

State of the Sector: Drug and alcohol family support



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About Adfam¹

Adfam is the national charity working to improve life for families affected by drugs and alcohol. We do this through empowering family members and carers, supporting and training frontline workers, influencing decision-makers and campaigning for improved family support services nationally and locally. We want anyone affected by someone else’s drug or alcohol use to have the chance to benefit from healthy relationships, be part of a loving and supportive family and enjoy mental and physical wellbeing.

Acknowledgements

We would like to thank the practitioners and service managers who took the time to participate in the two online surveys; *Drug and Alcohol Family Support – 2014 Health Check*, and *State of the Family Support Sector 2015*. The questionnaires were thorough, requiring respondents to provide sometimes detailed and potentially sensitive information. We hope and believe that this report is an accurate reflection of their views and opinions.

We would also like to thank the three service managers who took part in anonymised telephone interviews, as well as Paul Urmston, Chief Executive for ESH Works Ltd, for participating in an in-depth interview and allowing us to attribute his comments. Lastly, we’d like to thank the practitioners who provided invaluable feedback in phone interviews in 2016.

¹ www.adfam.org.uk

Introduction and Policy Context

In order to gain an understanding of the current state of the family support sector, Adfam created two surveys. The first, *Drug and Alcohol Family Support – 2014 Health Check* (HC) ran between August 2014 and March 2015. The second, *State of the Family Support Sector 2015* (FSoS) was open for responses between September 2015 and October 2015. The surveys sought to explore current trends and developments in drug and alcohol family support in terms of sustainability, funding, networks, partnerships, client needs and the delivery of services.

The Care Act, which came into force in April 2015, created new rules and eligibilities for carers and those they care for, including those who care for someone because of drug and alcohol problems. It placed a new duty on local authorities to take a proactive approach to identify those in need of support, and provide a range of services to meet local needs. Under the Act, a carer of any age who provides unpaid support to a family member or friend who could otherwise not manage is eligible to receive a carer's assessment. The UK Drug Policy Commission (UKDPC) has recognised this group of carers affected by drugs and alcohol as one with significant needs, in view of the stress of living with and/or caring for someone with such complex problems.² Carers of those who use drugs and alcohol can experience severe stress and physical and mental health problems, as well as an impact on their employment, social lives, relationships and finances.

Families are often an unpaid and unconsidered resource in providing care to their relatives. Indeed, the support provided by families would cost the state an estimated £747million a year if it were instead to be provided by health and social care services.³ Families commonly provide 'services' such as routine care and support, home detox, accommodation and day-to-day care. We know that family members and friends can be an incredibly useful source of support to the substance user, and there is an increasing amount of evidence that family support can positively influence outcomes for drug and alcohol users,⁴ including encouraging and supporting them to enter treatment and increasing the likelihood that they remain in treatment. It is therefore important for the whole family to be supported in their own right. When families are supported themselves, they are more able and better equipped to support and encourage the user's recovery journey.

The government has recognised that *'treatment is likely to be more effective, and recovery sustained, where families...are closely involved.'*⁵ Furthermore, the Care Act is a positive recognition not only of the crucial role family members play in providing care and support to substance users, but of their need for support in their own right. However, the surveys did not capture services' experiences of implementing the Act, and the findings are perhaps too premature to be able to gauge the impact for family support services.

It must be remembered that there is significant diversity in the provision of family support: it can be provided by integrated services with drug and alcohol treatment services, a standalone family support service or generic carers services, and can operate in the voluntary, statutory and private sector.

² UK Drug Policy Commission (2012) [The Forgotten Carers: Support for adult family members affected by a relative's drug problem](#) (pdf)

³ Copello and Templeton (2012) [The Forgotten Carers: Support for adult family members affected by a relative's drug problems](#). UKDPC

⁴ Meyers et al (1999) [Community reinforcement and family training \(CRAFT\): engaging unmotivated drug users in treatment,](#) 10 *J Sub Abuse* 291

⁵ HM Government (2010) [Drug Strategy 2010 Reducing demand, restricting supply, building recovery: Supporting people to live a drug free life](#) (pdf)

Generally family support services are still feeling the effects of the significant restructuring of health and social care structures, brought about by the Health and Social Care Act 2012 which, as well as setting out new structures, stated that mental and physical health must be treated with equal importance. The loss of a ring-fenced drug and alcohol treatment budget and its wider inclusion in the public health budget may similarly be affecting a number of family support services delivered as part of an integrated service with treatment, compounded by recent cuts to local authority budgets. Changes over the past several years will have led to positive opportunities for some and significant challenges for others. This report will provide an overview of the state of the sector, highlighting examples of some of those experiences.

What's really happening?

Commissioning

i. Changes in the way services are commissioned

An almost equal number of FSoS respondents reported having seen changes in local commissioning trends as those who did not. Many of those who had experienced changes described a greater emphasis on partnership working and having to offer a wider scope of services. The uncertainty around funding was also highlighted by several respondents.

"In new tenders, commissioners are looking for joined up interventions, which include smoking, sexual health, mental health." (Survey respondent, FSoS 2015)

When asked to describe changes in commissioning trends, a mixture of positive and negative experiences were reported. Positive examples included a new 'family focus', and recognition of the value of family support services. Others highlighted negative impacts, such as shorter contract lengths, commissioners wanting 'more for less', reduced provision of services and an 'unhelpful' or 'heavy' focus on outcomes.

"Commissioning leads have changed from the substance misuse specific to public health, who don't appear to have the broad understanding of some of the challenges/complexities. Plenty of consultation, but views not reflected in the model. Hearing negative perceptions from service users of not being heard." (Survey respondent, HC 2014)

"Good and bad. Some loss of focus on drugs and alcohol but this appears to be getting stronger, as people realise the important part we have to play in the wider determinants of health and the public health agenda." (Survey respondent, HC 2014)

One comment in the HC survey raised the issue of families being used solely as a means to encourage service users to successfully complete treatment, rather than receiving support in their own right:

"Support for families affected by a loved one's drug or alcohol misuse are being forgotten. The money is going to drug and alcohol services to train up suitable family members to support the user. The families are being used as a tool." (Survey respondent, HC 2014)

ii. Size and scope of services being commissioned

Around a third of respondents across both surveys thought larger services were being commissioned over smaller ones. Many saw this apparent preference as a negative development.

“Seems to be a trend in decommissioning small, local organisations with significant local knowledge and reputation, in favour of large organisations that usually haven’t worked in the area – no attempt to subcontract specialist family support.” (Survey respondent, HC 2014)

“Smaller [charities] that receive the least financial support are expected to provide more services with less money. Therefore, there is an expectation that volunteers will pick up the slack. This is difficult if trained individuals are needed to provide the service, as most professionals are not willing to give their time for nothing.” (Survey respondent, HC 2014)

“We see a focus on family support being given to smaller, more local services, away from the mainstream addiction treatment service. This enables family members to distance themselves from the treatment provider and avoid the stigma.” (Survey respondent, HC 2014)

Several HC respondents reported a move towards more generic services being commissioned, and others also noted an increased focus on multi-agency working and partnerships. Opinions differed widely: some perceived this as a negative development, whereas others considered the drive towards integration more positively.

“The integration of drugs, alcohol and DIP [drug intervention programme] services has improved service delivery. This has required a training programme to increase skills.” (Survey respondent, HC 2014)

In FSoS, around a third of respondents reported that more generic/integrated services were being commissioned, compared to 14% who thought more specialist services were being commissioned. All four phone interviewees discussed a greater emphasis on the integration of services, although experiences and opinions, like survey respondents, differed:

“The bulk of family support services is integrated. We are the only one that sits outside that now. The commissioner at the time wanted to put us into that group, but I was able to...highlight and identify the need for [us not to be].” (Service manager, Yorkshire and the Humber)

“The drug and alcohol stuff used to be different, but now we’ve merged. It’s a positive step, it’s worked for us. For example, it’s allowed access to counselling and relaxation vouchers. It’s made a big difference – as long as you keep the specialist workers.” (Service manager, South East)

“Family support in [a neighbouring county] is provided by the main service provider... I don’t think it’s a good thing because family members, in our experience, don’t want to be going into drug and alcohol provider premises... Also, I think family members need that specialist support, and main providers are focused, in the main, on the user... The problem with having them separate is getting sufficient referrals.” (Paul Urmston, Chief Executive at ESH Works)

Phone interviewees generally reported positive relationships with their commissioners. One service manager also sat in the local commissioning team, and described the advantage of his role in being able to ensure that family support is prioritised:

“I’m always ensuring concerned others aren’t overlooked. Families are pivotal to the success of the new model.”

Another service manager of an integrated service reported a positive relationship with their commissioners and maintaining regular contact. However, they were keen to highlight the impact of the Care Act on their service:

“They’ve [commissioners] just launched a commitment to carers. The carers assessments are a different kettle of fish...we’re all struggling with that, including commissioners. They are trying to address gaps – we’re the only ones that send clinicians to homes, and are seeing carers in their own home.”

Opportunities for the main service and family support providers to discuss their activities, feedback and share learning are provided by quarterly contract reviews, according to one service manager. However, another was less enthusiastic about the local commissioning situation:

“Unfortunately, we’re not commissioned by the local authority anymore. They took the money and put it into integrated treatment services. They [commissioners] are not adequately addressing gaps. Had we not had [grant] money, there would be no provision in our local area. The local treatment service subcontracted us for 1.5 days per week, which tells you how much money there is for family support. It’s appalling!”

iii. Commissioning cycles

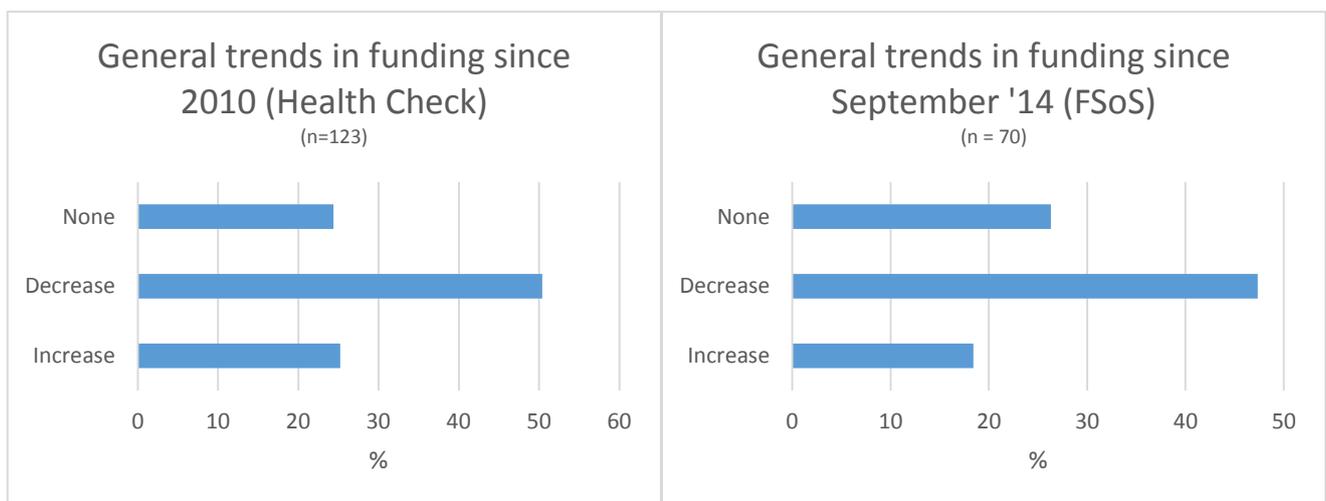
A trend towards shorter rather than longer commissioning cycles was apparent, although plenty of respondents reported not having seen any changes in commissioning cycle lengths.

“This year it’s all about one contract for each county in the drug and alcohol field. Small charities are no longer catered for; they are expected to partner up with a larger charity. That’s not good, as we lose a lot of specialised individual charities.” (Survey respondent, HC 2014)

“There was no specific provision in the area, and we now have a one year funded project to work specifically on family support.” (Survey respondent, HC 2014)

Funding and the impact on services of changes to funding

i. Trends in funding



Around half of respondents in both surveys reported a decrease in funding. Almost a fifth of FSoS respondents reported an increase in funding in the previous year, whilst a quarter of those in the HC survey reported an increase in general funding trends since 2010. Some respondents were keen to highlight the uncertainties and difficulties around the state of funding:

“The field is precariously underfunded, which is a disgrace. There should be a national mechanism to invest in support for families, rather than being at the mercy of commissioners with greater or lesser levels of insight into the value of this vital work.” (Survey respondent, FSoS 2015)

“The funding has been sporadic and uncertain from year to year, so the future of the project is always at risk.” (Survey respondent, FSoS 2015)

“We are struggling to continue to run the service, our staff team has been cut and we face further uncertainty around funding. We have to rely on various funding streams with different outcome requirements, which means sourcing funding and meeting targets can take over the important therapeutic work we offer. The mantra of providing more for less is becoming unsustainable.” (Survey respondent, FSoS 2015)

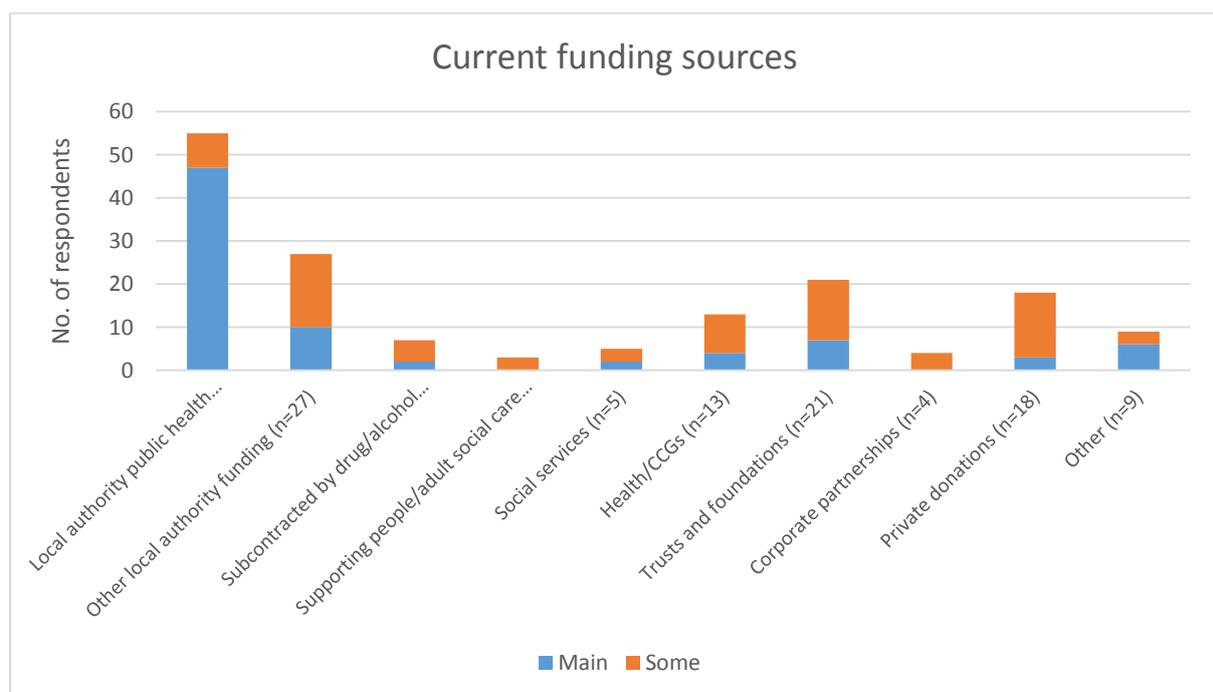
Others, however, described having sustained their funding in the face of a challenging landscape, or having received slight increases due to funding for a new staff member, for example.

Comments in the HC survey similarly highlighted a range of local experiences. Many were concerned about reductions in funding or anticipated reductions in the near future. Two respondents from services preparing to be decommissioned were anxious about the future of family support in their areas:

“[The service] is due to be decommissioned... [National treatment provider] will be the new provider for adult treatment in [the area], including families – but only where the user is in treatment.” (Survey respondent, HC 2014)

“Services for carers/families due to be decommissioned... we are extremely concerned that there will be no service/support for carers/families in their own right.” (Survey respondent, HC 2014)

FSoS additionally asked respondents to record their funding sources and the level of funding received from those sources. It was not, however, mandatory that respondents record their level of funding from each of the individual sources listed.



The graph shows that the majority of respondents worked in services where the main source of funding was local authority public health budgets: of the 64 respondents, 47 stated this was their main source, and eight said they received some funding from this budget. Other local authority funding was the second highest source, with 10 stating it was their main source, and 17 receiving some money. Trusts and foundations are also funding family support services, with 21 respondents reporting receiving at least some funds from this source. Eighteen respondents said they received some funding from private donations, and 13 reported being funded by health/clinical commissioning groups. Funding from Supporting People/adult social care, corporate partnerships and social services was less common. Seven respondents received funding as a result of being subcontracted by a drug/alcohol service, and nine reported receiving funding from a source not listed, including church groups, Police and Crime Commissioners (PCCs), fundraising and rental income. The Big Lottery Fund was also mentioned several times.

The interviews with service managers and the Chief Executive of ESH Works corroborated this mixed picture of funding sources, with funding coming from grants, local authority public health budgets, other local authority budgets and, for one service, two subcontracts from drug and alcohol treatment providers. Two of the three service managers reported decreases in funding; one of whom attributed the recent reduction in the organisation's funding to cuts to local authority budgets:

"We're grant funded by various organisations, including two subcontracts by treatment providers to do the family service within the organisation. The landscape is not stable, and we're in an iffy position as a small, volunteer organisation. The funding has decreased." (Service Manager, South East)

"The funding for the concerned others service is currently provided by the local authority, PHE and public health within the local authority... Given the cuts that local authorities have had to absorb – and have had to for the past few years – this has resulted in a recent reduction in our own budget this year and, consequently, next year, and probably the year after." (Service Manager, Yorkshire and the Humber)

A service manager from the South East reported that funding had been 'fairly' stable for the past three years but, coming to the end of a three-year contract, was concerned about the future and possibility of re-tendering:

"We don't know if we'll get an increase or decrease, but I'm not expecting an increase. In the family support sector, I think it's been fairly static, partly because now we have more good examples of how much families save the state and all that evidence, which is a good preventative argument."

Paul Urmston was more optimistic about current funding, and described a positive local recognition of the value of family support services:

"As a commissioned service, we are quite stable, because there's a lot more empathy from funders with the plight of families trying to deal with an addict... The last round was four years ago, and the cycle was: 2years +2years +2years – so, a potential six years funding... We're hoping that as we fulfil our role, we will get another two year extension and that will be the last of the extensions on offer. Then, the service will have to be re-commissioned."

Survey and interview findings indicate an overall trend of decreased funding for family support services, with around half of respondents in both surveys reporting decreases. What emerges overall

is an unstable and precarious picture of the funding environment for a significant number of family support services across the country.

ii. The impact of funding changes

Service managers reported a number of impacts on the delivery of services as a result of funding instability, including loss of staff members, reduction of staff hours, heavier caseloads and the loss of services such as respite and complimentary therapies.

“It has directly affected our family support service in that we’ve had to reduce one service user from a full-time to a part-time post to enable the roll on of funding.” (Service Manager, Yorkshire and the Humber)

“It’s unstable at the moment, which has a huge knock-on effect on operations. You know, who we can recruit, how long we can give our staff contracts and with the continuity of service generally. Also, the lease on the building – our trustees won’t let us take a long-term lease because of the risk of re-tendering.” (Service Manager, South East)

Survey respondents were asked whether cuts to funding or decreased capacity had led to a loss of staff or prevented key functions from being carried out – the majority felt they had. One comment highlighted the problem of high staff turnover due to the insecurity of funding. Just over a quarter said they had not experienced funding cuts.

iii. Staff capacity, workloads and morale

An overwhelming majority (95% of HC and 74% FSoS) of respondents had experienced an increase in their personal workload. Some attributed the increase to reduced funding, others to increases in families coming forward for support. Several respondents also noted an increased focus on reporting and bureaucracy, which they thought was having a negative impact on the delivery of services. Some suggested that peer support was being expanded to fill gaps in provision.

“Less days’ employment for the same amount of work.” (Survey respondent, HC 2014)

“Referrals have increased and remained steady, and we have a permanent waiting list which we have not had previously.” (Survey respondent, HC 2014)

“More paperwork and risk assessments.” (Survey respondent, HC 2014)

“There is now a two month waiting list to access the family therapy service, and a peer mentor scheme is being developed to expand the availability of support.” (Survey respondent, FSoS 2015)

According to phone interviewees, staff morale was reported to be generally positive, despite three service managers raising issues of capacity in their services. One described working at “around 90-95% capacity” consistently, and having to curtail the provision of home visiting services.

“Staff morale is mixed. Because of the reduction in funding and potential withdrawal of funding, they’ve been advised there may be redundancies, which is upsetting, but we’ve been working hard to overcome the need to make people redundant.” (Service Manager, Yorkshire and the Humber)

The importance of volunteers was highlighted in three of the four interviews.

“We lost two members of staff, and that gives you an indication that other people have been taking on extra caseloads. The other aspect is that volunteer work has increased because of that.” (Service manager, South East)

One service manager described their stretched staffing situation and the role of volunteers in ensuring that service delivery continues; yet, despite these challenges, staff and volunteer morale was said to be strong:

“We’re under-resourced, but what we do have is amazing volunteers – we couldn’t manage without them. We have two part-time workers who are stretched across the whole county, and they couldn’t do it without the support of the volunteers. There are about 840 families, with two part-time workers... Staff morale is pretty good, actually. We did a staff survey last August and 96% said they were happy with their work. I think, also, that about 94% of volunteers felt their work was meaningful and useful.” (Service manager, South East)

ESH Works uses a peer-led model, with volunteers providing the main bulk of service delivery. Paul Urmston explained:

“We’re peer-led, so most staff are volunteers – ex-service users or families we’ve supported. All the staff we’ve recruited in the last two years have come from that route, and I think that’s key. I think, because of the way we’re structured, it’s quite manageable right now. There’s no caseload situation, because it’s peer-led; so, it’s done in support groups and one-to-ones as and when they occur. If capacity becomes a problem, we redirect people to the group support.”

Staff and volunteers

i. Numbers of staff/family support staff, staff status and qualifications

The majority of survey respondents worked for fairly small organisations. In FSoS, over half of respondents managed a service with less than ten staff members in total, and only 6% worked for an organisation with more than 100 staff members. Two-fifths of respondents in the HC survey said their organisation employed 10 or fewer staff members.

Moreover, a significant number of organisations reported employing only a small number of specialist family support staff (three or fewer). Survey findings showing that the majority of dedicated family support staff are either full-time paid workers or volunteers.

ii. Support and supervision structures

Both surveys asked respondents whether they considered their organisations to have adequately developed support and supervision structures, and results were predominantly positive. Of the FSoS respondents, over three-quarters felt they did have adequate structures, with comments describing clinical, peer, group, internal and external supervision arrangements, monthly case reviews and staff meetings that provide an opportunity to support family support staff.

Two comments stated that no external supervision for staff was provided in their service, with one attributing this to the loss of support from the local drug and alcohol commissioning team. Others recognised the need for development and/or improvement of existing support and supervision structures, with one respondent saying,

“This is a new approach for us, so still identifying appropriate support structures.” (Survey respondent, FSoS 2015)

In the HC survey, an almost identical proportion (77% compared to 78% in FSoS) of respondents felt their organisation provided staff with adequate support. However, several respondents highlighted

challenges around support and supervision policies, including a lack of time due to large caseloads and changes in staffing levels.

“I feel that we do have good supervision in place but I would greatly benefit from systemic family focused supervision as well.” (Survey respondent, HC 2014)

iii. Access to continued professional development

Responses were similarly positive about access to continued professional development opportunities, such as training and events. More respondents thought that staff did have sufficient development opportunities in the FSoS survey (71%) than in the HC (63%). Around a quarter of respondents in both surveys felt their organisation had ‘some’ access to continued professional development, and only a small percentage (4%) of FSoS and a tenth of HC respondents did not think that staff were sufficiently able to take advantage of such opportunities. It may be that development opportunities have improved since 2014; however, we cannot say for certain given the methodological limitations.

Comments from both surveys were varied and showed a range of experiences. Some FSoS respondents reported accessing training opportunities provided by the organisation itself, the local council, third sector organisations, PHE and the local drug and alcohol action team. Two respondents said their organisation encourages staff to identify training they would like to attend, with one saying that training needs were identified via supervision to respond to emerging trends. However, some respondents said that because of financial constraints and cuts to funding, the opportunities for professional development had suffered. One respondent stated that it was an underdeveloped area within the organisation, and recognised this as a gap; whilst another commented that many training and event opportunities take place in London, which was inaccessible.

“Training identified via supervision, service needs and responding to new emerging drugs and trends. Access to a joint provision of safeguarding training.” (Survey respondent, FSoS 2015)

“A lot of training/events are based in London, so not accessible.” (Survey respondent, FSoS 2015)

Of those that felt they had access to continuing development opportunities, the types of training on offer included: mandatory legislation updates; core skills training on attachment, parenting, planning and assessment; safeguarding; confidentiality; equality and diversity; domestic abuse and working with carers. Nevertheless, taking all comments together, it seemed that opportunities had been restricted due to cut budgets.

“We can’t afford to pay for training – and we are so stretched we can’t attend as we have no one to cover for us in our absence.” (Survey respondent, HC 2014)

The three service managers interviewed all described having a small training budget, with one manager reporting that it is continually decreasing. They did, however, express a commitment to staff development; stating that where a training or development need is identified they seek to provide appropriate opportunities.

“We don’t have a lot of money for training and workforce development. We have a training budget, but it’s not huge... We’re lucky in that we work with lots of partners and can access training through them, including the local authority. For example [the main treatment provider] offers training courses and all our staff are doing that at the moment.” (Service manager, South East)

Paul Urmston said that ESH Works ensures that a portion of the budget is put aside to train volunteers and staff; although, this is mostly provided to volunteers, given that they deliver the

majority of the organisation’s projects. The service had trained six staff members in alternative therapies in the past year. Despite this, the training budget was said to be “*never enough – people always want more training.*”

Clients: Support needs and services

i) Services and interventions

Respondents were asked about the types of support on offer to family members in their organisations, and were able to select all of those which applied. Respite was the most infrequently provided, and one-to-one support was the most common in both surveys. Group, telephone, and practical advice and support are offered by the majority of services, and over half of FSoS services provided structured/formal interventions. Other services on offer included employment, advocacy, tenancy, bereavement, parenting and email support; carer’s assessments; criminal justice educational sessions; resource development and Skype support.

Survey respondents were also asked to state which, if any, evidence-based interventions were provided to families in their services. The responses are set out in the box below.

Type of Intervention	FSoS (n=54)	HC (n=71)
The 5-step model	31%	48%
Community Reinforcement	28%	24%
M-PACT	17%	13%
PACT	11%	13%
Triple P	17%	24%
SMART Family and Friends ⁶	26%	N/A

The most commonly offered intervention in both surveys was the 5-step model, followed by Community Reinforcement. As reported in FSoS, SMART Family and Friends was also provided in over a quarter of services. A variety of other interventions were listed in the comments, including CBT (Cognitive Behavioural Therapy), Holding Families, Strengthening Families, PUP (Parents Under Pressure) and a range of other family focused and parenting interventions (e.g. 12-step programme). One service reported providing Equine Assisted Therapy (FSoS), and two said they had developed interventions themselves; one using a “*combination of the best features*” of existing evidence-based interventions.

Two-thirds of FSoS respondents reported delivering joint interventions with the user and family members/friends. A wide range of interventions were described in the comments section, including structured interventions, such as M-PACT, CBT and Triple P, and informal group work, meetings and joint sessions. Some respondents said they provided couples and family counselling, and several also offered family mediation. Less common responses included the provision of Social Behaviour and Network Therapy (SBNT): an intervention shown to be effective with harmful drinkers, which utilises cognitive and behavioural strategies, helping clients build family and social networks.⁷

⁶ This option was not provided in the Health Check survey.

⁷ Watson et. al. (2015) ‘A randomised controlled feasibility trial of family and social network intervention for young people who misuse alcohol and drugs: study protocol (Y-SBNT),’ *BioMed Central* (web resource)

The telephone interviews provided similar findings, with services offering practical advice and information, telephone support, one-to-ones, group support and structured interventions. One service manager described operating a unique approach whereby the services offered are flexible and responsive to client needs:

“What we do is say, ‘we are the concerned other’s service, what can we do to help?’ rather than, ‘this is what we do.’ If there’s a list of services offered, and that’s not what they want, they won’t come in. We don’t rule anything out and work in conjunction with a range of services... We say it’s a menu chosen by them.”

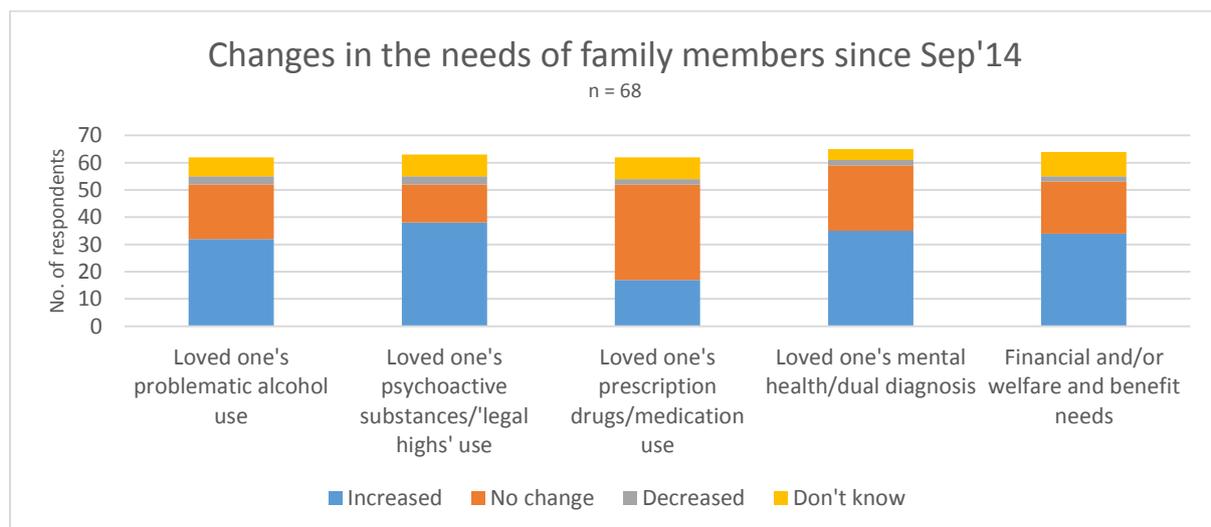
Another service manager worked within a service which follows the 5-step model, provides home visiting services and joint structured interventions working with the family and user together. Paul Urmston highlighted the importance of proactive engagement with local families, describing the service’s successes in engaging and recruiting family members through education sessions, and involving users in the provision of family support.

“People would come and be educated about drugs and alcohol, but didn’t want to admit a problem in their family. We found that approximately eight of 10 family members [attending the education sessions] would want to stay and talk about someone they knew – so, it was a way of capturing those...”

A key initiative in starting the [family] support groups was the participation of an addict in recovery. This was breaking new ground five years ago, but I believe it’s now accepted as a beneficial approach... The use of a person in recovery is one of the things that’s really made the service work.”

ii) Needs of families

In the more recent FSoS survey, respondents were asked whether the needs of the family members they worked with had changed since September 2014 in relation to several specified issues. The graph below shows the number of respondents who thought needs had increased, decreased, remained unchanged and those who were unsure, across five domains. Participants need not have responded to each domain individually.



The graph shows that in four of the five domains, more than half of respondents thought family members’ needs had increased. Perhaps unsurprisingly, the domain respondents felt had most increased was in relation to their loved ones’ use of novel psychoactive substances (NPS) – or ‘legal highs’ – with almost two-thirds considering that families’ needs had increased as a result of this.

Only around a quarter thought that the needs of families had increased due to their loved one's use of prescription drugs or medication. Few respondents to any domain (less than 5%) felt that needs had decreased.

In the HC survey, respondents were asked what trends they had seen in the needs of their clients. The two most common trends described an increase in families accessing services due to their loved one's alcohol and NPS use. A large number of respondents said that alcohol was becoming a more common reason for family members to access support, and an even greater number reported an increase in NPS use amongst the loved ones of their clients. With regards to alcohol, some respondents attributed this to particular populations: for example, an increase in drinking amongst women and older generations. Similarly, NPS were often referred to in the context of use by young people. A small number of respondents noted a decrease in family members accessing support due to a loved one's use of opioids or crack cocaine.

"Older people, over 50s, are a generation who are increasingly turning to services for support due to the impact of alcohol use." (Survey respondent, HC 2014)

"Increase in legal high use. The issues that parents are facing are more around dealing with...mental health and behavioural type issues..." (Survey respondent, HC 2014)

A service manager interviewed also discussed the rise of NPS, noting a rise in the longer-term harms related to NPS use, such as bladder and bowel problems, and describing the added impact this has on families. Some comments drew links between the rise in NPS use and mental health issues. The number of family members concerned about their loved one's cannabis use was said to have increased by some respondents, and others reported an increase in families accessing support around their loved one's use of prescription drugs and over the counter medications. Families accessing support due to a loved one's steroid use was reported in the HC survey, and accessing support for financial and welfare issues was said to be becoming more common.

"Certainly more alcohol/legal highs/prescribed medication over the last few years but increasingly the trend we see is families that have multiple and complex needs due to a host of societal factors. Poverty (including fuel and food), domestic and financial abuse, dual diagnosis where there is little or no community mental health support and families are dealing with frightening and dangerous situations without necessary specialist intervention." (Survey respondent, HC 2014)

The number of families accessing support because of a loved one's mental health issues and dual diagnosis was said to be increasing by several respondents. Some indicated that family members' mental health was worsening, and others reported an increase in complex needs amongst families. One service manager stated that local data showed an increase in families reporting domestic violence, mental health and criminal justice issues. However, they did not consider this to be evidence of an increase in those problems; rather, they said:

"There's been an awful lot of work done in highlighting these issues, and we ask people now, whereas before we wouldn't ask about things like domestic violence."

Indeed, reported increases in the numbers of families accessing support for certain needs do not necessarily evidence an increase in those needs. It may be that services are simply getting better at identifying those needs, or that awareness of these needs had improved amongst family members themselves, driving them to access support.

Partnership working amongst family support services

i. Relationships with other family support services

A large majority of FSoS respondents (83%) felt they had positive relationships with other family support services. Positive comments described services' links and joint working with other family support and local carers services. Noted advantages included shared clients, an increase in referrals, good feedback, strong partnerships, joint events and the creation of better multi-agency approaches to working with families. Negative comments highlighted a lack of family support services in the area with which to build relationships, low numbers of referrals and an unwillingness to share information amongst agencies.

"There sometimes can be a conflict of interest and a reluctance to share information. There is a concern that families will become overwhelmed by too much intervention and this causes confusion." (Survey respondent, FSoS 2015)

A general appreciation of the importance and value of joint working was discernible from the comments as a whole.

"Services in this space have always been limited. In this borough, those who offer services know that it is critical that we work together to get value for money, as well as deliver to contracts that are demanding." (Survey respondent, FSoS 2015)

A number of HC respondents also described having closer relationships with other family support services and increased joint working amongst a range of local agencies:

"More partnerships with domestic abuse services, carer's organisations, children's social care and early support and intervention teams." (Survey respondent, HC 2014)

Some respondents did not consider their relationships with other family support organisations to have changed. Only one respondent explicitly stated that their relationships had deteriorated, saying, *"Due to staff shortages, [it's] been difficult to attend networking events to build relationships."*

The barriers caused by the tendering process to building strong relationships with other services was mentioned by several respondents.

"We are all often competing for the same contracts and funding, which can be difficult." (Survey respondent, HC 2014)

"They are now less willing to share experience and are unwilling to discuss what we're finding difficult, as no one wants to be seen as doing anything but brilliantly, due to fierce competition for funding." (Survey respondent, HC 2014)

"Partnership working with statutory colleagues continues to be strong, but with colleagues in the voluntary sector...it has become more competitive." (Survey respondent, HC 2014)

ii. The impact of reforms and changes on relationships with other family support services

In FSoS, most respondents did not think their relationships with similar services had been affected by changes and reforms to health and social care structures and ways of working. A small number of respondents described improved relationships, and two attributed this to an increase in joint working. Conversely, several described negative impacts of the changes, and some said that changes had increased competition amongst local services.

“Everyone seems busier trying to do more with less resources. This obviously impacts the ability to provide support and the quality of support - at the same time as more support is required by ever more complex families. We no longer have any capacity to do outreach to build relationships, and referrals drop if we do not have a presence in a local area.” (Survey respondent, FSoS 2015)

“There is more competition for targets to be met and, sometimes, the welfare of the individual family’s needs or who is best placed to support the families is not always taken into consideration.” (Survey respondent, FSoS 2015)

Again, the HC findings mirror those of FSoS, revealing that the majority of respondents did not believe changes and reforms had any impact on their relationships with other organisations offering family support. Some respondents said that relationships had improved because of strengthened partnerships, and one thought that recent reforms had resulted in a better recognition of the value of family support services.

“We are in the early implementation of our commissioned family programme, but this has increased the relationship building...Joint home visits have increased, which helps resources.” (Survey respondent, HC 2014)

“Perhaps they [funders] see the need to acknowledge us due to the emphasis on patient/carer voice, whereas previously they would have ignored us.” (Survey respondent, HC)

Two HC respondents referred to the problems arising out of competition between services – *“We no longer work together. It’s a Them and Us situation”* – and others reported that recent changes had led to worsened relationships, due to cuts, capacity issues and the de-commissioning of other local family support services.

Post-2013 structures

i) Knowing who to access and levels of engagement

Given the funding pressures on family support services, it is important for these services to know who to access within their local decision-making structures and build effective relationships. Approximately three-quarters of FSoS respondents said they did know who to access and speak to in their local structures, compared to 57% in the HC survey. This may be a positive indication that services’ understanding of the new structures created by the Health and Social Care Act 2012 has improved in the year since the HC. Similarly, substantially less FSoS respondents reported not knowing who to access in their local decision-making structures (9% compared to 17% of HC respondents).

Of those positions and roles respondents had been able to identify in local structures, these included PHE, DAAT (local drug and alcohol action teams) and adult and children’s services commissioners, managers and heads of service. Few FSoS respondents stated they had identified contacts within their local Clinical Commissioning Groups (CCGs) or PCCs. One respondent said they had links with GPs, and two described knowing how to access local politicians.

“Relationships exist within the drug and alcohol commissioning team and we know who to speak to, but it is difficult to develop other relationships, for example within the CCG, or to know what other possible funding streams could be worth pursuing.” (Survey respondent, FSoS 2015)

HC comments showed greater evidence that respondents knew how to access a broader variety of local decision-makers, including commissioners in public health, the DAAT, PHE, CCGs, PCCs and local

councillors. Several mentioned links with local safeguarding teams or boards and two respondents said they knew how to access their local Healthwatch.

The agencies with which respondents had most engagement were local public health teams and PHE, with over a third in both surveys reporting close working with these agencies, and nearly half reporting at least some engagement. Respondents were also in contact with Troubled Families teams, although over half said this did not amount to a close working relationship. Around two-thirds said they had some engagement with the CCG, Health and Wellbeing Board (HWB), and slightly less with PCCs (59%). Only two respondents reported engagement with Transforming Justice.

ii) Opportunities for building and sustaining relationships

In the earlier HC survey, 60% of respondents felt they did have adequate opportunities for building and sustaining relationships, whilst 40% did not. This is broadly similar to FSoS results; where around two-thirds felt they had sufficient opportunity to build and maintain relationships with local agencies. Respondents said they were able to build and sustain relationships through meetings, steering groups, regular email contact, committees, networking groups and joint protocols.

“We attend regular meetings, work in partnerships, have open days where [these agencies] can attend to see what we’re doing, work closely with the police – especially IMPACT – input on GP newsletters, shared care meetings, safeguarding meetings and work very closely with social care.” (Survey respondent, FSoS 2015)

Where barriers were identified by respondents, these included a lack of commitment to family support by local commissioners and decision-makers, and a lack of response from various agencies when contact was attempted. A number of survey respondents also stated that a lack of engagement with different agencies was due to capacity issues within the service. However, one HC respondent questioned the value of multi-agency meetings, even where they do take place.

“Opportunities to build relationships is definitely reduced. It tends to be of an informal nature at events or open meetings, when we know certain individuals will be attending. We have great difficulty in booking meetings with many of the individuals we need to meet up with.” (Survey respondent, HC 2014)

“Not enough time for networking.” (Survey respondent, HC 2014)

“Due to agency capacity, we have to focus on service delivery, which impacts on availability to pursue and meet decision makers.” (Survey respondent, HC 2014)

iii) The impact of the new structures

According to survey respondents, whether the creation of these agencies had increased or decreased the attention that family support services in the area were receiving varied: over a third of FSoS respondents thought it had increased and 16% thought it had decreased. Around a third did not think the new structures had impacted the level of attention given to family support services.

In the HC survey, the question was an open-ended one, enquiring about the impact of the creation of the new agencies on commissioning, joint working and the attention on family support. The variance in local experience was clearly illustrated: two-fifths had not yet seen an impact, just under a third felt negatively about the impact, around a quarter felt positively and three respondents highlighted both positive and negative impacts. Positive perceptions of the changes included greater attention to and recognition of the value of family support, a clearer focus and increased funding and joint working opportunities.

“The Troubled Families Programme has had a positive impact, in recognising the value of our service’s work...” (Survey respondent, HC 2014)

“Commissioning is more stable. Commissioners are very in touch with the service delivery and visit on a regular basis. Police in each service area liaise with teams and are involved in joint events... there is representation at MARAC, [a carer’s forum], joint working with PHE and health services have improved.” (Survey respondent, HC 2014)

“They have changed commissioning and it has been unstable for a while, but it’s just been another transition period we’ve adapted to. It also provides new opportunities.” (Survey respondent, HC 2014)

In contrast, negative comments described less stability, decreased funds, insufficient understanding of family support and barriers to joint working, due to both a lack of opportunity to network and the feeling of competition amongst local agencies. One respondent articulated some of the most commonly reported negative impacts:

“The diversity agenda has made things quite challenging, as we do not fit neatly into any of them, rather covering a wide range of agendas and commissioning streams. The tight focus...has meant that many of the people responsible often don’t see our service as something that relates to what they’re doing, and we have to work very hard to make sure they see how we fit in. The competition created by the various tenders have made partnership working more difficult than ever... and people are more reluctant to share knowledge and ideas. The atmosphere is one of suspicion as many organisations fight to stay afloat.” (Survey respondent, HC 2014)

It is safe to assume from the mixture of responses relating to the impact of structural changes on family support services that local experiences differ greatly – even amongst individual local services – depending on a number of local variables and characteristics.

“We have a great working relationship with our local teams. The difficulty is that there are so many meetings to attend it’s impossible to participate with them all, therefore, you have to be really involved in reading up...” (Survey respondent, HC 2014)

“It is difficult to realistically engage meaningfully with all [the] organisations we would wish to. There are tenuous links with some and firm relationships with others. Joint working and training (for example with the Troubled Families programme) has been positive.” (Survey respondent, HC 2014)

Evaluation

Survey responses suggest that a wide variety of evaluation methods are utilised by services, with some using several different methods for evaluating and monitoring their work. Several respondents noted that they are required to meet agreed outcomes, as stipulated by their commissioners or funders. An FSoS respondent highlighted the challenges of meeting outcomes set by multiple funders requesting different evidence and outcomes:

“We currently have four separate funding streams and need to provide different monitoring information to each on a quarterly basis. Monitoring is taking over and shifts the focus away from the actual work delivered.” (Survey respondent, FSoS 2015)

Others reported using recognised evaluation tools, such as the Family or Outcomes Star and M-PACT. However, many also described using an outcomes measurement tool developed in-house. A range of evidence was gathered by services, for example:

“Each family member is invited to be part of a self-monitoring programme, measuring changes relevant to their situation at start of contact, regularly throughout and an exit survey...All participants are invited to give feedback against a set of aims/outcomes in 1-2-1 sessions, group sessions and workshops. We undertake an annual satisfaction survey...Statistical information...for instance, the number of callers, length of call, who makes the call, what drugs are involved...as well as other relevant information. Other agencies are invited to feedback on an annual basis about the value of our work with their clients.” (Survey respondent, FSoS 2015)

Many services used a range of methods to gather client feedback, including satisfaction surveys. A number of respondents, particularly in the HC survey, said they were required to submit regular reports, often quarterly.

Services made use of this evidence in many different ways, with common responses including: to present and report to commissioners, help write bids and for internal purposes, to identify need and improve service delivery.

“The evidence is used in promoting the work we do, to report to commissioners, to demonstrate to staff/volunteers the needs of the service and outputs/outcomes achieved. The evidence is also used when looking for funding.” (Survey respondent, FSoS 2015)

“Maintain a library or ‘hub’ of evidence including outcomes and monitoring, young people’s participation, pictures, case studies etc. It is used towards quality practice improvement, funding and reporting, research and business development.” (Survey respondent, FSoS 2015)

Some respondents sent their evidence to agencies such as children’s services and the Local Safeguarding Children’s Board. Other comments, rather than focusing on reporting to funders or partners and securing bids, were more family or carer-focused, stating that the evidence gathered was used to identify needs, and monitor and design appropriate action plans to support the family.

“They are used to monitor the qualitative outcomes of both the ‘therapeutic alliance’ and the improvement in the overall sense of personal wellbeing of the concerned other.” (Survey respondent, HC 2014)

“It is being used to gain a bigger picture and to see if the programmes we offer are making a real difference to family lives.” (Survey respondent, HC 2014)

Looking to the future

In both surveys, respondents were asked to describe their hopes for the future of families affected by substance use, their organisation, region and the family support sector as a whole. A substantial amount of narrative content was gathered, and similar hopes were expressed in both sets of responses. The majority of respondents hoped for an increased recognition of the value and importance of family support. Some were keen to emphasise that there should be continued or increased recognition of the need for families to be supported in their own right, independently of the substance user; whilst, on the other hand, others hoped for greater inclusion of families in the treatment of their loved one.

“I would like to see increased provision. I think the potential for families to become an active part in the recovery journey for substance users is hugely untapped. Not only can we provide support for families in their own right, but we can also support them in supporting their loved one. Rather than

excluding them from treatment we should bring them in. I see family services as being a key part of this.” (Survey respondent, HC 2014)

“For more dedicated facilities to be provided to the concerned relatives across the region. I would also like to see family services which are known for delivering family/carer support services within a model of good practice to be replicated across the region. For the concerned others to be more recognised as a key facility to their relatives in the recovery process.” (Survey respondent, FSoS 2015)

Another common hope amongst respondents unsurprisingly centred on continued funding and being able to sustain the organisation’s delivery of services in a climate of financial uncertainty. Anxiety over whether services would be able to maintain their funding and continue to provide vital services to families was evident in responses. However, others were more ambitious, stating that not only do they hope to sustain their service, but to extend provision to more families and offer a wider variety of support options.

“To sustain the service we have developed over the last year. Our caseloads are manageable at the moment, but they are increasing every month, so our funding needs to be sustained.” (Survey respondent, FSoS 2015)

“We hope to provide ongoing support for parental substance users in addition to children affected by parental substance use. Yet, as an organisation, ideally we would like to extend our support provision and reach out to more families and develop a peer mentoring scheme amongst and within families affected by drug and alcohol use.” (Survey respondent, FSoS 2015)

“My main hope is that the positive reforms remain positive and that funds are available to continue the work that all family support groups offer. My hope is that the organisation continues to flourish and become sustainable in the future (a long shot). I hope that all agencies continue to work together...and learn from others...” (Survey respondent, HC 2014)

A large number of respondents hoped for improved access to a range of services for families, and many referred to improved joint working with local partners. Effectively tackling the impact of stigma also prominently featured in respondents’ comments.

“I’d like there to be a bigger drive to reduce stigma of addiction for both the addict and their family.” (Survey respondent, HC 2014)

“More robust early intervention around hidden harm and parental substance misuse, greater resources allocated to families affected by substance misuse. In addition to the above, that the family support sector continues to prioritise developments in this field and establishes more platforms for services to work together for the purpose of undertaking family intervention and engagement with troubled families.” (Survey respondent, FSoS 2015)

Others said they hoped for better provision of preventative work and early intervention to reduce harm. Improved access to peer support and support around parenting was mentioned in several comments, and some respondents expressed their desire to see improvements in access to and joint working with mental health teams. A number of survey respondents indicated a need for better dissemination of good practice, and hoped that the quality of service provision would improve in the near future.

“Treatment services need to be afforded the time to work with the needs of the family. Target driven outcomes is impacting on what can be offered in the support needs of families...The county to look at the needs of families and to develop service need together, rather than commissioning in isolation,

and find duplication or gaps. For the family support sector to consolidate the work that is being carried out throughout the country and to look at best practice, highlight changing needs and plug gaps.” (Survey respondent, FSoS 2015)

Whilst some respondents argued for continued access to specialist services for families affected by drugs and alcohol, others hoped for greater integration. Again, this highlights the divergence in views and experiences across the country.

“I hope that family support services remain strong to their vision and ethos and do not give way to merging with treatment services, as I feel this may dilute family support as it all becomes about the service user.” (Survey respondent, HC 2014)

“For more dedicated facilities to be provided to the concerned relatives across the region. I would also like to see family services which are known for delivering family/carer support services within a model of good practice to be replicated across the region.” (Survey respondent, FSoS 2015)

“To see family support integrated across all services.” (Survey respondent, HC 2014)

In terms of respondents’ main worries for the future of families affected by drug and alcohol use, their organisation, region and the family support sector as a whole, funding, cuts and reduced resources were most prominent. Other comments, whilst not explicitly referring to funding or cuts, made references to reduced access to services; which, it is reasonable to presume, would be based on cuts or losses of funding to services providing family support.

This finding is shared by the HC survey, with many respondents reporting funding or restricted resources as one of their biggest worries. Many respondents expressed concern over families being able to access appropriate services in the future, suggesting that the funding and commissioning landscapes are uncertain for these organisations.

“I am very concerned that efficiency savings will start to cut across the ongoing development of family services and the focus of government moves into the criminal justice arena.” (Survey respondent, FSoS 2015)

“Continued reduction of funding and to what level that will continue, but no adjustment of the expectation of funders for service provision. They seem to still expect the same level of service, if not more, for less funding.” (Survey respondent, HC 2014)

Some respondents were concerned that larger organisations are being commissioned over smaller organisations, and worried about the potential loss of specialist services as the drive towards more generic service provision in some areas continues.

“That it will all get swallowed up by the larger charities who will look to the families solely to help the user, forgetting that the family need support in its own right.” (Survey respondent, FSoS 2015)

“I suspect we will lose funding next year and possibly the tender. Family work will still continue across the drug treatment agencies but not formal family therapy as it is costly to train staff and commissioners may feel that 5 step is enough to offer families.” (Survey respondent, HC 2014)

Some FSoS respondents expressed concern that dedicated family support for drug and alcohol use is missing out on funds, being allocated rather to local Troubled Families teams. Other respondents described increasing needs amongst families affected by drug and alcohol use in their local area and had doubts as to whether adequate provision of services could be maintained.

“The increase in drug users means that more families are affected...” (Survey respondent, HC 2014)

“Current family intervention programmes tend to focus on troubled families, and those with emerging behavioural problems. Local parent support group focuses on Class A drug...dependency problems. Criteria for MPACT very stringent and excludes a number of presentations.” (Survey respondent, FSoS 2015)

Another concern related to the ability of local family support services to demonstrate the value of family support to ensure that they are prioritised locally and that the need for such support is recognised. Several respondents also suggested that, in some cases, families are reluctant to access support because of issues such as stigma, and this makes it even more challenging to make the case for investment to commissioners and funders. Concerns over the impact of welfare reforms on families were indicated by several respondents.

“It is often difficult to demonstrate the impact that support has and there is concern that without this we cannot demonstrate the need for our service. We would welcome a recognised model of assessment which would support in demonstrating outcomes.” (Survey respondent, FSoS 2015)

“Government sanctions in changes to the welfare system may impact greatly on the families, especially when the service user is sanctioned and then the family loses money to live on. This has a knock-on effect that includes the wider community being affected by increases in crime, eviction, school attendance, service user not retained in treatment etc.” (Survey respondent, HC 2014)

The three service managers anticipated a challenging time ahead for family support services. One, from a service in the South East, expressed concern over what they perceived to be a move away from specialist, dedicated family support services:

“I think it’ll be quite fragmented, if the trend follows...there might be a recognition of the specialist work that family support does...the grassroots stuff, that’ll carry on, but I’m not really sure where the professional support will be. Fragmentation is the word. People are expecting you to be a recovery worker and family worker, and I’m sure that’s possible, but who gets the prime service? I’m not very hopeful, not within a statutory [setting]. The third sector will continue because it’s led by the needs of the people.”

Another service manager from the same region spoke more positively about the possibilities of integration, despite reporting an increasing demand on family support services:

“The way to go is to merge, and get all the generic family services working together. You have to manage the huge demand, and we have to work smarter, use technology and try and offer a personalised service, which is really hard when you’re managing such volume. We’ve definitely seen an increase in people accessing the service.”

A service manager from the North of England envisaged that the sector would look, “*much leaner*”, but recognised that opportunities are available despite financial restraints:

“We have to work smarter, not harder. There is an opportunity, a chance, but ultimately it’s down to pounds and pence. We could go down the self-sufficient route and operate on a voluntary basis, but I’m hoping that’s way, way off.”

Paul Urmston also commented on technological developments and the changing means of communication, as well as expressing a hope that families are supported to become more involved in the treatment of their relatives:

“I think there will be a lot more social media support because that’s the way of the world at the moment, whether family sector or not, and we’ll go with that. I have a vision that family members

will start to be a lot more involved in the treatment of their loved ones – not sure how it'll happen yet, but it's the way it's going...As with all family carers, they understand the people, and with the right education and awareness, they might be better placed to support the people with an addiction. Some formal education being put in place for those people would be good...We're evolving to that sort of model: supporting families to support the recovery of their loved ones. We'll have to start using more of the online methodology."

Annex 1: Methodology

This report draws its findings from several components:

- An online survey in Autumn 2015, promoted to managers of family support services: 141 respondents (FSoS 2015)
- An online survey in 2014/15, promoted to managers of family support services: 164 respondents (HC 2014)
- Interviews with three service managers of family support services, chosen from FSoS survey respondents to represent a mix of locations, types of support and sectors. Phone interviewees were selected from respondents who chose to leave their contact details. Only one respondent worked for an organisation in the private sector, and did not leave contact details. Accordingly, it was not possible to interview a representative from the private sector. These interviews have informed the themes in this report, and are included throughout.
- An interview with Paul Urmston, Chief Executive of ESH Works Ltd, a voluntary sector service provider for those using drugs and alcohol and those affected in Warwickshire. It is a peer-led mutual support organisation, providing a range of support options, including daily drop-ins, one-to-ones, support groups, family education sessions and complimentary therapies.

The surveys were promoted in DS Daily and Adfam's website, publications and social media, and were open to all service managers of family support services in England. The surveys used convenience sampling and were thus open to sample-bias: respondents were self-selecting, and need only to have been aware of the surveys and had the time and desire to complete them. This can lead to over-representation and under-representation from particular groups, and may not be accurately representative of the family support sector as a whole.

The surveys were anonymous, although respondents could choose to leave their name and contact details if they wished. As such, we are unable to determine how many respondents completed both surveys. From those who did leave names and contact details, it was possible to identify at least two respondents who had participated in both.

It is important to note that HC respondents were asked to base their responses on their experiences since 2010, whilst in the more recent FSoS survey respondents were asked to consider only their experiences in the year prior to the survey (i.e. since 2014). Whilst the majority of the questions in the two surveys are identical, some variations exist in the phraseology. In addition, some questions which may have been open-ended in the HC survey were multiple choice questions in FSoS. Despite the similarities between the two surveys, caution should be taken when directly comparing the two sets of data, given the methodological variations. Differences will be indicated where relevant.

In FSoS, 141 respondents began the survey, but 31 respondents were disqualified on account of not managing a family support service, leaving a remaining total of 110 respondents. This qualifying question was not asked of HC respondents, of which there were 164. Respondents were not required to answer every question and were able to skip questions as they pleased. The data in this report will be described in both percentages and actual numbers, varying to aid comprehension. Percentages have been rounded to the nearest whole number.

However, the online surveys and telephone interviews generated a large amount of narrative content, and it is this qualitative evidence that will be the focus of this report. We believe that the words of practitioners can provide the most powerful evidence of the current climate for family support services, helping to form a clearer and more 'real' picture than statistics are able to convey.

This narrative content will be presented in a balanced way, without assumption. The opinions expressed throughout are those of the respondents, and do not necessarily reflect Adfam's views.

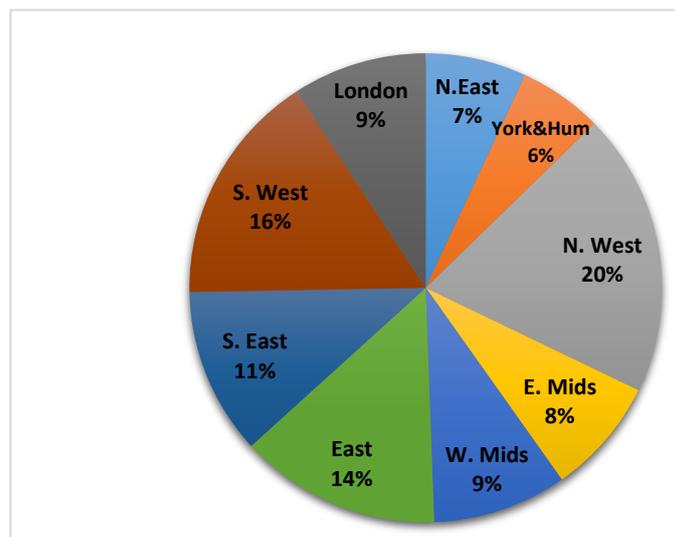
Whilst Adfam recognises the limitations of the research, we are confident that this report provides a useful snapshot to inform community and residential drug and alcohol treatment providers, practitioners in the wider health sector and commissioners.

Annex 2: Respondents by region, type and sector

Region

The chart on the right shows the distribution of respondents by English regions. It shows that a fifth of respondents were based in the North West of England, followed by 16% in the South West. The regions least represented were Yorkshire and the Humber (6%), and the North East of England (7%).

This question was not included in the Health Check: we do not know the geographical representation of those respondents.



Type

Almost two-thirds of FSoS respondents said they managed a service that was part of an integrated drug and/or alcohol treatment service. Nearly a third managed a standalone family support service, and only 5% were part of a generic carers service.

In the HC survey, 62% of respondents managed an integrated service, around a quarter managed a standalone family support service and 12% managed a service which was part of a generic carers service. Therefore, the majority of the views expressed throughout are those of managers of integrated services.

Sector

Seventy per cent of FSoS respondents worked for a third sector/voluntary organisation, compared with 28% in the statutory/public sector and only 2% in the private sector. Proportionally, slightly fewer respondents managed a voluntary sector service in the HC Survey (64%) as compared to those in the FSoS, whilst more were managing statutory services (31%) and private sector organisations (4%).

Interviewees

Two of the three service managers were situated in services in the South East, and one in Yorkshire and the Humber. Paul Urmston, the Chief Executive of ESH Works Ltd, a service in the West Midlands, was also interviewed.

We interviewed service managers from each of the three service settings: part of an integrated service, part of a generic carers service and a standalone service. Given that no respondent managing a private sector service opted to leave their details for a follow-up phone interview, it was not possible to interview a manager from the private sector. We did, however, speak to two service managers in the voluntary sector and one in the statutory sector. ESH Works is also a voluntary sector organisation. This is a fair reflection of the responses to both online surveys: the majority of respondents worked for voluntary service organisations.