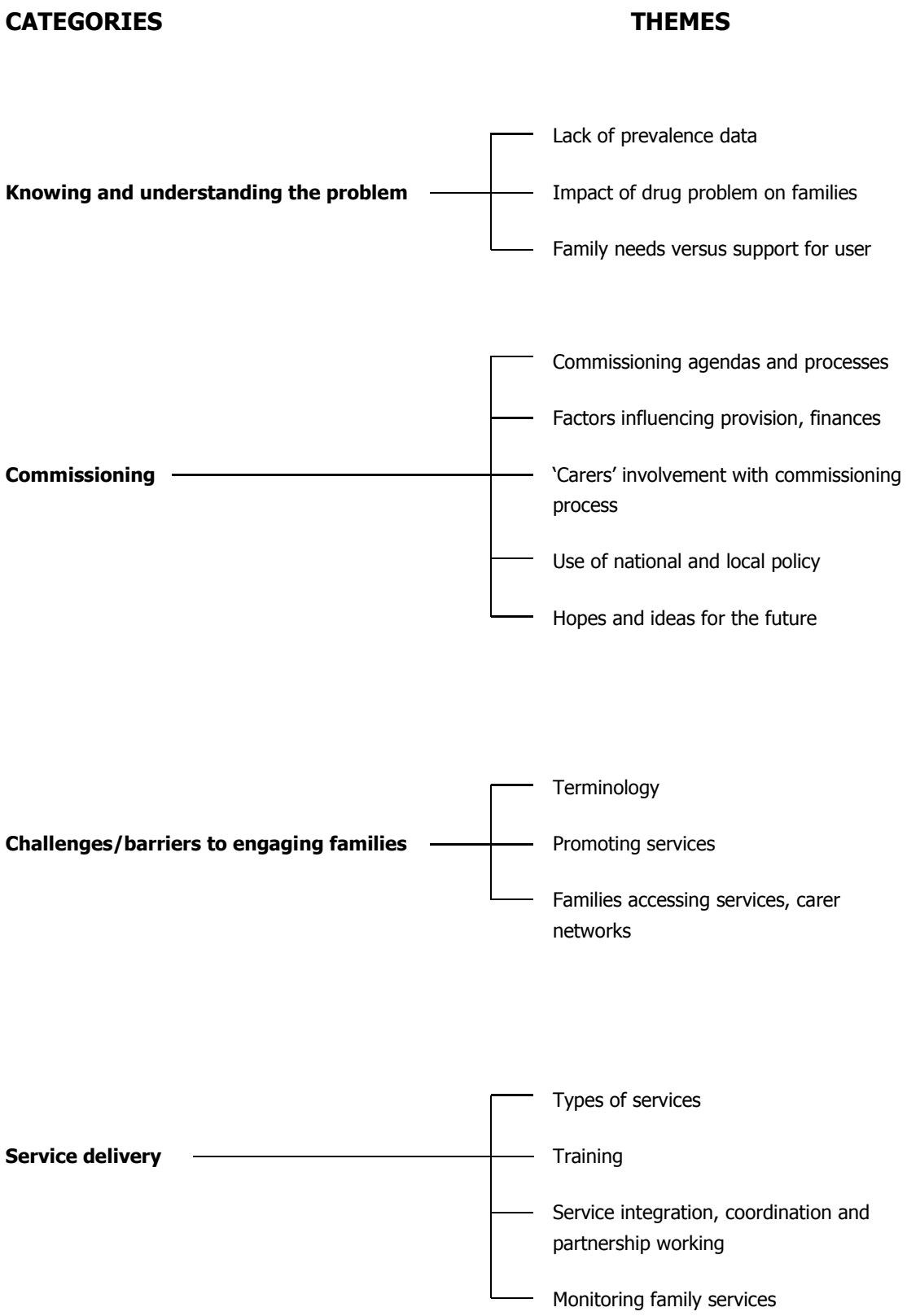
This analysis was conducted on transcripts of 20 commissioner interviews for England and eight Alcohol and Drug Partnership (ADP) coordinators for Scotland. All interviews were read by two members of the research team (LT and AC for England and GC and AC for Scotland) and notes were made identifying key recurring themes that were most frequently present in a number of the interviews. These themes were then organised into higher order categories. The researchers then worked together to finalise a final framework that included four main categories that emerged as being important from the qualitative material. Overall it was found that the themes identified in this analysis were common in both English commissioners' and Scottish ADP coordinators' interviews. There were however, a number of issues that had more prominence in Scottish interviews and are discussed later following the description of the categories that were common to both countries. The four categories and corresponding themes within each are described below. Each theme is briefly outlined with a description of the main key issues related to that theme. Illustrative quotes are included to reflect what interviewees said. Categories and themes are also summarised in Figure 1.

The four categories identified were: 'Knowing and understanding the problem'; 'Commissioning factors'; 'Challenges/barriers to engaging families' and 'Service delivery'

4.1 KNOWING AND UNDERSTANDING THE PROBLEM

Commissioners generally had some grasp of how substance misuse can affect families and of the importance of supporting families through services, as well as the link and importance of families within the recovery agenda, although there was much variation. Some commissioners appeared to understand the range of needs that family members have and how these could be met. There were three themes within this category that are outlined below.

Figure 1: Categories and themes from commissioner/ADP interviews



Prevalence: How many family members affected are there in the area?

What appears evident, from interview transcripts, is a lack of precise knowledge and detail about national and local prevalence and lack of data on the size of the problem at a local level that could guide provision. There is some mention of needs assessment but little detail with reference to 'how many families' resulted from these initiatives. There were attempts to carry out needs assessments in a small number of areas but examples are very few and limited in the robustness of the approach which was mostly geared to drug user prevalence.

Overall, the sense was that the problem is still very much under-estimated and the response does not match what we know from prevalence estimates of the size of the problem (e.g. the UKDPC phase 1 study, Copello et al., 2009) and what is needed.

"We have prevalence data in terms of drug problems – we know something about our penetration rate in terms of that. In terms of the number of families we don't know an exact figure"

"In general it's about 2,200 in treatment … One would have thought a significant proportion of them would have had families and friends (with issues)".

Most commissioners talked about the difficulty estimating the numbers of family members affected in their area. Whilst most recognised this to be a significant and large problem, available accurate estimates were absent for all areas interviewed. Most commissioners relied on extrapolating figures from the numbers of drug users in treatment that were more familiar to them through various estimate exercises that had been conducted.

"we've yet to be able to get that data anywhere....there's huge gaps in terms of planning around family needs".

When attempting to estimate family members some interviewees related this to an estimate of drug users that were parents on the assumption that this *"indicated the presence of a family unit"*. Other interviewees used various algorithms that varied from using a ratio of 1 family member affected for every drug user, in another case the figure was 2 and, in yet another example, 3 family members per user.

Overall, despite the weakness of the knowledge on prevalence there was recognition of the significant size of the problem. The one possible exception was one interviewee who felt that the drug users in treatment were mostly single, isolated and had poor contact with their families and other social networks.

Impact of drug use problems on families

Specific description of the impact of drug use on adult family members was largely absent from interviews apart from general references to the fact that families are

important and more particularly within the 'recovery' agenda. There were some exceptions for example one area reporting a survey of affected family members that appeared to confirm the kind of symptoms of stress reported in the research literature.

"We had about 40 [carers who responded to the survey].....75% said it impacted upon their working life, 100% said it had a deleterious impact on their family finances, 55% said their social life and 65% had a fear of leaving the person they were caring for at home....where people sought help, 50% saw their GP, 25% a generic carers service and 25% nowhere at all."

In other interviews, the impact was described in terms of what the result of drug use may be on family units.

".....the significant factors which would show up in such a family would be substance misuse and domestic abuse and offending and mental ill health..."

Family needs versus support for the user

There appeared to be a theme present in the interview transcripts whereby two needs related to adult family members were described. One was the recognition that families have got needs in their own right and the other the recognition of the importance of families in supporting the recovery process of the drug user. Whilst these two needs are not mutually exclusive, it was rare for interviewees to stress both as opposed to just one or the other, with most interviewees emphasising the role of families in recovery, perhaps as a result of recent developments of this concept in UK drug treatment. There were references to family members being integral to treatment and the need to involve families as indicated by the 'recovery' agenda but these statements on the whole tended to be broad, vague and lack specific detail on how this could be done:

'...getting a more recovery focussed treatment system that works alongside families as well as the individual who's using the drugs.'

'I am expecting some of the model of treatment around including, involving families to be incorporated within that but that's not specific to just the family members alone....'

There were some interviews, however, where a range of needs were articulated more clearly

"...there's their needs in their own right as family members and carers and there is what the whole family gets from the treatment services [for drug users]"

KEY POINTS: KNOWING AND UNDERSTANDING THE PROBLEM

- The problem of adult family members affected by drug use of a relative is still very much underestimated
- There needs to be more clarity in terms of identification of adult family members as a specific group of people with needs in their own right e.g. partners, parents, grandparents
- Once identified as a group, robust estimates of prevalence need to be established for each particular area
- There needs to be recognition that adult family members have two related but distinct needs. These include receiving help and support in their 'own right' as well as where appropriate supporting the drug user's treatment.

4.2 COMMISSIONING PROCESSES

A number of themes were related to this category and are outlined below.

Commissioner agendas

An important theme emerging from the interviews was the need to get family members/carers issues on the agenda to start with and how it was getting easier to promote family issues now and this is opening more doors to commissioners.

There was a general sense that commissioners want to do more, but have their own boundaries and parameters which limit what they can do. Many try to be supportive and show flexibility and creativity so more can be done by working with other services that may not be part of their commissioning portfolio e.g. generic counselling services, social care etc. There is evidence from some commissioners that they are sometimes able to be flexible and support family work even when it is not part of service contracts.

An issue that emerged through the majority of English interviews was the fact that most areas were undergoing a process of re-tendering and re-commissioning of services. Descriptions of services *'going out to tender', 're-tendering tiered services'* and *'our services have just been re-commissioned'* are plentiful in the interview transcripts. Commissioning cycles and re-commissioning processes brought opportunities but also injected uncertainty and fragility into services. There was a sense that services to families were at particular risk in some areas because of re-

commissioning. However, there was a clear sense from other commissioners that they were using the opportunity (when reviewing contracts and re-commissioning) to put more in place for families with new models and contracts (links here in particular to the recovery agenda). There was also an example of one area that has gone back to the drawing board to think about 'carers'.

The variation is illustrated in the next two quotes. In one area, the perception was that:

"There is always competing priorities and that's why carers is never number one and makes it to the top of the list"

Whilst in another area the intention was to place 'carers' at the centre of the treatment system or see them as 'partners' in the treatment enterprise:

"…part of that treatment spec is to put carers and service users right at the middle of the treatment system'…we've viewed for some time the carers and family members as being one of the key stakeholder groups……to have family members as "partners" in treatment services."

However, there was also recognition in some areas that work was at the early stages:

"… in terms of family members and things we're just really getting going…"

One commissioner felt that more guidance was needed from national structures:

"I don't think … traditional commissioning processes are well placed to provide the services that this cohort of individuals requires. Or if they are, I haven't found a way of doing it yet. And what would be really helpful would be if there were a national advisory service who could offer support to commissioners to develop a service of this nature, based upon a collection of good practice examples. Because, you can't reproduce any one scheme in another area uniformly, because other areas are all so uniquely different. And the parents and carers that we are dealing with are all so uniquely different that reproducing one scheme in another area, in my experience doesn't always fit".

The overall picture appears to be one where the adult family member area has acquired more prominence in the past few years but there is still uncertainty as to what is best to commission, where family services fit within priorities and re-commissioning and limited acknowledgement of the full range of needs that family members have. The latter was still the exception rather than the rule.

Factors influencing provision, finance

There were a number of references here to funding issues, rural distribution of the population and prioritising high deprivation areas. Most were not solely related to

family members but to drug treatment in general. There was a sense in some interviews that when the treatment budget is tight, family member services may not be a high priority. In addition, there was a sense that *'local commitment'* was influential in determining services available for family members. There was little mention of level of need or prevalence influencing decisions apart from reference to what is evident in a particular area through local knowledge:

"....we go very much with what's being presented and what we hear from service users…"

The main issue that emerged within finances was the availability of funding to develop family services. There was a sense here in the data that funding for family services within drug treatment resources created challenges. A reference was made by one commissioner to the need to use *'drug treatment money'* to fund family services whilst in another area some under spent money was used to create a post to work with families in the hope that the funding would become long term later on. The picture is one of variation with some commissioners recognising the shortage of funds:

"…but I suppose personally in terms of carer services we haven't really probably put as much money in to those services…"

There was one mention of there being a proportion of the drug treatment budget to be used to support families in the past but that no longer applied. Linking the findings from the qualitative interviews to those of the on-line survey reported elsewhere (Copello and Templeton, 2012), the overall picture is one where established services appear on the whole to feel secure about maintaining current provision but there may be more uncertainty in some areas with regards to new initiatives and developments for family members. In terms of maintenance of services it is necessary to consider this in the context that services are mostly small and hence the possibility of reducing funding further is limited.

Carer's involvement with the commissioning process

Carer involvement was recognised as important and many areas were actively trying to develop this, as was evident from the treatment plans and strategies reviewed earlier. In fact carer involvement was one of the most consistently identified issues in the plans and strategies. However, it seemed that in practice this was on a small scale, depended on a particular individual or circumstances in each area, and relied on a small number of champions. Hence this might be fragile and dependent on the specific individuals being able to stay involved.

Getting carers involved at a strategic level and the roles and opportunities associated with this, together with the benefits this could provide to commissioners, were identified. Alongside this there was also some recognition of the support/training that carers need for such a role.

There were ample examples of references to carer involvement in the transcripts from interviews with most areas managing to have some input, although arrangements varied significantly. Involvement appears to occur in a number of ways and varies across different areas. At one level, there are examples of good communication between commissioners and family member services as part of partnership arrangements

"… [carer services] are part of that recovery partnership…– and then if I need to ask them about anything I can always give them a ring."

"Our carer representative…has played a very important part and we've been happy to have him on things like needs – Annual Needs Assessment Expert Groups, so he's raised the issue there. He's been a member of our annual Planning Forum for our annual planning exercise and he's obviously raised the issues there and we've been very happy for him to do so….More importantly they have to report them to our carer representative who happens to be very fierce on checking this data very helpfully. Pushing services to be very accountable for how well they are delivering this agenda. The carer representative is part of the expert planning group."

The examples above contrast with other areas where involvement was not so successful and productive

"…we have got a carers' user group but to be perfectly frank, although we've tried to get them accessed if you know what I mean, we've tried to get them integrated and accessed it hasn't been entirely successful."

"Very difficult to engage [family members] in anything formal because of the issues of sitting in a room saying that you can't manage your life…"

Other ways of involving and consulting family members were also described. Two areas reported organising conference events bringing together family members and listening to their views

"…we had a big carers day in a hotel where people could just come in and give us their views.....we got about a couple of hundred carers through on the day and they gave us all their views of what they wanted and then based on that that's what we re-commissioned....we just started with a blank piece of paper technically....we looked at best practice, we listening to the views of carers, listened to the views of people who wouldn't come in to the service and why they wouldn't come in and then started again."

"…there is a conference across the whole area, which came out of carers (during the consultation) wanting to tackle the issue of confidentiality and information sharing and what this means for carers. Carers are saying that it's very hard when they can't get information from services about their relative's treatment

etc., yet it's the carers that are left dealing with the situation at home. Carers are saying on a very basic level that, "I just want to know they're ok."

Overall, the interviews suggested that there is a range of ways of involving carers and there is much to learn from areas where this has been implemented successfully and effectively. Clearly some areas have found this more challenging. It was apparent that engagement in terms of influencing services worked well where there was a formal arrangement where a family member representative (which was usually someone with personal experience of being a family member) attended key meetings including treatment planning, monitoring and reviews and the system allowing their views to be recognised and listened to. Carer conferences and events were also felt to be useful and productive.

Use of national and local policy guidance

All commissioners were asked about the influence of national and local policy in the development of family member services. The first theme that emerged was that of the contrast between national policy and guidance and local policy. In some areas the commissioners felt that local policy or local needs were more influential in determining the type and volume of services delivered. On closer inspection whilst there is acknowledgement that national policy and documents have influenced decisions to some extent (with the most commonly mentioned documents in England being NTA guidance, NICE, Adfam and the drugs strategy; in Scotland there is ample mention of the 'Road to Recovery') it is important to note a number of issues.

First, as stated already there is a tendency for commissioners to acknowledge that families are important in a general way, i.e. supporting user treatment, increasing likelihood of positive outcomes but less evidence about the recognition of the needs of family members in their own right. The latter recognition seems to be more influenced by local issues such as the availability of family members at commissioning level, the commissioner background or other local service development influences. When considered as a whole, these findings suggest the need to increase recognition of the family members needs in their own right to a higher extent and also provide clearer guidance on what may be a template for comprehensive family services across areas. This is also related to the initial theme of lack of clear prevalence data available upon which to make decisions.

In line with other themes, the picture here is one of varied initiatives that depend more on local circumstances that clear guidance, despite there being a higher level of recognition of the problem at national level than in previous years. So for example, whilst one area is focusing on the lack of Behavioural Couples Therapy as recommended by NICE, another area is trying to incorporate families in the recovery process without clear direction or vision, and yet another area is focused on the provision of whole family services and another focuses on families in their own right. One could suggest that there is still some way to go in developing a clear and

comprehensive understanding of the impact of drug addiction upon adult family members of drug users as opposed to more rhetorical general statements about the importance of family members.

In terms of local policy there is little more than broad and brief mention to local policy and lack of evidence of a coordinated approach to consider various local policies that have relevance to this group together e.g. substance use but also carers policies. There is some evidence that more work is going on in some areas e.g. the development of Family Strategy in one area – although this is generic to families and not specific to substance misuse – and the approach in one area where a person was identified to be a central point of contact for all family work. Overall, the impression is that local need and commitment has more sway than national policies and agendas.

Hopes and ideas for the future

In this section the findings mirror the picture described so far. Most areas will have some idea of a gap in their provision and these vary. Two areas suggested the development of web-based methods to deliver information that is accessible for family members and does not require presentation at a service in person. What was interesting was the large number of areas particularly in England that described the development of self-help as being one of the ideal areas for increased provision.

"...there needs to be instant available web access, or availability of something like 'Facebook', so that people can immediately access the right information."

"We're encouraging the growth of mutual aid groups as much as we can. We're getting like-minded people together and we're running a Recovery conference to try and work for mutual aid."

These intentions do not appear to be based on any research among family members to identify preferred means of accessing or receiving services, although having a range of options is likely to be important. It is perhaps unsurprising in the current fiscal conditions that the emphasis is on services that whilst important and clearly needed, are mostly relatively less costly to deliver and therefore do not have significant financial implications.

KEY POINTS: COMMISSIONING PROCESSES

- There is much change taking place with re-commissioning of drug services. Commissioning processes should support the maintenance and development of adult family member services. This should be clearly identified within the commissioning agenda
- There is uncertainty as to what is best to commission. Consideration needs to be given to a national advisory service to guide commissioners in terms of adult family member services
- There are examples of successful involvement of family members in the commissioning and service review process but these vary. There should be standard ways in which family members can engage further with these processes across all areas.

4.3 CHALLENGES/BARRIERS TO ENGAGING FAMILIES

There appeared to be a general sense that engagement is a significant challenge for several reasons e.g. shame, stigma, the attached likelihood of offending and also family members not identifying themselves as family members affected. Four themes were identified and are described in more detail below.

Terminology

The terminology used to refer to family members was inconsistent with the use of the term 'carers' by a significant number of the interviewees but the recognition that some family members may not perceive themselves as 'carers' and hence not identify their needs with some of the services on offer. The terminology used to describe family members was perceived to be important in a number of ways. One was that using the term 'carers' may help to de-stigmatise family members by seeing them as carers in the same way as those carers of other relatives with problems e.g. people with dementia. It also, has the potential to facilitate access to mainstream carers' services and carers' assessments. The problem, however, with the use of the term is that as stated family members do not always perceive themselves as carers and this may act as a barrier to help-seeking and accessing generic carer services.

"...because of the stigma around alcohol and drug use tend not to identify themselves as a carer. Also the person with care needs, the actual drug user, may deny that they need or are getting support. So in effect they say they don't have a carer, so there's a two way thing here."

There were several comments that service users often do not want families involved; or do not have contact with, or good relationships with, their families, all issues that seem to affect engagement, although this should not prevent provision of services for family members in their own right although initial identification from drug users may not be possible. At the more extreme end there was some use of language that could be perceived as judgemental to describe family members or their actions e.g. *'co-dependency'* and *'collusion'*. In extreme cases the need of family members and users appears to be perceived as irreconcilable and in opposition, although this is seen in only a minority of cases.

Promoting services

"What would help family members access services? - "Knowing what's available; how to access it and when to access it."

While the statement above reflects an aspirational view, the reality offers some contrast. Commissioners talked about needing to do more to promote services and to engage family members. Some talked about the need to get out in to the communities and to do more with for example GPs (and more generally at the Tier 1 level). There were several comments about working more at the community level.

"....we've advertised in Primary Care services – you know – GP services, all that kind of thing and people – it's taken a while for people to come forward and request support". "We're trying to get GPs on board with promoting services (carers) because if people are going to them with stress or ailments or anything else because they're having to carry so much through supporting a drug user then the GP is in a perfect position to have a conversation with them about maybe getting them some support"

"A lack of awareness of the services doesn't help. We even – at the moment we discover that a lot of GPs are not aware of services we have on offer. So even if somebody goes to their GP which might be a typical point of reference for many families it's more than likely that their GP won't know who to point them in the direction of."

"We did a survey not long ago that we circulated….asking questions like did your GP refer you to a self-help group? None of them did so these are the issues we are raising."

"....I think it's fair to say that there is a greater recognition but I still think we've got a lot to do....[for all that] there's a lot of activity I think it can be

piecemeal, I don't think we have necessarily advertised and have a robust referral and collective pathway, so obviously some families can fall into a void ...we need to get our act together and....we're trying to work closer with social care to integrate our services more effectively..."

Some commissioners talked about the need to engage and support family members earlier i.e. before the crisis points and to do more to support family members where the drug user was not engaged in treatment. There was some awareness of the need to consider particular groups of family members such as Black and Minority Ethnic (BME) groups, grandparents, families of offenders. A commissioner commented on '*proportional representation'* of BME groups in treatment.

A theme in some areas in terms of reach of services was a need to support both family members whose relatives are engaged in treatment **and** those who are not, and a sense that services and commissioners are better with the former than the latter. Linked to this was the need to recognise that family members need support available for more than a few hours once a week.

Families accessing services and family networks

There was an awareness of the need to consider how families access services, e.g. the challenge with the vastness of rural areas in some areas, the 'tribalness' in another area, or the concentration of services in central parts of one area (with nothing available in the outlying urban areas/estates where there are likely to be high concentrations of family members).

One of the potential dangers implicit in the perceptions described in a number of interviews is the sense that family members are not coming forward for help, with an implication that this is the family members' problem as opposed to a challenge for commissioners and service providers.

"They don't just come forward very easily. And the other thing is assuming that people will actually ask – but it takes people a while to actually ask for support because of the issues in coming forward".

There is also mention of doing more to get 'carers' to develop their own networks.

KEY POINTS: CHALLENGES/BARRIERS TO INVOLVING FAMILIES

- It is important to consider the impact of 'shame' and 'stigma' in preventing adult family members coming forward and requesting help. Strategies should be adopted to minimise this impact
- Terminology to describe adult family members, such as 'carers', can sometimes prevent self-identification and recognition by this group and prevent access to valuable services e.g. carer services. These services should be promoted more clearly in relation to this group
- Adult family member services where available should be promoted more actively both in terms of target recipients of the services but also other more generic services including primary care
- There are challenges in more rural areas to achieve engagement of adult family members in services

4.4 SERVICE DELIVERY

There appeared to be real diversity in what is available in different areas. The support apparent is very wide ranging but is rarely mainstreamed and is quite 'piecemeal', something which commissioners do accept. Four themes were identified and are described below.

Types of services

This category included references to a range of services that were reported to be delivered to families as part of the local treatment system. Consistent with the web survey responses (Copello and Templeton, 2012), the pattern was for all areas to describe the availability of some form of support, information, signposting and advice. Some areas reported counselling and group support, although the uptake of groups was acknowledged to be very varied. Respite is mentioned, although to a much lesser extent, and finally a minority of areas described more intensive whole family provision, such as Moving-Parents and Children Together (M-PACT), Breaking the Cycle (BtC) or Strengthening Families Programmes or, at a generic level, Family Intervention Programmes (FIPs) and parenting support. There was little or no mention of structured therapeutic interventions for adult family members in their

own right, such as 5-Step Method. The spread of services within individual areas is explored further in the next analysis that looked at 8 separate areas in England and the same number in Scotland.

An integrated partnership service (NHS and non-statutory sector) in one area appears to be a rare example of a fairly comprehensive service which has been thought through by commissioners. Within this arrangement, statutory and non-statutory providers are formally organised within a partnership with structures for monitoring work whereby one provider partner collects and reports data on adult family member activity on behalf of the whole partnership. The partnership works closely together to offer easy access to support and treatment for anyone whose drug use has become problematic as well as family members affected. There is a single point of contact for initial assessments.

The overall picture however, when considering all interviews is that the services being commissioned appear not to match what one would predict would be the level of need, for example only one (specific) small part-time service in one area. However, the lack of local prevalence data on family members specifically makes it difficult to highlight these gaps.

There seems to be a lack of specification of 'evidence-based' interventions (a small number of instances but clearly a gap). There is more evidence for this on the provider interviews and the analysis by area. Linked to this lack of evidence based approaches available there is recognition from some commissioners of the need for specific expertise and training. However, it seems that there is not a lot that is going on in terms of specific training in working with families, and numbers which are being trained are quite small which limits what can be done.

Training

Descriptions of training varied. Most reports included mention of training requirements and training organised for the area or specific workers. Three area commissioners in England made reference to DANOS standards as being the guide in terms of requirements of the workforce. The dominant training appeared to be substance related or generic counselling as opposed to family focused, apart from a few exceptions. Where family training was mentioned it usually involved one off events as opposed to ongoing planned initiatives. There was reference to Adfam and Action on Addiction training in a few English areas and STRADA in Scotland.

Service Integration, coordination and partnership working

The overall perception from interviews was that joined up working was inconsistent with very few areas showing a well organised and planned partnership system of working. About one third of respondents of the web survey described working as part of a partnership arrangement so this is an important area to review and consolidate. There are some examples and there is awareness and action from some

commissioners in trying to join up with other sectors e.g. generic carers services, social services (both adults and children), primary care, mental health, and domestic violence. There appears to be potential to do more with generic carers service although again there were links here to understanding that families affected by addiction may well also need specific support, and the issue discussed of attaching the label 'carers' to this group

There was also recognition of the need to work more in partnership outside of drug treatment system with recognition of the need to engage with other sectors to support families' needs e.g. debt, relationship counselling, and bereavement and the need to bridge the gap between adult and children's services and some of the challenges posed by trying to implement this.

"…we can send people to their GP, mental health service…debt counselling, relationship counselling…there is no process of obtaining feedback on the outcome of any referrals…"

In one area, it was reported that the identification of someone to act as a coordinator of family services was significant and important:

"…she's going to be co-ordinating all our family intervention side bit for us and working with a senior practitioner to determine which level of intervention is required for that family unit.....so it means we've got one central person who will co-ordinate all the family interventions in XX and work that way....we just wanted to make sure that we got best value for our money and people weren't going to the wrong level of intervention....cos we did a mapping exercise you know and social services do a little bit and other people do a bit, so we kind of said let's go round the table, let's map what we've got, let's put them into a hierarchy, so low level, medium level or high level, cos we don't want people to go straight to high level if their needs could be met [with] a lower level intervention, it's about getting best value for money with what we've got in the area....."

Monitoring family services

Generally monitoring came across as vague and lacking in detail from the commissioner interviews, with a number of interviewees describing this area as *'work in progress'.* The data collected is basic, there is variety in what is done, and there is variety in what is known from such data and how it can be used, yet in some cases even at this very basic level the data collected seems to go beyond what is required nationally.

In some cases monitoring is done by different sectors of commissioning and communication may be weak and there is mention of the challenges that this lack of integration of the different components of services create. Some commissioners mention targets and how helpful it would be to have targets for carer but there is

also recognition that setting targets for family members is challenging. There is little mention of outcomes.

The picture here is very mixed but overall the systems for monitoring do not appear very well developed. Some of the description of monitoring arrangements is general and not specific, in other instances; the treatment system is monitoring one aspect of the help for family members. What is not evident from the interviews is a well thought out system of monitoring the work and support offered to family members that takes into account the various ways in which family members access help, their range of needs as described in the previous section, takes into account prevalence. Where targets are present the numbers indicate low volume in relation to likely prevalence.

KEY POINTS: SERVICE DELIVERY

- There is low implementation of named evidence based interventions both for working with family members and also engaging their support in the treatment of their drug using relative
- Plans should be developed to achieve a competent work force to respond to the needs of adult family members, with clear training plans and targets
- Despite some examples of integration and partnership working, overall there is still much room for improvement in terms of well-developed methods for joint working across specialist and generic services
- Monitoring of activity with adult family members need to be either developed or improved in those areas where some

4.5 OTHER ISSUES IDENTIFIED IN SCOTLAND

As described, the analysis was conducted on all commissioner and ADP coordinator interviews and the framework and findings emerged from both countries. There were however, a number of issues that were more prominent in Scotland from interviews with ADP coordinators.

Self-help groups were mentioned by all interviewees, either, in some areas, where these were quite successful and working well with support from services, or in other

cases, difficult to maintain or develop. Whilst it is not possible to know whether the use of self-help groups is not present to the same extent in England, it was noticeable that the Scottish interviews made more mention of this form of help and of organisations devoted to the support of group activity including promoting, setting up and maintaining support groups.

The document **'Road to Recovery'** was mentioned by all interviewees as being influential in the thinking about families and development of services. There was no similar English document that was so consistently mentioned by commissioners. Having said this, the emphasis from the document was more geared towards involving families in the recovery process with less detail of family member needs in their own right.

In some of the Scottish areas, the **extremely rural** nature of the area posed a number of significant challenges; with difficulties for family members accessing services and stigma also acting as a potential barrier in these areas, where the risk of other people in the area (e.g. neighbours, people from the same community) finding out about the problem appeared to be prominent and perceived as a greater barrier in the smaller communities. Also, self-help groups had often failed in some of these areas and alternative forms of help such as those that could be accessed anonymously over the web were mentioned as potentially helpful.

The interviews with the Scottish ADP coordinators all included references to **generic carer services** and in some cases the relationship between specialist and generic services appeared to be robust. There were also areas where the uptake of generic carers' assessments was low however and this was linked to some of the issues identified in terms of stigma, awareness for family members of the fact that these services are available to them.

The role of the Scottish Families Affected by Drugs (SFAD) was mentioned in a number of the interviews as providing support and guidance and valuable help setting up groups.

Whilst there was recognition of the influence of the 'Road to Recovery' document, there were also references in some areas that services pre-dated the strategy and hence were not so much influenced by policy but local needs and influential family members.

Finally, there appeared to be recognition that the children affected by substance misuse agenda had made a significant impact in Scotland and services for children were more robust and developed than those for adult family members.

KEY OVERALL POINTS FROM COMMISSIONER/COORDINATOR INTERVIEWS

- There is widespread recognition of the fact that drug problems affect families. This was consistently recognised across all interviews with only the minority not identifying this as a key issue.
- However, there is lack of prevalence figures or estimates.
- Needs assessments, where conducted, tended to be weak on the assessment of the level of adult family members affected and no prevalence data was quoted in any of the areas. This hampers consideration of the adequacy of provision.
- Commissioning services for adult family members pose a number of challenges. Identification, recognition of the full range of needs, development of a range of responses, funding and joint working and coordination are all issues that need to be addressed to different degrees in all areas.
- The use of the general term 'family' and general statements about family work obscure the lack of a clear view of different impacts on different family members and recognition of the range of different service responses needed.
- It is particularly important to distinguish the needs of children on the one hand and the needs of adults family members on the other, with the latter having needs in their own right as well as being able to support drug user treatment. All strands need to be identified or services will not be comprehensive.
- Identification, visibility and accessibility of services and responses within more generic services need further attention and development.

5. Analysis of complete interview sets for areas in England and Scotland

In order to explore the service provision in more depth within various areas, further qualitative analyses was conducted by looking at sets of interviews within a range of areas in England and Scotland. This analysis proceeded sequentially in 2 steps; (i) initially sets of interviews from 6 areas (4 in England and 2 in Scotland) were analysed in detail. The main result of this stage of analysis was the production of a coding framework. The framework comprised of 3 main categories namely 'Understanding, strategy and vision'; 'Implementation' and 'Treatment systems'. Each category included a number of themes. This framework was subsequently used in a sample of 8 areas in England and 8 areas in Scotland. The main findings from the analysis by area are described in the next sections under headings for each category. The summary analysis for each area is illustrated in tables 3, 4 and 5 for England and 6, 7 and 8 for Scotland. No area is named in this report; each area was assigned a number. Specific areas or services will only be identified later in this report in order to illustrate examples of practice and only where consent was obtained.

The areas used for this analysis for England included 2 inner city; 3 cities; 1 town and 1 rural area. Overall, the analysis involved 8 commissioner interviews and 27 service provider interviews. The sample included at least one area from each of the regions that formed part of the sample. To some extent the selection of the areas was driven by pragmatic considerations. We started the analyses with some of the areas where field work had been completed and as we progressed, we attempted to include areas to represent the various geographical regions as well as different population densities. The selection method is less problematic for the type of analyses we conducted based on qualitative material. It is possible that we missed some extreme examples (e.g. extremely poor provision or excellent comprehensive provision areas) but the consistency of the results across the whole project and the various components suggests that the areas covered are likely to be representative of most of the country.

For Scotland the analysis was conducted on all 8 areas that were sampled and it included 3 cities, 2 semi-rural and 3 rural areas. Overall, the analysis involved 8 ADP coordinators and 29 service provider interviews. A more detailed breakdown by area can be seen in Appendix 3.

The detail of the findings for each category can be seen in the tables whilst an overview of the main findings evident for each category is outlined below.

5.1 A COMPARISON OF AREAS IN ENGLAND

Understanding, strategy and vision

This category includes what interviewees said about the extent of the problem, the needs of families and about a vision and strategy for the area and is summarised in Table 3. One of the main findings here is the variation in the level of understanding of the problem that was evident between the different areas. Whilst within all areas there was broad recognition that family members are important, can be affected by drug use and have needs of their own, the extent to which this translated into actual service commissioning and delivery varied greatly. There was a tendency for areas where the commissioner's view was less developed to also have less developed services. At one end, for example within Area 2E, there was a view that family members should be seen as 'partners' in the treatment enterprise, and at the other end in Area 1E the perception was that the 'carers' agenda was unlikely to become prominent in the future and in Area 4E that there is conflict between the needs of family members and the needs of users. Similarly, some commissioners had a much clearer view of the fact that family members have a range of needs and this manifested itself later in the range of service provision. Area 3E, for example, perceived families as having 'low', 'medium' and 'high' level of needs and service provision and was then attempting to respond to each of these levels.

In terms of vision, again there was much variation, even in this small sample. In some cases there was no clear strong vision evident from the interviews, yet in other cases, such as Area 2E, there was a clear strong statement of wanting to see families as 'partners' in the treatment enterprise. Despite mention being made of strategy, there was no evident formal local family member and substance misuse strategy in any of the areas apart from mention of a generic family strategy in area 6E.

So, in summary, there was much variation between the 8 areas in terms of understanding and vision. Whilst there was little evidence of outdated models of families being perceived as a problem and most areas recognised that families had legitimate needs, the extent to which this was seen to translate into initiatives and service provision varied as well as is discussed in the next section.

Table 3: Understanding, Strategy and Vision: English areas

	Area 1E	Area 2E	Area 3E	Area 4E	Area 5E	Area 6E	Area 7E	Area 8E
Knowledge and Understanding of the problem	Knowledge weak Perception that drug users have little contact with families/are single Difficult to involve fms when needs are complex 'To be honest it is not one of our main *focus* at the moment' 'Likelihood of carer involvement creeping up the agenda is limited'	Good robust knowledge and positive orientation. Statutory/non statutory partnership set up with fm response considered across the partnership. Seen as an important area of work. Want to see developments in this area	Good grasp of the problem at a local level. Mapping exercise has been conducted. Robust consultation with users and carers. Carer's event attracted about 200 fms. Provided the platform to develop current provision. Fms needs seen as : 'Low', 'Medium' and 'High' level and services designed accordingly	Perception that a service is provided but there is conflict 'potential conflict' between fms and users. Use of judgemental language including 'colluding' 'co-dependency' that may act as barriers. Recovery acknowledged as an important driver	Understanding and knowledge of the problem not as developed as other areas. General statements about carers' importance and carers' needs. Important for adult carers to increase knowledge of the drug problems. Seen as 'work in progress'. No real knowledge of numbers of family members in the area	Appropriate grasp of the needs of family members. '..there's their needs in their own right as family members and carers and there is what the whole family gets from the treatment services' Perception of a wide range of needs of family members. No data on prevalence available	Recognition of the importance of family members. Prevalence unknown but recognition of higher level of prevalence than services could meet. Funding limits family members service provision a situation more acute in current financial circumstances	Treatment system going through significant reorganisation. Family members are important and need support in their own right as well as involvement in the treatment of drug user. Poor data on prevalence. Needs analysis to be conducted for users and family members

Strategy and Vision	Weak. Not a priority. Perception of Barriers. 'We need direction from above'	Robust. Integrated into treatment reviews. Need more for families in their own right. 'Family members as partners in treatment'	Family members seen as important and needs recognised. Fms needs need to be met and constantly reviewed	Weak, not evident from interviews. Engaging fms perceived as difficult	Identified the need to consider carers but no indication of specific plans or initiatives based on estimates of prevalence and information	There is a general area family strategy and also developing a 'Drug and alcohol family strategy' Gaps identified. Important for services to work together.	Some services available. Ideally would like to see a more comprehensive family service but funding is limited	Families seen as important in treatment system. Trying to build a response in new services Principle underpinning recent commissioned changes included attempts to increase capacity recognising unmet need for family members

Implementation

The findings from this category are summarised in Table 4. This includes the levels of service provision for each area and the perceived drivers that influenced the current level of provision. The types of service are also discussed when comparing provision to the template from the UKDPC phase 1 work in the next part of this analysis. Overall, here again, there is a lot of variation. What is most striking about this data is the fact that there seems to be little similarity between the areas beyond the basic provision of advice and information. Some like Areas 1E and 4E appear to rely mostly on one service. Others like Area 2E aim to provide a range of responses across the drug services within a partnership arrangement. Area 3E appears to have a range of services that can provide a response but integration between the various services appears to be weak. What seemed clear also is that the level of services offered is not adequate to meet need, particularly taking into account prevalence estimates from UKDPC phase 1 work.

In terms of the drivers influencing provision, almost unanimously, it was felt that local needs or 'demand' were more influential that national policy or guideline. However, one difficulty is that given the lack of local prevalence data and the fact that many family members find it difficult to come forward and ask for help, the reliance on this type of data is likely to be problematic. Area 3E provided a good example of consultation with 'carers' that involved a large number and led to successful developments. This contrasts with Areas 1 for example where engaging family members in consultation processes was perceived to be a significant challenge.

In summary, provision across the 8 areas revealed a high level of variation with little rationale for what services were provided apart from reference to local need and demand yet with limited available data on local need.

Table 4: Implementation: English areas

	Area 1E	Area 2E	Area 3E	Area 4E	Area 5E	Area 6E	Area 7E	Area 8E
Services	-1 Family Service that delivers 1 to 1 No joint working -Main stream services have just received 'Family and friends' training	Across partnership -Face to face support -Guided self-help -Care-planning -Information -Workshops -Fm clinics with professionals -Holistic therapies -Respite/social activities -Naloxone	-Individual face to face support -12-week rolling programme -Peer support groups -Residential week -Intensive fam. Prog. from 2012 -Telephone helpline -Generic services -Generic couples therapy	-Counselling -Complement. therapies -Respite -Information -Signposting -Face to face support -e-mail support -Peer support	-Regular self-help group -one to one support For up to 12 weeks -Counselling for family members	-Intensive whole family support service -Structured counselling -Newly commissioned whole family service	-1 to 1 counselling -Support groups -Respite -CRAFT (Community Reinforcement and Family Training) -Involvement of family members in user treatment	-1 to 1 support -Group support -Advocacy -Information and Advice -Telephone support -Peer support (early stage and mostly focused on drug users) -Involvement of family members in drug user treatment
Developments influenced by	Does provision reflect prevalence: 'No idea'	Local needs rather than national policy	Local needs identified through consultation. Perceived good provision for current identified needs	Local drivers more than national policy/guideline	Local developments Limited awareness of National guides or prevalence	Influenced by NTA guidance, 'Think family', Adfam guidelines and local need	National documents including NTA, 'carers guidance' and Adfam guidelines. Also carer related policies	National guidance and policy including NTA, NICE , Drug Strategy, '…not one overarching document'

Treatment systems

This category was concerned with issues of treatment delivery and the systems supporting treatment delivery and the findings summarised in Table 5. In general, one would predict that the more robust the arrangements for supporting implementation and delivery of adult family member services and support, the more coherent and robust the response to family members will be in a particular area. The overall category included: monitoring; outcomes; assessments; pathways between services, communication, training and the presence of a family member representative for the area.

Here again, as in previous categories, the overall picture emerging is one of variation and inconsistency. Only Area 1 specified a target of 120 families per year and this was linked to the main service provider. Other areas did not have an overall family member specific target. A linked issue is the weakness of monitoring activity for this type of work. Area 2E was probably the most robust in this regard, with a system whereby one of the services in the partnership reported family work on behalf of the whole partnership. Even in this case, it was acknowledged that the system was in development and there was much room for improvement. In the remaining areas, monitoring arrangements appear vague or very limited. Not surprisingly, outcome measurement was also poor. Some areas reported current developments of their method of outcome measurement that had relevance for family services but the closest to robust outcome measurement was within some of the programmes of work e.g. Strengthening Families Programme; M-PACT, Breaking the Cycle and not part of an overall treatment outcome measurement system.

Assessment of family member needs again was very patchy in quantity and quality. In some areas, there was a good level of carers assessments conducted, yet in others it was negligible. In Area 2 for example there was a system of assessing the needs of families every time a drug user was assessed but this was not evident to the same degree in other areas. Treatment pathways again were not clear. Area 2 had a partnership arrangement and therefore clear pathways seemed to operate well within the partnership. There was less evidence of pathways outside of the partnership. Whilst from some of the service provider interviews it appeared clear that different providers communicated and cross referred, this was also patchy and varied between areas.

Communication within the treatment system appeared to show much room for improvement. Only 2 areas had robust formal arrangements for a family member representative, 3 areas had involved family members in consultation and 2 identified this as a gap. It was clear that in areas where a family representative had a clear role and sat in key groups, the influence was a significant and an important one.

Finally, overall, training seemed to be more generic or addiction focused with less evidence of family specific training or even less focused on evidence based interventions. There was some mention of specific training events focused on families in two areas (5-Step Method,

Community Reinforcement and Family Training and Action on Addiction training) but not in other areas.

So overall, the picture of the system supporting family members' services is that it is weak, with lack of clarity on monitoring, outcomes, pathways and the extent to which services are evidence based.

KEY POINTS FROM ENGLISH AREAS

- There is much room for improvement in terms of developing a stronger understanding and vision in relation to adult family members. These vary significantly even within a small set of English treatment areas.
- Provision of services for adult family members varies also across English areas. Different areas deliver different services mostly determined by local circumstances and influence but not clearly linked to prevalence as the latter is mostly unknown. No two areas delivered the same set of responses.
- The treatment system appears to be underdeveloped in relation to adult family member services. Monitoring is inconsistent and weak and outcome measurement is absent apart from specific treatment programmes, mostly focused on whole family approaches.

Table 5: Treatment systems: English areas

	Area 1E	Area 2E	Area 3E	Area 4E	Area 5E	Area 6E	Area 7E	Area 8E
Target	120 families per year	Not specified	No target. Perceived as difficult to set.	Not evident	Not evident		Not evident	Not at present. Hope to set up
Monitoring		1 service reports on behalf of the partnership	Some records are kept but not formalised. 60-70 families per year	Not easily available data overall. 120 fms registered with one service. 8 to 10 receiving 1 to 1 help at any one time	Unclear arrangements	Some monitoring through service contacts. Recording at early stage	Some monitoring of carer services. Information 'wasn't brilliant'. Weak but looking to develop	Quarterly monitoring but mostly focused on user
Outcomes	In development	In development. Evaluation by outside agency	Not clear. Some measurement within individual programmes		Not evident	Within specialist programmes. Not central	Not evident or specific to family members	Not specific to family members
Assessment of family members	Patchy. Depends on knowledge of assessor	Initial assessment across partnership. 3 levels of fm involvement: 1.FM needs in their own right 2.Support for user appointments 3. Joint involvement in treatment	Working with Social Services to improve carer's assessments. Assessments at range of services	Carer's assessment. Low volume	Not clear. Some assessment within fm components but not in other services. Perception of conflict of interests between fm and user needs	'challenge' to develop in services for users	Within different service components	Assessment through BTEI initiative. Family members assessed as part of family focused service

Pathways	Not clear between different components of the treatment system	Good, clear within the partnership	Discussed and identified. Level of need leads to level of intervention. 'one central person coordinates all the family interventions'	Not clear	Not clearly articulated	Not formally described but robust contact between services	'Silo working' up to recently. Network is bringing organisations and services for carers together	Appear to be clear except some overlap between services.
Communication	Much room for improvement	Good, through partnership management groups	Good between services. Good with carers (6 monthly reviews)	Patchy. Some uncertainty about the future of services. Not much communication between user rep and carer services	Some communication but also some conflict		Network is having a positive impact in promoting communication. Appears to be working successfully	Appears to be adequate in relation to family member services.
Family member/carer representative	Not evident	Very good person. Highly influential. Sits on key groups	Not clear if formalised. Some fms developed services.	Not evident	Recent appointment. Works part of the week. Seen as potentially very important	Attempts to involve fms at every stage of commissioning	Family support worker contributes towards strategy development and organisational issues	Representation at key management groups but no formal post
Training	Mostly generic rather than family specific	Mostly generic. Some family specific. 5-Step Method training	Some family specific through non-statutory organisation	Mostly generic	More evidence of generic training. Group work, counselling. Not fm specific	Some generic but also specific family focused training provided locally	Some training initiatives. Adfam principles. Need to develop further CRAFT	Various initiatives. Some generic but also some specific e.g. 5-Step Method, SBNT. Recent family focused conference. Training plan no mention of family focus

5.2 A COMPARISON OF AREAS IN SCOTLAND

Understanding, strategy and vision

Similar to the English areas, the level of understanding, strategy and vision appeared to vary between areas. A summary can be seen in Table 6. Some areas, e.g. 6S, had robust knowledge and awareness of the problem and reported this had been the case for a number of years, predating recent developments in recognition of the importance of families through policy (e.g. 'Road to recovery'). Other areas recognised the needs of family members but felt that more work needed to be done, whilst a minority of areas reported that the adult family members' agenda was not a priority, mentioning services for drug users, alcohol users or children as higher in the priority list. Area 1S also perceived that there was a range of needs within the broad group of 'families' and attempts were made to respond to these through various services, including the delivery of an intensive family prevention programme for whole families. In the case of Area 2S, the commissioner was relatively new to the post and whilst recognising that family members were important, felt that their area was at the very early stages of having an adequate response to the problem.

Overall, across areas there was some perception that the needs of children have been recognised to a larger extent than those of adult family members affected. In two areas, the rural characteristics of the area posed significant challenges in terms of accessibility and stigma.

In relation to vision, there was again variation with some areas having a clearer vision of what is necessary to meet need. There appeared to be a stronger more developed vision in areas where there was greater communication between the coordinator and family members and family member groups. It is fair to say that most areas had made some mention of adult family members in their strategies but that at present there is not always clear evidence that some of the aims identified in the strategies have been achieved.

Table6 : Understanding, strategy and vision: Scottish areas

	Area 1S	Area 2S	Area 3S	Area 4S	Area 5S	Area 6S	Area 7S	Area 8S
Knowledge and Understanding of the problem	Good knowledge and recognition of the problem. High level of focus on children and kinship care. Identification of the need for a range of services: carer generic services; specialist carer services and involvement in user treatment. Emphasis on supporting the whole family. 'We are at an early stage	There is an awareness of the needs of family members. '...the level of provision is much lower that the need out there. The issue we have is that particularly the needs of adult carers are not picked up. 'Need to change culture of treatment services to be more family friendly'	Awareness of the problem and needs of family members. There have been attempts to develop support groups that have not always been successful. Perceived problems with stigma and rural area spread. Focus more on alcohol but perception that carer services are strong	Some acknowledgement although the emphasis is more on children rather than adults affected and drug users themselves. 'Our services are predominantly focused on the alcohol and drug users themselves'. Family members perceived as difficult to identify	The way our services are delivered, currently our main services focus on individuals and their treatment...not kind of the wider role of family'. Recognition that national policy perceives families as important but not seen as a priority. 'We've no idea what people want' Identified need in general but no specific prevalence work	There is a robust knowledge, awareness and recognition of the problem. Focus on family members has been on the agenda for a **number of years.** On family support service set up in 1984!! Ample involvement and consultation with family members about the extent of services delivered, the development of future services and service improvements - cited as an example of good practice in the Road to Recovery	Perception at commissioning level that families affected by drug use are not an area of priority. More focus on alcohol than drugs overall and sense that the number of families affected is low. Perception that there is no evidence from services that large numbers of family members are seen	Good grasp of the problem and contact with family members but more on an informal basis. Main emphasis on supporting groups. Identified a need for the ADP to have someone with a specific remit to work with family members. More services for young people.
Strategy and Vision	Recognition of the importance of families and the need to consider families when a drug problem is present	Weak. Not evident from interviews. Currently very underdeveloped. Need to improve fm services.	Family members seen as important and needs recognised	Strategy identifies need to focus on family members but barriers are perceived i.e. stigma, identification and rural spread.	No evident clear vision or strategy. Not perceived as a priority.	Recognition of the importance of families and the need to involve fms in order to inform service delivery and development	Impact on and services for families affected by drug problems not seen as a priority or a significant problem in the area.	Recognition of the needs of family members. Aims to continue to support fms but funding is limited

Implementation

A summary of the results in included in Table 7. In line with the picture so far, there is a pattern whereby all the areas reported provision of advice, support, information and signposting for family members. Whilst this was reported in all areas, it is not possible to gauge the extent to which these services are easily available across the area and as discussed later, the volume of some of these responses is unclear. There is also some indication from some areas of the challenges in accessing services, particularly in rural areas. Counselling was reported to be available in all areas, mostly generic in nature as opposed to specific to families and drug use. A number report groups but the success and use of these is mixed. Area 6S for example reports a group programme with 17 active groups whilst area 7S reported low uptake of groups. This would suggest that areas can benefit from learning the active ingredients to support successful group programmes. The role of Scottish Families Affected by Drugs was noted as important in supporting the development of support groups in some areas.

Carers assessment through generic services were offered but uptake was mixed and this was perceived to be due to lack of awareness in family members. In Area 2S however, one of the carer organisations had 3 workers specifically to work with family members affected by substance misuse.

Kinship carer support was mentioned in some areas whilst Naloxone training was also available. Kinship support was delivered through parenting programmes in a number of areas. There were also references to specialist counselling and bereavement support.

Only one area (1S) described a more intensive family prevention programme, although this was limited to 6 weeks, and one area (6S) had a parenting programme. Whilst there were other parenting programmes mentioned, most were focused on helping young people affected by drug using parents. However, it was of note that some of the parenting programmes were quite active in supporting kinship carers.

Table 7: Implementation: Scottish areas

	Area 1S	Area 2S	Area 3S	Area 4S	Area 5S	Area 6S	Area 7S	Area 8S
Services	-Carer service provides emotional and practical support -Counselling -Short breaks -Alternative Therapies -Telephone support -Self –help groups -Intensive Family Prevention Programme -Support for kinship carers	-Information -Advice -Signposting -Emotional support -Counselling in their own right -Courses for fms -Joint work with fms and users -Some respite -Some self-help but patchy -Support for kinship carers	-Family support groups -Carers assessment -Practical support, information and signposting -Counselling, telephone or face to face -Specialist counselling support	Mostly delivered by one service -Face to face support -Signposting -Respite -Alternative therapies -Counselling -Naloxone training -Self help groups	-Information and advice -Emotional and practical support -Signposting -Alternative Therapies -Counselling -Attempts to support through treatment for users but limited success	-Practical and emotional support -counselling -Respite -signposting -Parenting training (a lot of which is geared at kinship carers) -Alternative therapies -Bereavement groups -Yearly remembrance service -Kinship services -Involvement in users' treatment -Naloxone training -community events	Most provision through more generic services apart from specific addiction advisory service that offers 1 to 1 counselling -Counselling -Signposting -Support -Emotional support -Group support was available but no uptake	-'ad hoc' support -Support groups -Naloxone training - Alternative therapies -counselling Helpline -Support with housing -home support -involvement in user treatment
Developments influenced by:	'Road to recovery' Local needs and fm representation	'Road to recovery' Local consultation carried out but carers consideration limited 'Demand' determines provision	Local strategy and National documents. 'Road to Recovery' and 'National strategy for carers and young carers'	National policy	National policies focused on carers and on Recovery. 'Ad hoc' developments influenced by experience and knowledge at a local level	National strategy, 'Road to Recovery' also local strategy focused on supporting vulnerable children and adults. A lot has been developed out of need	'Road to recovery' quoted as influential. Also national domestic abuse delivery plan.	'Road to Recovery' quoted as influential. Also 'Changing Scotland's relationship with alcohol'

Treatment systems

A summary of the results relating to this theme in included in Table 8. The overall picture of the treatment system across the 8 areas is varied and shows potential for further development. No area had an overall target for family members although in some areas, there were identified targets for specific services, e.g. 6S and 8S.

Monitoring was patchy, mostly centred on drug user treatment rather than family member services or contacts. Some areas reported that they were currently developing more robust systems. In some cases, coordinators had figures but these did not appear to be systematically collected and used for monitoring. One coordinator remarked that they were not required to monitor these figures. An exception was area 6S where the monitoring system was more robust and there appeared to be more integration across services. In this area, the commissioner was more familiar with the range of responses available and the need to monitor activity across all these systems.

In terms of outcome measurement, this mostly appeared to take place within specific treatment programmes rather than more widely. Finally, pathways between services and communication varied. One example (3S) illustrated a more integrated pathway where all services had a clear referral pathway to one service that coordinated future care and support and signposting where necessary. The importance of carer events to promote services, particularly within urban areas, was also noted. One area described a yearly memorial service that had been organised for a number of years and has been very successful attracting family members affected by drug use.

In terms of training, there were some initiatives with half of the areas reporting family focused training as opposed to more generic initiatives.

KEY POINTS FROM SCOTTISH AREAS

- Similar to England, there appears to be much room for improvement in terms of developing a stronger understanding and vision in relation to adult family members. Whilst the role of families in supporting drug user treatment seems to be readily identified, there is less degree of acknowledgement of the needs of adult family members in their own right.
- Provision of services for adult family members varies also across Scottish areas. Different areas deliver different services mostly determined by local circumstances and influence but not clearly linked to prevalence as the latter is mostly unknown. No two areas delivered the same set of responses. Some of the extreme rural areas pose some challenge in service provision including accessibility and the accentuated impact of stigma as a barrier in small communities.
- The treatment system shows ample potential for further development in terms of needs assessment, development of targets, monitoring and outcome measurement in relation to adult family member services.
- There is low implementation of evidence based interventions

Table 8: Treatment systems: Scottish areas

	Area 1S	Area 2S	Area 3S	Area 4S	Area 5S	Area 6S	Area 7S	Area 8S
Target	Not evident	Not evident	Not evident	Not evident	Not evident	Not evident	Not evident	Not evident – some for separate services
Monitoring	No robust system at present. Developing subs misuse information system that will allow recording of fm activity in the future. Risk of 'Double counting' 'Services for fms are popular'	System in development. Quarterly reports but emphasis on users and not fms. Perceived as challenging process	Some fm services appear to have robust recording systems. Patchy across the whole system. Developing different ways of recording.	Robust monitoring system within the main service provider – both phone calls and visits –not reported to ADP	Generic carer services – low volume Drug user treatment services: 'It is not something we are required to monitor'	High volume of work through the various services. Robust monitoring systems.	Some monitoring of individual services but no robust family member focused system	No robust system for family members although some figures are available
Outcomes	Only within individual programmes e.g. Family prevention programme.	Mostly for drug users. '...in our monitoring of services we don't put in outcomes for carers at all'	Some outcome evaluation through commissioning. ADP has set of outcomes services have to meet.	Robust measurement of outcomes within the main fm service – not reported to ADP	'It's a kind of grey area with carers because there are no specific outcomes; it is something that is being developed	Some examples of robust outcome measurement	Some measurement within services	Some process measurement

Assessment of family members	Through the various service components	Mostly through the different services	All services refer to one carer service as first point of call for assessment	Within fm service. Carers assessments available but not taken up	Mainly generic. Some fm involvement in treatment for users but low volume	Within fm services and also treatment services for drug users – the generic carers centre offer assessments	Within each separate service	Within separate services
Pathways	Not clear	Not clear, Some signposting and cross referral from separate service provider organisations	Various services trying to improve pathways and awareness of services for fms	Pathways between the two main services appear pretty clear. Some feeling that support to FM and DU should be delivered in the same place: "More joined up." Need more 'joined up' working.	Predominantly self-referral of fms. Some signposting between services	There appear to be clear links between the different services- this has been helped by community events	Mostly self-referral into services	Not very evident
Communication	ADP coordinator has good grasp of all service components. Communicatio n patchy between services	Patchy	Good communication between services. Carer strategy development officer.	Unclear from interviews how robust communication is. Uncertainty of funding of main service provider for fms	Appears to be patchy – services make little mention of other services	Robust communication between services	Appears to be robust knowledge of different services	Appears to be good between services
Family member/ carer representative	Yes. Involved in various groups	Not at present. Felt to be a gap		Not evident	Currently user rep. 'Including family members is the next step...'	Good communication between commissioning and family members. FMs involved in various service management	Not evident	Not evident Some more 'ad hoc' communication

						committees		
Training	Some family specific within treatment components e.g. SFP	Not family specific	Mostly focused on carers assessments and counselling. Current work on training carers	Within the fm service	Generic training for assessors. Some specific family training planned for the future	Current work to develop training programme addressing working with families affected by drugs	Some family and addiction focused training through STRADA	Addiction focused, some delivered by SFAD and STRADA

6. Comparison of service provision with a template for a comprehensive service

In this chapter, the findings from a comparison of the picture of provision obtained from the interview material[3] with the levels of provision recommended as part of the Phase 1 UKDPC research (Copello, Templeton and Powell, 2009) are presented. Provision of services at each of these levels was not asked about directly as part of the interview schedule. Nevertheless, the qualitative interviews with service providers gave us information allowing exploration of this issue based on post-hoc classification of services according to the different levels. The potential limitation of this approach needs to be borne in mind when considering the findings. However, we re-contacted three key informants after conducting the analysis and checked our results in these areas with their perception of provision in each level and we found them to be accurate. A summary table of the results for the 16 areas can be seen in appendix 6.

Each level of provision is outlined below (from Copello, Templeton and Powell, 2009) followed by observations from the qualitative interviews.

LEVEL 1: RESPONSES TO FAMILY MEMBERS IN NON-SPECIALIST SETTINGS

Family members may approach the whole range of services and agencies requesting advice, information or direction towards sources of help. This requires training of staff so that the impact of drug problems on families is understood and basic information or signposting can be provided. In addition, good quality leaflets, access to web based information and signposting should be available.

The extent to which responses of this nature that involve recognition and assessment in non-specialist settings are provided seemed to be very unclear. In some areas there was evidence of carer assessments but even here, in most cases the volume appeared low compared to expected prevalence. Out of the 16 areas, we found clear statements about carer assessments in 6 and reference to other services such as housing and financial advice in 2. Irrespective of whether there may be more instances not detected in our interviews, there was only one evident example of a plan to develop and coordinate a response to family members across a range of generic services taking into account the variation in presentation and needs of this group (Area 3E). Other areas, acknowledged the need to work more closely with General Practitioners and increase awareness and identification at the primary care level. Most of these areas, however, recognise this as work in progress.

[3] The areas included in this analysis were the 16 areas for which information on family service providers had been obtained within the field work period.

LEVEL 2: ASSESSMENT: BEST PRACTICE IS NOT ONLY RELATED TO INTERVENTIONS.

The existing evidence, for example on the influence of family relationships and stability on outcome, strongly supports the need to assess family relationships when people enter treatment, a practice that is not widespread within treatment services.

Level 2 relates to the assessment of family needs when users approach treatment services (a recommendation from NICE in England). In general there appears to be a lack of any systematic and comprehensive way of implementing this work, although some areas described some work in progress. In one of the areas, there are plans to assess family members every time someone is assessed for a drug problem and even though this is at an early stage, there is a commitment to take this forward. In another area, there was a centralised gateway service that assessed all family members and the expectation was that when family members were identified, they were referred to this service. Across all other areas, despite some good examples of assessments in specific services that had family member components, there did not appear to be any clear action plans in place to increase this level of provision.

LEVEL 3: SERVICES SPECIFICALLY FOCUSED ON PROVIDING HELP AND SUPPORT TO FAMILY MEMBERS IN THEIR OWN RIGHT.

The provision of these services is patchy across the UK and can be improved. Some evidence based interventions such as the 5-step intervention (Copello et al., 2009) can be delivered in family focused services and provide a useful framework for workers.

There was more provision within Level 3 and here is where most areas have concentrated. All areas described some provision for family members including information, general support, advice and signposting. Counselling was available in most areas although the majority of areas were offering generic counselling rather than approaches specifically developed for and focused on the impact of drug addiction upon the family member. This was also found in the results of the web survey conducted as part of this project (Copello and Templeton, 2012).

In a minority of areas, reference was made to more evidence based interventions. As discussed already, there were challenges identified in providing services for family members whose relatives were not in treatment, although this was less of an issue in Scotland even though some of the support was described as 'ad hoc'. One of the limitations here is that in the absence of clear and robust monitoring systems, it is difficult to know the volume of the service provision. In most cases, there was recognition that services were not likely to meet real need.

LEVEL 4: RESPONSE TO FAMILY MEMBERS DELIVERED AS PART OF SERVICES FOR DRUG USERS.

It is important that a response to family members is delivered as part of services for drug users. This is in line with clinical practice recommendations from NICE (2008) in England

This is an issue that was recognised in the majority of areas, yet provision was patchy and perceived as a challenge. Out of the 16 areas, 6 described attempting to involve family members in the treatment of the drug user. This posed a number of challenges, including how to manage working together in a positive way, how to engage families in this process and how to deal with worries from drug users when considering involving family members. No specific approaches were mentioned. It is also worth considering that as part of the web survey it was found that this type of work was not done frequently with most services reporting this type of work as involving less than ten percent of the services workload. There was little mention of the offer of more structured approaches for family members within treatment services for drug users, unless they were 'ad hoc' or there was a family service component attached to the drug service.

LEVEL 5: INTENSIVE FAMILY-BASED THERAPEUTIC INTERVENTIONS

Some services will have the capacity and capability to deliver some of the more intensive interventions reviewed. Behavioural Couple Therapy has been recommended as part of the NICE guideline and can be used with drug users who have non-drug using partners. In addition there are a number of interventions that show promise and together cater for the needs of the whole range of family relationships. These include Multimodal Family Therapy; Community Reinforcement Approach and social network approaches. These will require a higher level of training and supervision for staff that will not be available in all services.

The overall picture here was again varied and the delivery of intensive family interventions or programmes focused on helping adult family members was low. Out of the 16 areas, 4 described some form of intensive family programme. Whilst there were references to parenting programmes to support using parents of young children affected, the availability of programmes focused on the adult family members was very low. Two areas described taking part in a research pilot study of Social Behaviour and Network Therapy.

The comparison summarised in table 4, confirms what is evident so far from the analysis that the level of provision for family members affected by substance misuse in these areas is underdeveloped, inconsistent and shows large variation.

KEY POINTS FROM COMPARISON OF 16 AREAS TO LEVELS OF PROVISION

Level 1. The service responses to adult family members in non specialist settings were varied and inconsistent. Two areas appeared to have a strategy that recognised the need to increase identification and the provision of a response at a range of non-specialist settings e.g. GP, A&E, Other medical settings, Police etc

Level 2. Assessment of the impact of the problem on adult family members as part of the initial drug user assessment is patchy. Where it occurs, it tends to focus on supporting the drug user as opposed to identification of adult family member needs.

Level 3. Most areas provide information and advice as well as some generic counselling although provision is not based on a robust assessment of prevalence, need and necessary volume of provision

Level 4. Adult family member involvement in drug user treatment is an issue identified in most areas but it is still at an early stage of development with some services lacking confidence and strategies to conduct this work

Level 5. Implementation of evidence based structured interventions to help adult family members is low, a finding also from the web survey

7. Conclusions and Discussion

Some of the findings have been discussed as part of each analysis reported and key issues have been summarised at the end of each section. This chapter aims to pull these together and highlight the main conclusions.

Overall, the different qualitative analyses conducted seem to converge and provide a picture of the extent and nature of current recognition, service response and provision to adult family members affected by drug problems in England and Scotland. The findings complement those of the web survey that was also conducted as part of this work (Copello and Templeton, 2012). Taken together, the web-survey and in depth interviews contribute to building a picture and there are important issues to highlight. The qualitative work helps to explore the services and supporting systems available in a set of areas in more depth and therefore identify gaps in provision and key factors that can develop and support good comprehensive provision. Some of the limitations of the methodology used are also discussed later in this section.

Overall, what appears to be found consistently is that provision is very varied and influenced by a range of different factors. The overall picture is still of patchy provision influenced by local circumstances. Whilst there is increased recognition of family needs and the fact that drug problems lead to harm not only to the user but also to close adult family members, there appears to be yet a lack of translation of this recognition into the development of comprehensive services. The 'recovery' agenda and 'Road to Recovery' in Scotland have led to a clearer articulation of the importance of involving and supporting families in the recovery of the drug user, but the impact of this recognition is still at an early stage in terms of practice. The needs of adult family members in their own right seems to be less clearly described in policy, local plans and resulting services.

Part of the challenge is that provision is based on a range of views and local experiences but limited robust prevalence data to underpin local needs assessment. The problem with basing provision on 'demand' is that the problem is hidden, partly as result of stigma, and this makes it likely that expressed demand for services is much lower than need. Where needs assessments are reported, they tend to be part of a broader assessment, in most cases the main focus being drug use rather than families, and only in one area there was an attempt to estimate prevalence with all the challenges that this poses. Mostly, robust and specific estimates of the number of adult family members affected were absent from all areas and this underpins a number of resulting weaknesses in that it is difficult to establish an adequate response when there is limited knowledge of how large the problem is.

Four categories were identified as part of the analysis of commissioner interviews namely; 'knowing and understanding the problem'; 'commissioning factors'; 'challenges/barriers to engaging families' and 'service delivery'. Analysis of each of these categories yielded a number of key issues that are outlined at the end of each reporting section. Whilst it is helpful to categorise these as 4 separate issues, there is also a clear interaction and

interrelation between the different components. Weak prevalence data may stem to some degree from lack of clarity in the understanding of the problem and lack of a clear view on what needs to be measured in terms of prevalence. This can in turn lead to difficulty estimating the range of service provision needed and how to surmount the challenges faced to engage with families (or indeed clarity on what family members are important to engage) in order to achieve a clear action plan for services to respond to adult family members' identified needs. Specific weaknesses within the treatment system include no overall targets for adult family members for the area, unclear monitoring arrangements, no consistent measure of outcomes, all leading to an underdeveloped service response for families. Whilst recognition of the problem has increased, these systems need to be developed in order to translate recognition into action. There has been no external requirement for data to be reported (in contrast to detailed reporting regimes for drug treatment) which compounds the issues discussed.

It is likely that the weaknesses apparent in the treatment system are the result of underdeveloped processes to support that system that can be improved with increased clarity and plans based on a solid understanding of the experiences of adult family members including:

- who the adult family members affected are;
- what their experiences are; and importantly
- how many there are.

Precision in what is meant by adult family members is crucially important. Terms used to describe affected adult family members can create confusion or uncertainty as seen by discussion of the term 'carer' in some of the interviews. In some interviews there was talk about families in general terms, and little identification of the various adult family members that may be affected e.g. partners, parents, grandparents. In other interviews, the term 'families' was used as a general term and what was really discussed was the impact on children.

There are still some misconceptions present such as the belief that there is always a conflict of needs between users and family members, the belief than drug users are not in contact with their families and the view of families as 'colluding' with the problems although there were no examples of these views in Scotland. It was good to see that these views were the exception rather than the rule.

We found low implementation of evidence based approaches across the treatment system. This problem is not only present in family interventions as it is also evident in drug user treatments. Evidence based approaches were the exception rather than the rule. In terms of training, it was mostly generic or drug use focused with limited examples of family specific training although some services reported a wish to develop this in the future and there were indications of plans to change this in some areas.

The project used qualitative interviews in an attempt to explore this area. Whilst these interviews gave us depth of understanding of important issues, there are some limitations of this method in terms of ensuring that we obtained a totally comprehensive picture as we

may have achieved conducting a more basic less in-depth survey of particular areas. We took a number of steps to minimise this risk (comparison of the information obtained from interviews with web survey data, prompting service providers as part of the interview to suggest any other services). It is also the case that, in the absence of any comprehensive register of services to provide a sampling frame, robust quantitative studies are also difficult. On balance, it was felt that the qualitative interview method would allow us to capture some of the dilemmas that respondents described and the complexities which were evident in interview transcripts when attempting to deliver and coordinating a comprehensive response. To some extent, there were difficulties apparent throughout the field work in terms of feeling certain that all levels of responses at a local area were captured. Whilst this is in part a limitation of the methodology, it also highlights the lack of clear coordination and grasp of the responses that are implemented and involve different systems at the local level, with separate monitoring arrangements and planning cycles e.g. drug treatment, social care, primary care etc. The web survey conducted alongside this qualitative study provides additional information against which to triangulate the findings.

8. References

Copello et al., (2009), *Adult Family Members and Carers of Dependent Drug Users: Prevalence, social cost, resource savings and treatment responses,* London: UKDPC.

Copello & Templeton, (2012), *A UK wide survey of services for adult family members of drug misusers*, London: UKDPC.

NICE, (2008), *Drug Misuse: Psychosocial interventions*, Leicester: The British Psychological Society & London: The Royal College of Psychiatrists.

NTA, (2008), *Supporting and involving carers: a guide for commissioners and providers*, London: NTA.

O'Farrell TJ., Murphy M., Alter J. and Fals-Stewart W, (2007), *Brief family treatment intervention to promote aftercare among male substance abusing patients in inpatient detoxification: transferring a research intervention to clinical practice*, Addictive Behaviours, 33: 464–471.

Orford, J., Templeton, L., Patel, A., Copello, A. and Velleman, R. (2009). *Qualitative study of a controlled family intervention trial in primary care: I. The views of family members. Drugs: Education, Prevention and Policy*, 14 (1): 29–47.

The Scottish Government, (2008), *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem*, Edinburgh: The Scottish Government.

Appendix 1: Commissioner interview guide

This is a mapping exercise surveying the provision of services to meet the needs of adults affected by a family member's substance misuse problems

1. What services are you aware of in your area?
    a. Are there any services that you specifically commission?
2. Can you describe what is specifically provided for family members?
3. Are there national or local policies that have influenced the range of provision?
    a. How well do you think the services available reflect policy and guidance?
4. What factors influence the range of provision available?
5. How many families or individual family members receive services?
    a. How does the extent of services delivered reflect local prevalence?
6. What are the arrangements for data collection and monitoring?
    a. How does data inform planning and commissioning for family members?
7. What requirements are there for the levels of expertise and training for those providing services to family members?
8. Are there any developments in provision for family members that you would like to see in your area?
9. What would help to improve the services for family members in general?
10. Anything else you would like to say?
11. Please can you provide us with the following contact information for:
    a. Family services: specialist substance use agencies or generic carer agencies
    b. Specialist treatment services (Tiers II & III)
    c. Affected Family member services

Appendix 2: Service provider interview guide

Semi structured questionnaire for service providers

1. Please describe briefly your organisation and the services you provide?

2. Do you deliver any services to adults affected by a family member's substance use? If yes, can you describe what they are.

3. Is there a model or theory underpinning the services you deliver? Please describe.

4. How do people hear about and get referred to your services?

5. How many family members do you help each year (if available ask for figures or estimates for last year)?

6. Are the services for family members being evaluated?

7. Have the people providing these services received specific training? What are the supervision arrangements?

8. What are the key policies, if any that guide this work (confidentiality, safety)?

9. What other organisations can you refer family members to for help and support?

10. Are there any other services you know about in your area that are provided for family members of people with substance use problems?

11. Where do you get your funding from? What is your annual turnover? Are you experiencing/anticipating any funding difficulties? What are the funding arrangements for the family member components of your service?

12. Are there any developments in provision for family members that you would like to see in your area?

13. What would help to improve the services for family members in general?

Appendix 3: Areas used for qualitative analysis in England and Scotland

England

Area 1E: Inner city – 1 commissioner and 2 other interviews

Area 2E: City – 1 commissioner and 3 other interviews

Area 3E: Town – 1 commissioner and 3 other interviews

Area 4E: Inner city – 1 commissioner and 5 other interviews

Area 5E: Town – 1 commissioner and 4 other interviews

Area 6E: Rural – 1 commissioner and 4 other interviews

Area 7E: City – 1 commissioner and 3 other interviews

Area 8E: City – 1 commissioner and 3 other interviews

Scotland

Area 1S: City – 1 coordinator and 5 other interviews

Area 2S: City – 1 coordinator and 4 other interviews

Area 3S: Semi-rural – 1 coordinator and 4 other interviews

Area 4S: Semi-rural – 1 coordinator and 2 other interviews

Area 5S: Rural – 1 coordinator and 3 other interviews

Area 6S: City – 1 coordinator and 3 other interviews

Area 7S: Rural – 1 coordinator and 4 other interviews

Area 8S: Rural – 1 coordinator and 3 other interviews

Appendix 4: Review of Adult Treatment Plans/Strategies

ENGLAND: (Part One documents) 2010-2011 for in-depth study areas

Area	Consideration of Families and Carers	
East Midlands		
	No. of mentions	Review
East Midlands (EM)	18	The family and the impact of familial substance misuse on dependent children is one of the 'headlines' of the 2010-2011 local strategy. Lists a commissioning priority as "Develop a family focused and tailored approach to working with parental and familial substance misuse in line with the 'Think Family' agenda". However, there is little mention of families in terms of the needs assessment information which is given, there is little detail in terms of supporting adult family members and there is no mention of the East Midlands Family & Carer Strategy.
EM	13	States that part of the vision is "Recognising and managing the frustrations of families and carers by increasing treatment services" attention to the needs of family and carers with better communication". There is a statement made about carer involvement in commissioning and providers promoting the involvement of families &carers in treatment but there is little detail given beyond this, other than with reference to parental substance misuse/children (and joint working protocols). Mention of carer support as part of a prison pilot. There is no mention of the East Midlands Family & Carer Strategy.
EM	13	Wants to "commission an effective drug treatment system that focuses on recovery, and has a positive impact on outcomes for drug users and their families", although there is no mention of families/carers in the priorities listed at the end of the plan. There is a short section on families and carers at the end of the plan where a few things are mentioned, including the role of the local carer support project) and parental substance misuse/children, but there is little attention given to adult family members. There is no mention of the East Midlands Family & Carer Strategy.
EM	15	The introduction mentions that families and carers were one group involved in developing the strategy. Several mentions of the Think Family agenda and parental substance misuse. Statement that improvements are needed in "Embedding the requirement for family friendly services in all service development, review and Service Level Agreements". A priority is given to "Acknowledge the role and support the needs of families and maintain and improve the provision of family support and involvement in treatment services, increasing the level of family interventions offered" although no further detail is given other than a finding from the needs assessment that "Treatment services should work with family/carer support services to develop family friendly policies and literature". There is no mention of the East Midlands Family & Carer Strategy.
West Midlands		
	No. of mentions	Review
West Midlands (WM)	27	Aims to do more, as part of wider recovery approach, to support families/carers and friends – "we also expect to see a continuance of increased demand for advice, information and support from families and friends as our service provision in this area is promoted as an integral part of the outreach and communications strategies". Highlights naloxone pilot programme, says there are plans to offer more family interventions, including with primary care shared care arrangements (in addition to support groups), and indicates that families were considered as part of both needs assessment and care planning audit. Section at end of plan considers families and carers but little additional detail is given.
WM	17	Focus on families is towards safeguarding, troubled families and developing a co-

		ordinated approach involving a range of services (and some details of how this will continue to be achieved through supporting these children and families). Statement that families can support/reinforce drug use. Recognises need to undertake more consultation with users and carers about service provision.
WM	15	Families and carers were included in workshops that supported the development of the strategy. Recognition of need to involve users and carers in commissioning and planning. Priority area listed as needing to target services to families in greatest need. Highlights improvements made to facilitate engagement of women and pregnant drug users in to treatment – this is followed by the statement, "Family support is identified as a definitive area in need of improvement by service users and provider services alike" but little detail is given.
WM		No adult treatment plan available for review.
London		
	No. of mentions	Review
London (L)	3	Says that the Area Drug Strategy will include measures to support children and families. Lists a priority to develop and implement measures to support families, focus is on safeguarding and young people in treatment.
L	15	Plans to extend overdose training to families and carers. Specific mention of the Carer's Project and its work. Mention that the parental substance misuse worker (Children and Families Services) supports families.
L	37	Families and friends were included in gathering views to develop the strategy. Says that a principles of drug treatment will be "Service users and carers will be at the heart of services - we will listen to and act upon the views of partners, service users, friends and family members" and adds later that "we recognise that families can play an important role in obtaining good treatment outcomes". A lot of focus is on reducing harm associated with parental drug use and in responding in line with Think Family agenda. Identifies a gap in terms of having a consistent approach to working with families. Recognises more work is needed to identify and record carers, facilitate their engagement with services and raising awareness – highlights that Tier 1 services could do more in this area. Plans to involve family and friends in developing materials to support access to services (including role of families in encouraging users to access treatment).
L	5	Link to carer's strategy is mentioned with regard to harm minimisation and overdose management. Other mentions of familes/carers seem to focus on support users to manage family relationships, engage with social networks and so on – there is no direct reference to families in their own right.
South West		
	No. of mentions	Review
South West (SW)	8	Majority of reference to 'family' is through mention of the Drugs Strategy and how this will influence work in Swindon though little detail is given.
SW	19	Plans to continue involving carers in planning, development, commissioning and performance management of services, and wants to improve engagement and involvement of family members in all aspects of treatment. Plans to review commissioning of carers assessments for this group. Recognises, overall, an unmet need of services for carers, families and significant others. Recognises the importance of carer involvement but notes impact of loss of carer champion.
SW	21	Wants to improve involvement of carers at a commissioning level. Discusses 2008 Carer's Day and subsequent re-commissioning of Carer's Service. Summarises the 12 week rolling programme which is now available and lists tasks to improve this – including carer's feedback, performance monitoring and protocols around carer's assessments. Lists a commissioning priority continuing to improve services to carers. Also mentions the need for support where there is parental drug use and, as part of this, supporting grandparents who take on caring responsibilities. Identifies the need to consider the expansion of Hep B & C services to include non using family members who may be at risk.
SW	21	Highlights need for more drop-in and flexible responses to facilitate engagement of a range of groups of people, including families. Mentions main sources of family support and highlights need for greater coverage in certain areas of the County. Lists one of the priority areas as providing overdose prevention and life support training to users and families. Note that all mentions of carers relate to young carers and a lot of family focus is geared towards young people and the wider family agenda.

North East		
	No. of mentions	Review
North East (NE)	18	Says that there has been lengthy consultation to guide development of carers services. Some key issues are highlighted – carers not seeing themselves as carers, lack of information about services, inconsistent availability of training and respite. Highlights that the first point of contact for carers is their GP but that few GPs "recognised the need to refer patients to other agencies". Other mentions of family support seems to be in the wider context of the Think Family agenda.
NE	23	Mentions that carer services, among others, are at risk through "the anticipated reduction in adult PTB" (pooled treatment budget). Highlights appointment of Service User and Carer Inclusion Strategic Lead in 2009-2010 and that carers (and users) and "meaningfully involved" with planning and delivery of the treatment plan. Recognises role of Carers Service (generic) and that carers (and users) will be active members of all DAAT meetings from 2010. Plans to consider how services to carers can be improved and to deliver overdose management training. Says that a key priority is to implement service user and carer strategies and ensure services are "self-sustaining". Wants to review availability of psychosocial interventions and says contingency management and family/couples intervention should be considered.
NE	12	Treatment plan is not for 2010-2011 but for 2009-2010 so has not been reviewed.
NE	12	Includes family support as part of key issues for 2010-11 Local Drug Strategy. States that, "The greatest challenge will be encouraging the full involvement of Users (and families) not only in their own journey through the system but also as advocates and role models to stimulate recovery". Says that more work is needed within shared care to support drug users and their families. Other mentions of families/carers are in relation to Think Family agenda and young carers.

SCOTLAND: Review of ADP strategies for in-depth study areas

Area	Consideration of Families and Carers	
Scotland		
	No. of mentions	Review
Scotland (S)	23	The ADP vision states that they are committed to supporting and achieving better outcomes for individuals or families affected by substance misuse. The focus on family members is linked to a local needs assessment that was conducted in 2010; this identified a significant gap in services available for family members and that "more support was needed for families and carers." The strategy has seven core outcomes that need to be achieved by 2014; commissioned partners will be expected to develop their services to achieve these outcomes. One outcome specifically addresses the needs of family members: "Children and family member of people misusing alcohol and drugs are safe, well supported and have improved life chances." Furthermore, in line with the Scottish Executive document 'National Quality Standards for Substance Misuse Services' (NQS) there is recognition of the importance of service user involvement in the development of services. Having carried out a pilot project on this last year the ADP is committed to involving both "service users and their families" so "they are at the centre of the services offered to them." No additional details are provided as to how the ADP will ensure these outcomes are achieved.
S	26	Outlines several key priorities over 2010-2012 which includes several references to family members; the main focus is however on safeguarding children and young people affected by substance misuse. Aims to deliver and evaluate more parenting programmes, particularly to kinship carers. Recognition of the importance of community engagement; a key priority includes working "in partnership with the Dundee Substance Misuse Forum representing the views and experiences of service users, their families, community groups and service providers" so that they can inform future priorities and actions of the ADP. Furthermore another community engagement priority includes offering support and information to families by working "with the Scottish Association for Families Affected by Drugs." Part of the action plan for 2011 includes delivering overdose prevention training to both service users and carers. A plan of action is summarised alongside each priority,

		outcomes are measured against set performance indicators but it is not clear how this information will be collected and timescales.
S	49	The executive summary states that from both national and local data available it is apparent that "positive work is taking place protecting vulnerable children and adults from the impact of alcohol and drugs, but we recognise the need for continuous improvement." A large part of the vision for 2011-2015 responds to this and outlines a number of priorities to ensure services meet the needs of families. This includes a work stream that focuses on "prevention and early intervention," identifying and providing support to family members as early as possible "to reduce the negative impact this behaviour has." A core outcome for this work stream is stated as ensuring that children and adults are "well supported and have improved life chances;" little detail is provided as to how this will be measured. Part of the ADP's strategy recognises the importance of using families' experiences and feedback "to the on-going process of services improving" and they are committed to using this knowledge to inform their approach. Section at the end outlines an action plan to provide "overdose awareness and training sessions for families and concerned significant others;" with a target of training 20 individuals a year. Two national documents ('The Road to Recovery' and 'Changing Scotland's Relationship with Alcohol') have significantly contributed to the vision outlined in this strategy and the local and national outcomes they have set and hope to achieve.
S	8	The strategy for 2011-2016 is heavily influenced by the national document 'The Road to Recovery,' which sees a greater emphasis on moving treatment services to "placing a clear focus on recovery." As part of this the ADP plan to have an integrated treatment service that will enable "family support services within treatment services." No details are provided as to how or when this will be achieved. Furthermore, it is not clear whether these services will include support that family members can access in their own right. The role of families and service users in developing services is recognised and identified as being important; a key short term outcome to be achieved over the next two years includes "increased involvement of service users and their families in service delivery and design." Again, no details are provided in relation to how or when the ADP hopes to achieve these outcomes. A key priority and vision outlined in the strategy is to make "individuals and communities affected by substance misuse safer" however in reviewing how this outcome will be achieved there is a greater focus on children; no reference is made to families or adults: "collect relevant data on the extent and nature of the impact of parental substance use and the impact on children."
S	6/14	The strategy for 2011-2014 is structured around three main priorities, one of which focuses on "protecting vulnerable groups" which includes both children and adults affected by substance misuse. A comprehensive action plan provides details of set objectives to "reduce the harm caused by drug addiction" by (1) working towards improving the capacity of universal services to "identify the needs" of vulnerable adults affected by substance misuse, (2) "improve practice, assessment and risk management," and (3) improve "responses and outcomes." The rationale for each objective, how it will be measured and who is responsible is provided; the objectives are shaped by both national and local documents including the City ADP Strategy Consultation feedback process (2011) and the Scottish Governments Core Outcome indicators for ADPs (2011). The document indicates that work has started to achieve set objectives however" more is still required" which will be the focus over the next three years. Furthermore, the ADP recognises the importance of joint working between services to inform service development and recovery of service users: "Continue to improve joint working between community forums, family support groups and the Recovery Network of the city."
S	54	The strategy for 2011 is informed by a local needs assessment that was conducted over 2010-11 to establish met and unmet needs, and national outcomes outlined in two key government policies 'Road to Recovery' and 'Changing Scotland's relationship with alcohol.' The ADP is committed to supporting children and families; there are family support groups available for "families affected by someone's drinking" but not those affected by drugs. There is a focus on developing such groups by working with "Scottish Families Affected by Drugs." Another priority area identified is to develop "more formal family support interventions" and "information systems to gather more robust local data regarding family support." Although an action plan is attached detailing actions and expected outputs to meet each priority little indication is provided as to how they will be

		measured. There is recognition of the importance and need to engage service users, carers and their families "in the ongoing planning and decision making for future service provision." The local needs assessment identified this as an area that needed to be improved.
S	53	Supporting children and families affected by substance misuse is identified as one of the key priorities set out by the ADP for 2009-2011. The vision set out is heavily influenced by national documents including 'The Road to Recovery,' 'Changing Scotland's relationship with Alcohol' and 'Audit Scotland: drug and alcohol services in Scotland.' The focus is on developing "networks of support for families and carers" by working with the Scottish Network for Families Affected by Drugs (SFAD) to "develop self-help and recovery groups" and continue to provide "one to one support through those services commissioned through health, social work and the third sector." There is a focus on keeping family members better informed and supported in local services, developing improved assessments and outcomes. There is also recognition of the challenges faced in engaging family members and the need to work with SFAD and the Scottish Drugs Forum to identify ways to "engage with those not already accessing services and look at how we can meet their needs." Details are provided in an appendix on the lead officers responsible for meeting each outcome, their targets and the resources that can be used, however there is no information as to how these outcomes will be achieved.
S	36	The local strategy outlined for 2009-2012 is driven by key themes highlighted in national government policies including 'the Road to Recovery' and 'Changing Scotland's Relationship with Alcohol.' The ADP outlines 11 objectives to be achieved, two of which are directly related to family members. They include focusing on the need to reduce substance misuse harm in "users, their families and/or their carers" and increasing the "capabilities of services to meet the needs of children and young people affected by drug and alcohol directly." Two significant priority areas identified include: (1) developing interventions to educate and work with vulnerable families and (2)"supporting people affected by substance misuse" by working "with families and their associated range of issues by offering support for all family members," specifically "counselling services for everyone affected by substance misuse." No detail is provided as to how or when these services will be developed.

Appendix 5: Extracts from UKDPC report on Phase 1 - Template for service provision

Family treatment and support– the way forward

The research literature on family interventions shows that there is a range of approaches that can be used to help people with drug problems and their families. We conclude that there is an increasingly robust evidence-base that supports family focused interventions in substance misuse, as demonstrated by the recognition of such approaches in clinical and policy guidance, such as that produced by NICE (2008) and the NTA (NTA, 2008). The research studies, in which there is careful control of the intervention, confirm that families can play a central role in the treatment of addiction problems and recent studies have shown that family approaches either match or improve outcomes when compared with individual approaches. Where more work is needed is in the implementation of these interventions and services, beyond the confines of research studies, in routine clinical practice (O'Farrell et al., 2007; Orford et al., 2009).

The research reviewed, suggests that there should be a range of responses available to family members affected by drug problems. It is possible to develop a template including levels of responses that could be used to monitor the extent of services provision across different areas of the UK.

Level 1: Responses to family members in non-specialist settings

Family members may approach the whole range of services and agencies requesting advice, information or direction towards sources of help. This requires training of staff so that the impact of drug problems on families is understood and basic information or signposting can be provided. In addition, good quality leaflets, access to web based information and signposting should be available.

Level 2: Assessment: Best practice is not only related to interventions.

The existing evidence, for example on the influence of family relationships and stability on outcome, strongly supports the need to assess family relationships when people enter treatment, a practice that is not widespread within treatment services.

Level 3: Services specifically focused on providing help and support to family members in their own right.

The provision of these services is patchy across the UK and can be improved. Some evidence based interventions such as the 5-step intervention (Copello et al., 2009) can be delivered in family focused services and provide a useful framework for workers.

Level 4: Response to family members delivered as part of services for drug users.

It is important that a response to family members is delivered as part of services for drug users. This is in line with clinical practice recommendations from NICE (2008) that state:

"Where the needs of families and carers of people who misuse drugs have been identified, staff should:

- Offer guided self-help, typically consisting of a single session with the provision of written material
- Provide information about, and facilitate contact with, support groups, such as self-help groups specifically focused on addressing families' and carers' needs *(clinical practice recommendation 8.10.7.1)*"

And in addition: "Where the families of people who misuse drugs have not benefited, or are not likely to benefit, from guided self-help and/or support groups and continue to have significant problems, staff should consider offering individual family meetings. These should:

- Provide information and education about drug misuse
- Help to identify sources of stress related to drug misuse
- Explore and promote effective coping behaviours
- Normally consist of at least five weekly sessions *(clinical practice recommendation 8.10.7.2)*"

Level 5: Intensive family-based therapeutic interventions

Some services will have the capacity and capability to deliver some of the more intensive interventions reviewed. Behavioural Couple Therapy has been recommended as part of the NICE guideline and can be used with drug users who have non-drug using partners. In addition there are a number of interventions that show promise and together cater for the needs of the whole range of family relationships. These include Multimodal Family Therapy; Community Reinforcement Approach and social network approaches. These will require a higher level of training and supervision for staff that will not be available in all services.

A key principle is that there should be a range of flexible services of different intensities that can respond to the varied and complex needs of families affected by drug problems. These levels should not be seen as a hierarchy in which level 5 is in some way "better" than level 4. All types of interventions should be available in order to meet the differing needs of family members. Finally, families and carers should be involved in the planning and commissioning of services as this will improve the effectiveness of services and the drug treatments system.

Appendix 6: Comparison of 16 areas with template for provision

Level of Provision[1]	Area 1E	Area 2E	Area 3E	Area 4E
Level 1: Responses to family members in non-specialist settings	Limited. Not evident from interviews	Good response in treatment system. Not so clear in other areas	Recognition of different levels of need and attempts to develop responses	Some carers' assessments. Low volume
Level 2: Assessment of family needs when users enter treatment	Overall patchy. No evidence of family needs included in assessments	Good initial assessment within user treatment incorporating family needs	Not evident from interviews	Not evident from interviews
Level 3: Services specifically focused on providing help and support to family members in their own right	Some provision although low for expected prevalence.	Some provision through partnership although recognition it can be improved	Good range of responses including 'low', 'medium' and 'high' levels of need	Some provision. Range of responses. Volume low
Level 4: Response to family members delivered as part of services for drug users	Not evident. Users perceived to have little contact with families. Barriers	Some good work. Room for improvement recognised. New cases are better than existing ones	Some evidence although more evidence on level 3 work	Limited. Weak. Perceived conflict of user and family needs
Level 5: Intensive family-based therapeutic interventions	Not evident	Limited. Plans to change and develop	Some delivery through Family service	Not evident from interviews

[1]Level of provision from Copello, Templeton and Powell (2009) *Adult family members and carers of dependent drug users: prevalence, social cost, resource savings and treatment responses.* London: UKDPC

Level of Provision UKDPC **Phase 1**	**Area 5E**	**Area 6E**	**Area 7E**	**Area 8E**
Level 1: Responses to family members in non-specialist settings	Not evident	Not evident	Not evident	Not evident
Level 2: Assessment of family needs when users enter treatment	Appears patchy overall. Some assessment in services	Seen as a challenge. Need to develop	Some activity in service components	Some work but need to develop further
Level 3: Services specifically focused on providing help and support to family members in their own right	Support and counselling	Structured counselling	Counselling and support. Some evidence based interventions	Group and 1 to 1 support
Level 4: Response to family members delivered as part of services for drug users	Not evident from interviews	Not evident from interviews	Some involvement of family members in user's treatment	Some involvement of family members in user's treatment
Level 5: Intensive family-based therapeutic interventions	Not evident from interviews	Intensive family support service	Not evident form interviews	Not evident from interviews

Level of Provision – from UKDPC **Phase 1**	**Area 1S**	**Area 2S**	**Area 3S**	**Area 4S**
Level 1: Responses to family members in non-specialist settings	Carer services provide assessments and have communications team to promote service	Some evidence of good response through carers' services Some GP referral	Carer's assessment. Central focal point for fm assessments. Identified need to work with GPs, A&E, police. Identified as 'challenge'	Carer support plans. No clear pathways
Level 2: Assessment of family needs when users enter treatment	Not clear	No evidence of a systematic approach across services	Takes place at single shared assessment	Not widespread. Anticipate developing in the future
Level 3: Services specifically focused on providing help and support to family members in their own right	Range of responses. Face to face, self-help.	Some provision including self-help	Range of response, mostly generic and some specialist	Range of responses through mainly one service
Level 4: Response to family members delivered as part of services for drug users	Work in progress attempting to involve fms in drug user treatment	Recognition but limited work so far Varies between services	Built into standard practice	Not standard but identified for future development
Level 5: Intensive family-based therapeutic interventions	Some through family prevention programme	Not evident from interviews	Not evident for adult family members	Not evident from interviews

Level of Provision – from UKDPC **Phase 1**	**Area 5S**	**Area 6S**	**Area 7S**	**Area 8S**
Level 1: Responses to family members in non-specialist settings	Some carers' assessment. Otherwise knowledge in other areas weak.	Some good examples of links with generic services	Some generic service provision	Some integration work with housing and finances
Level 2: Assessment of family needs when users enter treatment	Assessments of relationships but user focused	Some activity but mostly focused on children	Some activity	Some activity
Level 3: Services specifically focused on providing help and support to family members in their own right	Range through generic services	Range including individual help as well as active support groups and other activities	Yes, range of services	Counselling as well as 'ad hoc' support
Level 4: Response to family members delivered as part of services for drug users	Option available. Can be developed further	Some involvement of fms in users' treatment. Issue recognised	Not evident from interviews	Some involvement of fms in users' treatment
Level 5: Intensive family-based therapeutic interventions	Not evident from interviews	Support for kinship carers	Not evident from interviews	Not evident from interviews