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

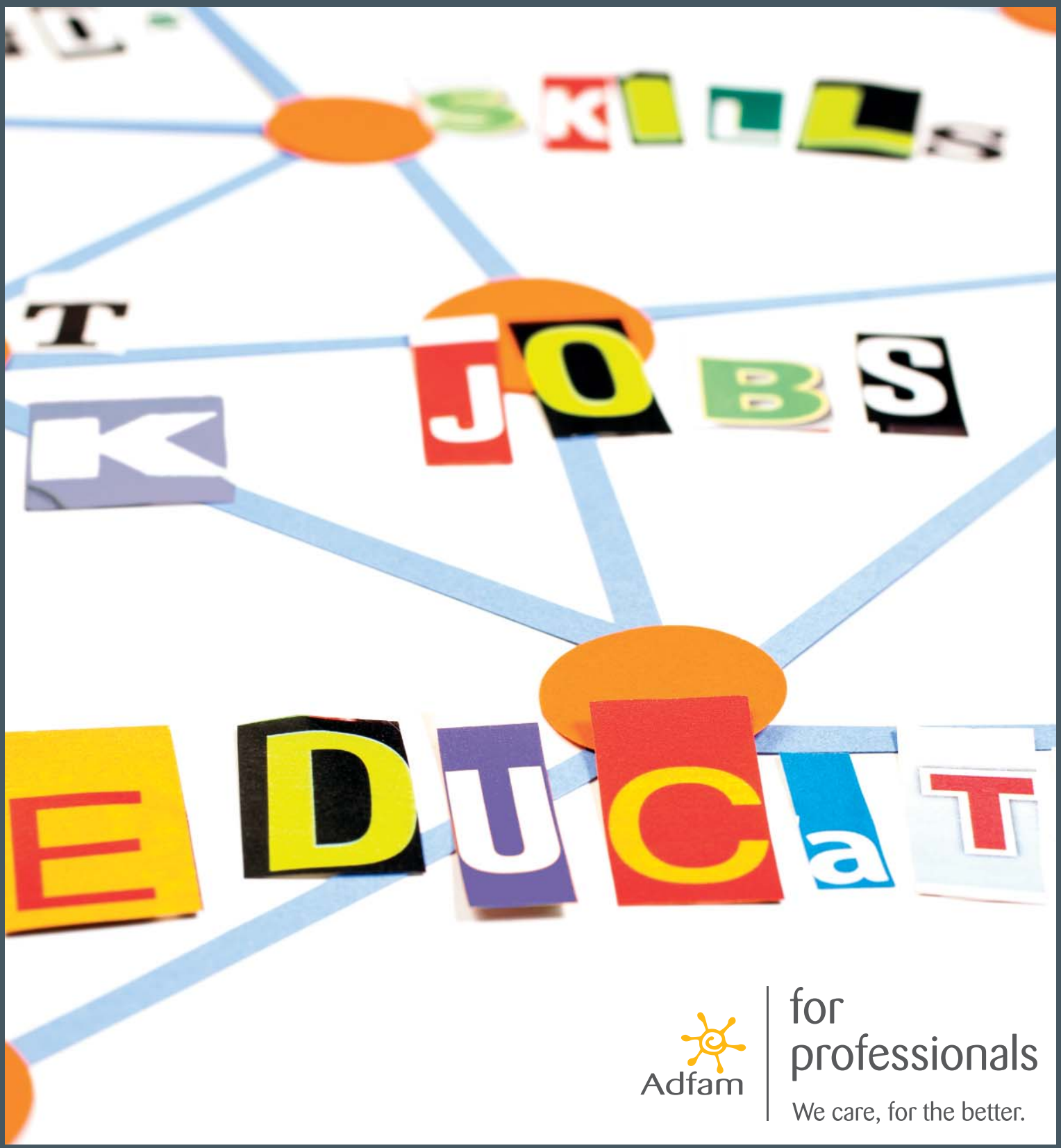
families upfront

SEPT – NOV 2012 ISSUE 6

> In focus: the drug and alcohol workforce

> Children, poverty and substance use

> Who are recovery champions?



Adfam

for professionals

We care, for the better.

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ADFAM'S SERVICES INCLUDE:

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

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Welcome

TO our existing subscribers thanks for your continuing support, and to *Druglink* readers we hope you will find something new, different and interesting in Adfam's magazine concentrating purely on families affected by drug and alcohol misuse.

It's now accepted that **drug and alcohol use doesn't just affect the individual** – it affects those around them too, most notably their families. At Adfam we've been hugely pleased to see, and be part of, this growing consciousness. But how to put this awareness into action is much less clear – whether it means harnessing the family's influence in getting users into treatment, supporting them as they attempt to make and maintain changes, or supporting families in their own right regardless of where the user is in their recovery journey. Even the term 'family' itself can be debated in this context, as debate shifts between children, parents, kinship carers, partners, siblings and wider social networks depending on who you talk to.

So *Families UpFront* is designed to give you the tools you need to **keep families high on the agenda** and provide effective support for them – whether you're a long-established, grassroots family support service, a treatment worker looking into how you might best involve families in your interventions, or a social worker wanting to learn more about substance use in a wider matrix of family problems and vulnerabilities.

Families UpFront is not just a run-down of news and events, which come and go; but a live and ongoing **good practice resource** to inform your work with families as it develops and evolves. Each edition contains a special section on a key area of interest for practitioners working in families, drugs and alcohol: previous topics include working with offenders' families, good practice in fundraising, stigma and substance use, domestic violence and measuring outcomes. In this edition, we are looking at you – **the workforce**.

Turn to page 10 for our InFocus section on the workforce

Vivienne Evans *OBE, Chief Executive, Adfam*

Safeguarding reforms incur backlash

The Government's revision of statutory safeguarding guidance *Working Together to Safeguard Children*, part of its move to 'axe bureaucracy' and 'overhaul' the child protection system, has been criticised by a new campaign. *Every Child in Need*, formed by a group of charities, campaigners and lawyers, is arguing that the Government's attempts to 'cut red tape' – in slimming statutory safeguarding guidance from 700 pages to 68 – in reality amount to the removal of a vital safety net for children failed by their local authority. 'A hands-off approach, allowing local authorities to do what they want, when they want, is dangerous", they argue, and note that the Government's own impact assessment concedes 'there is a risk of negative impact on children if central government is less prescriptive'.

The president of the Association of Directors of Children's Services has previously voiced similar concerns that cuts to guidance 'may have gone too far', but added that 'the days of learning by rote in social work are over'.

The consultation on the new proposals closes on 4 September; details of the campaign are available from ***www.everychildinneed.org.uk.***

Government given 'D+' for family-friendly policies

The Family and Parenting Institute recently launched *The Family Report Card 2012*, concluding that Prime Minster David Cameron is struggling to fulfil his pledge to create a family-friendly UK. The report argues that the difficult economic climate is making life extremely hard for many families, for example, through the cost of childcare increasing over and above wage rises. Also, the situation is being worsened by changes to tax rules, benefit entitlements and service provision, such as cuts to Sure Start children's centres. There are also concerns over work-life balance as instability in the labour market could lead to less family-friendly working hours; the quality of privately rented housing; and increases in the cost of travel.

Overall, the report card awards the Government a D+ grade and calls for the introduction of a 'family test' which reviews the potential family impact of any new policy.

The FPI has since revealed its intentions to merge with the Daycare Trust, another children's charity, to 'pool resources and expertise'. ***www.familyandparenting.org***

Childhood drug use on the wane

An annual statistical review from the NHS Information Centre has found a reduction in drug use amongst school-children. *Smoking, drinking and drug use among young people in England* has reported that 17% of 11-15 reported ever having used an illegal drug in 2011, down from 29% in 2001.

The report received mixed coverage in the wider media; the BBC reported that young people were 'shunning drugs for healthier lifestyles'; the *Daily Telegraph* emphasized that children as young as seven and eight reported using cannabis and ecstasy; and the *Guardian* was sceptical of how well the survey's self-selected sample – it is not compulsory for schools to respond – represents young people in the whole population.

Government tsar 'listens' to troubled families

For the new report *Listening to Troubled Families*, the Government's director of the programme, Louise Casey, spent time with 16 families to get to grips with the problems they face in-depth. She found 'entrenched, long-term cycles' of families both suffering and causing problems, not only with individuals but from generation to generation, including histories of physical and sexual abuse. She also spoke to families about anti-social behaviour (long a Government priority), wider social circles of detrimental influences, substance abuse, large numbers of children, violence and teenage mothers.

Doubts, however, have been raised about the sample size of the report – Casey spoke with just 16 families from 6 local authorities, all of whom were already engaged with intensive support. But as the author herself states, the report is only a 'starting place to inform our thinking'.

Supporting families: the key evidence

Adfam has released a new 'Evidence Pack' on the importance of supporting families affected by drugs and alcohol. Available free on Adfam's website (www.adfam.org.uk), the short briefing collects all the key sources of evidence on why families need support in their own right, the harms they experience when there is a drug user in the family, and how they can play a positive role in recovery. The evidence pack aims to equip family support services with the tools they need to make convincing arguments to funders, commissioners and other local decision-makers.

100,000 Scottish children at risk from parental drinking

As many as 10.4% of people under 16 in Scotland are vulnerable to emotional, physical and verbal abuse due to problematic parental drinking, according to new Government figures. Scottish child protection charity Children 1st, however, warned that the true figures could be much higher, and many children at risk are unknown to support services. Anne Houston, Chief Executive, said that "too many children are missing out on their childhoods due to their parents' drinking" and that many "feel the negative effects for years, with some suffering from depression, anxiety and low self-esteem".

Children 1st is running a campaign called *Wish I Wasn't Here*, presenting postcards from children who remember family holidays for the wrong reasons. ***See www.children1st.org.uk for details.***

Big Lottery Fund targets multiple needs

The *Improving Futures* programme will provide 26 projects across the UK with up to £900,000 to improve outcomes for children affected by multiple problems including domestic violence, poor health, unemployment, debt and housing issues. Each project is led by a voluntary sector service in collaboration with local authorities and other partners.

Peter Wanless, Chief Executive of the Big Lottery Fund, said that particular emphasis was placed on applications that could demonstrate effective early intervention for families on the cusp of acute need.

The initiative aims to build effective, replicable models that can lead to success elsewhere; many are using the increasingly popular key worker approach of a single professional developing a trusting and productive relationship with a family and coordinating work around them, and others are bringing in proven initiatives from abroad such as Incredible Years and Roots of Empathy.

The projects will last 3-5 years and aim to reach 10,000 families; outcomes and progress will be evaluated by a team from research and consultancy companies Ecorys and Ipsos MORI, alongside the University of Nottingham and Family and Parenting Institute.

Further details can be found at www.improvingfutures.org.

TUC challenges localism agenda

The Localism Act of 2011 was brought in with a clear message from the Government that it would allow local authorities a far greater degree of freedom over their decision making and budget setting priorities. There has been a great deal of debate over the bill and what localism really means, and recently the TUC and the National Coalition for Independent Action have produced a booklet bringing together varying opinions, mainly to challenge and discuss the purpose and ramifications of the bill. The TUC argue that the Government's 'market-led approach' may lead to increased private sector involvement in providing public services and undermine the localism agenda; Shelter propose that local changes to eligibility criteria for social housing 'could mean denying homes to people in severe need'; and the National Association for Voluntary and Community Action (NAVCA) expresses concern that the 'Right to Challenge' in the Localism Act could lead to 'more big contracts being hoovered up by the big national players' using small voluntary organisations as 'bid candy'.

The report is available at ***www.tuc.org.uk/tucfiles/354/Localism_Guide_2012.pdf***

NTA: 'treatment is improving'

The National Treatment Agency has recently released *From Access to Recovery: Analysing six years of drug treatment data*, which concludes that treatment has become more effective over the last six years, and that the more recently someone entered treatment, the more likely they are to recover from addiction.

Despite the progress made in treatment, the road is still a tough and challenging one for family members: heroin and crack users wait an average of eight years before accessing support for their addiction, and more than half of those in treatment had had at least two separate treatment journeys – that is, they had relapsed or dropped out and then returned. The NTA are clear that the results are not 'grounds for complacency' and that as time goes on, the proportion of people in treatment with complex, entrenched needs will rise; there remains a core of 21,000 people in continuous, long-term treatment.

The report might also offer a window into the future of substance misuse: users of drugs other than heroin and crack now make up the majority of people entering treatment for the first time.

The report can be viewed at ***www.nta.nhs.uk/uploads/six-yearstudy.pdf.***

ISTOCK PHOTO

Diary

● In it together: supporting prisoners' and offenders' families across agencies

This seminar, supported by the Family Strategic Partnership and the Department for Education, will look at how agencies can cooperate to better serve the needs of offenders' families and showcase successful multi-agency initiatives.
18 October, Birmingham.
www.prisonersfamilies.org.uk

● A question of balance: delivering an inclusive treatment and recovery system

The annual DrugScope conference will examine the variety of different services needed to provide a comprehensive system of drug treatment. Speakers and presentations, therefore, cover the spectrum from harm reduction and substitute prescribing to abstinence-based services and the needs of specific groups such as older drug users and LGBT clients.
6 November, London
www.drugscope.org.uk/events

● Alcohol awareness week

This year the theme will be 'it's time to talk about drinking'. Alcohol Concern are keen to address the stigma around discussing alcohol problems, and are providing free 'conversation starter cards' to stimulate debate on the problems of alcohol rather than just its positive aspects. The campaign will also challenge people to give up alcohol for a month in January 2013.
19-25 November, nationwide.
www.alcoholconcern.org.uk

ADFAM UPDATE: MEET THE TEAM

VIVIENNE EVANS

Chief Executive

It's my job to lead Adfam and make sure that we are really improving things for families affected by substance use; making sure that families' needs are recognised at the highest levels is an important part of my daily work. I am currently the chair of the advisory committee for the Family Drug and Alcohol Court project, and of the Skills Consortium; I also sat on the Advisory Council for the Misuse of Drugs and chaired its working group on the implementation of *Hidden Harm*. In 2008 I was awarded an OBE for my contribution to substance misuse prevention and families work.

1 Vivienne Evans 2 Omar Amin 3 Joss Smith 4 Kate Peake 5 Oliver French 6 Sarah Bond 7 Oliver Standing 8 Sue Goodliffe

OMAR AMIN

I joined Adfam in October 2004 and am the ***Director of Finance and Administration*** as well as Company Secretary. I have extensive experience in charity finance as well as retail and business banking. My remit covers all aspects of financial and office management including accounts, payroll, project finances and reports, statutory returns, HR and IT. I have an MBA from Cranfield University.

JOSS SMITH

I have worked at Adfam since May 2009 as ***Director of Policy and Regional Development***. My key roles include leading on Adfam's policy work, growing Adfam's supporter base with representatives from across partnerships and sectors, facilitating national consultations and seminars, and developing regional partnerships, networks and forums across the country. I am also the Vice Chair of a family support charity in Somerset and write a regular column in DDN on families affected by Drugs and Alcohol. Prior to joining Adfam, I worked in a variety of treatment settings including shared care, needle exchange, drop-in and residential rehabilitation.

KATE PEAKE

As ***Regional Development Coordinator,*** I support networks of family support groups to share best practice, influence the local political scene, and develop partnerships across regional areas. I also work with a small number of organisations on key challenges, supporting them to identify solutions and creating a bedrock of best practice. In addition I will be considering how to support family members who are not linked with a family support group, either for geographical or personal reasons, and setting up peer mentoring for people who work in the field.

OLIVER FRENCH

Policy and Communications Coordinator

Alongside the rest of the policy team, I monitor any news and developments in the drugs, alcohol, children and families sectors, and analyse what's most relevant to our audience for our fortnightly briefings. I respond to official consultations and try to keep families on the agenda in places people might forget them, like in safeguarding guidance or in measuring treatment outcomes, as well as undertaking specific research projects on issues like parental substance use. I write and edit content for *Families UpFront* and prepare it for print. I also respond to media enquiries and run the Adfam twitter account – follow us @AdfamUK if you don't already!

SARAH BOND

As ***Business Development Coordinator*** my role is to help establish sustainable revenue streams so that Adfam has a secure future and is less reliant on funds from elsewhere. In my day to day work this translates to building relationships with corporations, other organisations in the sector and of course our stakeholders – practitioners and professionals like you. I also manage and develop our training, publications and events to help provide practitioners with the skills, knowledge and support they need to better support families. If you'd like information about any of the services we provide, please email admin@adfam.org.uk or visit www.adfam.org.uk.

OLIVER STANDING

Since January 2010 I've worked at Adfam as the ***Policy and Projects Coordinator***. On the policy side I respond to Government consultations, contribute to *Families UpFront* and develop the fortnightly policy briefing. On the projects side I manage Adfam's domestic violence work, which is focused on children who use drugs and alcohol who also abuse their parents; and run our workforce development project on building practitioners' skills. My background is in social policy and communications in the third sector.

SUE GOODLIFFE

I am currently the ***prison services team leader*** for Adfam, and I'm based in the visitors' centre at HMP Peterborough. I support offenders' families with building, rebuilding and maintaining positive relationships, help organise their visits and prepare for release. I have been with Adfam for the past six years, but previously I've worked at a secure unit for young people, a night shelter and a refugee hostel, and as a resettlement officer.

Another year in the life of **ESCAPE Family Support** in Northumberland.

Doesn't time fly? How quickly the year has passed since I wrote my first *Notes from the community* for *Issue 2*!

For those who do not know ESCAPE Family Support, we have worked in Northumberland since our inception as a self-help group in late 1994, initially providing education, support, counselling, advice, a phone line and empathy for parents of substance users. We have grown substantially since then, with headquarters in Blyth and ten satellite bases throughout Northumberland's sprawling two thousand square miles, providing support to drug and alcohol users, their parents, carers, families and friends.

ESCAPE still delivers open access advice, support, advocacy and information, as well as counselling and structured interventions, to substance users and their families and carers throughout Northumberland, including 24-hour helpline support, brief interventions, complementary therapies, diversionary activities, respite opportunities, social events and structured daycare programmes. We now employ 29 paid staff (three more than this time last year), who are now supported by 43 volunteers, student placements and peer mentors (up 43% on last year).

Our ethos is to work with individuals and their families at all stages of their treatment journey or their involvement with the Criminal Justice System – pre-arrest, arrest, pre-sentencing, imprisonment and release. Our Family Team works with family members whether their loved one is in treatment or not.

Our family team comprises a Manager (who is also our Children's Safeguarding Officer), three Family Support Workers (two full-time and one part-time) and a part-time Administrator. Two of our Family Support Workers are now trained and one accredited in Community Reinforcement and Family Training (CRAFT), delivering this on a one-to-one basis and within group settings. The three main aims of CRAFT are to improve the life of the 'concerned significant other', reduce the users' substance misuse and encourage a loved one into treatment. Family members participating in CRAFT report significant benefits for themselves and the substance user.

Dave Tinlin, one of our Peer Mentors, who we nominated to be an Olympic torchbearer

In addition, four staff are now trained to deliver Parent Factor training and this is helping to support kinship carers, parents of substance users and substance using parents and develop their skills, which in turn, improves the lives of children experiencing the hidden harm of parental substance use.

Our carer drop-ins and support groups continue to thrive. Carers Week events this year again included trips out and respite opportunities. We continue to support increasing numbers of kinship carers; most group members are grandparents caring for grandchildren and are often attempting to continue supporting their adult substance using son or daughter too. We hosted a party for the Queen's Diamond Jubilee attended by kinship carers and the children they look after. Events like this are helping reduce isolation and the children enjoy spending time with others who are also unable to live with their parents.

The family team have been using the Carer Support Outcome Profile (CSOP) developed by the Bridge Project in Bradford, which tracks carer treatment and outcomes for over a year, and we recently received a monitoring report for 2011/12. The report shows that our service achieves an improvement across all areas measured for its carers and family members, both in the initial stages of support and as it continues. This includes their relationship with the user and the rest of the family, psychological health and quality of life, demonstrating the positive impact our family services have on the lives of family members and carers.

Further statutory budget cuts have been implemented this year and we no longer receive funding from our Drug and Alcohol Action Team towards specialist family services. With the exception of a small grant from Northumberland Adult Services Carers budget, our family team is funded through charitable trusts and foundations. However, in the past year ESCAPE has still been successful despite the challenges we have faced and yet again our achievements are due to the dedication and commitment of our trustees, staff, and growing team of volunteers, student placements and peer mentors.

ESCAPE continues to prove that smaller organisations can survive the current challenging economic environment. Last November, we purchased NUM Hall in Ashington, strengthening our asset base. We are now progressing ambitious full refurbishment of this very large building which will house services and new social enterprises. We continue to forward plan and seize all opportunities.

Successes in 2012 included the privilege of being shortlisted for a Centre for Social Justice Award in the Addictions category for our holistic approach. Also, our Education, Training and Employment (ETE) and Supporting Women Around Northumberland (SWAN) projects were shortlisted for Howard League Penal Reform Community Programmes Awards and we were thrilled at the Community Sentences Cut Crime conference, when our ETE project won the runners-up award in their category. We are also very proud of Dave Tinlin, one of our Peer Mentors who we successfully nominated to be an Olympic torchbearer *(see left)*. Let's hope the coming year brings more successes!

For more information visit
www.escapefamilysupport.co.uk

Why now is the time to re-double our efforts on child poverty

*Adfam spoke to **Alison Garnham**, Chief Executive of the Child Poverty Action Group, about parental substance use and the challenges faced by disadvantaged children.*

What is child poverty and how is it manifested?

Child poverty means growing up in substandard housing that is cold or overcrowded; it means not having decent food or only owning one pair of shoes; it means not being able to join friends in after-school activities or for celebrations such as birthday parties. And it happens when families are short of resources, whether that is money, good health, decent jobs or safe environments. All in all, it is this lack of resources – especially, but not exclusively income – that is the hallmark of poverty.

We have mountains of evidence that poverty and low income steals away children's life chances and damages our society and our economy[1]. Child poverty leads to a health divide, an education divide and a wellbeing divide: poor children are more likely to be behind at school, suffer long-term health problems and chronic diseases, and die younger (including on the roads) than their wealthier peers. Children who grow up in poverty often feel negative about their lives and their futures, and have low self-esteem.

Child poverty also costs the country dear. The Joseph Rowntree Foundation (JRF) calculated that it costs us £25 billion a year to meet the additional costs caused by child poverty through the need for benefits and services, as well as forgone tax revenues in the future.[2]

How does it affect the whole family?

Poverty is an inherently stressful condition. Poverty, and particularly debt, increases the likelihood of mental disorders. The effects are particularly strong among women because they are more likely to handle family budgets, have caring responsibilities and are often the shock absorbers of reduced family incomes.[3]

We know that parents often go without in order to protect their children from the worst effects of poverty. They forgo their own social lives, purchases for themselves and in some cases even necessities such as food in order that their children have enough. In particular, parents prioritise expenditure on children to ensure that their kids 'fit in'. This is not surprising given that shame is a common response to poverty: the belief that being poor is one's own fault is widespread, and one that both children and adults living in poverty often internalise.[4]

> substance abuse is an explanatory factor for only a very small number of children growing up in poverty today

What is the relationship between child poverty and parental substance use?

While the impact of having a parent who misuses alcohol or drugs is very significant, the number of families with such parents is small. One estimate shows such families are not typical across the population: only 2.7% of families in Britain have an alcohol dependent parent, and 0.9% a drug dependent parent.[5] However, not all these families will be poor. While it may seem reasonable to assume that families with drug or alcohol dependency problems may be more likely to be poor – they may be less able to work, more likely to live on benefits and more likely to incur sanctions – at least some of the families captured by this statistics will be well-off.

Yet more than one in four children live below the poverty line in the UK today.[6] So while we don't know the exact numbers of children who live in poverty at least in part because of their parent's misuse of alcohol or drugs, we can say with certainty that substance abuse is an explanatory factor for only a very small number of children growing up in poverty today.

Is child poverty a reliable indicator of future substance use?

Not at all. Studies show that both drug and alcohol misuse do not vary significantly by income levels – in fact, the greatest incidence of heavy drinking is found in the professional and managerial occupations, with those who are unemployed the least likely to drink in excess of the recommended daily amounts.[7]

Is drug treatment a successful way of addressing child poverty in the long run?

Drug treatment is absolutely necessary for those families affected by substance abuse. But as the figures above show, only a small number of children growing up in poverty today live with a parent who abuses alcohol or drugs.

Instead, children are much more

1 See, for example, *CPAG, Ending child poverty by 2020: progress made and lessons learned*, June 2012

2 D Hirsch, *Estimating the costs of child poverty*, JRF October 2008

3 M Marmot in CPAG, *Ending child poverty by 2020: progress made and lessons learned*, June 2012

4 See, for example, T Ridge, *Living with poverty: a review of the literature on children and families' experience of poverty,* DWP 2009

5 N Gould, Mental health and child poverty, JRF 2006 Round

6 DWP, Households below average income: an analysis of income distribution 1994/5 -2010/11, June 2012

7 S Harkness, P Gregg and L MacMillan, Poverty: the role of institutions, cultures and behaviours, JRF June 2012

likely to live in poverty if their parents are in low-paid jobs such as shop workers, cleaners or call centre operatives; if a member of their family has a disability or is incapacitated through sickness; or if their parents can't find (enough) work and have to rely on state benefits. So while treatment and recovery are imperative for those families with addicted members, this in itself will not end child poverty.

What are the wider indicators in society and the current political situation regarding child poverty?

The vast majority of children live in poverty not because their parents are 'workshy', are drug or alcohol dependent, or cannot manage their children properly, as Government rhetoric suggests. They are poor because their parents do not have an adequate income to make ends meet.

Low income parents are often blamed for 'transmitting' poverty to their children through bad parenting. Yet research shows that at all ages, children's progress is still driven largely by factors such as social class, age and ethnicity.[8] While studies agree that parental behaviour can help improve children's attainment, this fails to explain the vast majority of differences between poorer and wealthier children.

In fact, parents at the bottom of the income scale lack neither concern nor ambition for their children. A 2008 DWP report showed, for example, that 50% of parents in the lowest income quintile hope their children will go to university, and a report published by JRF demonstrates that young people share these aspirations.[9] It is not parental behaviour that holds them back, but a lack of information as to how to navigate the worlds of education and work.

So rather than reduce responsibility for poverty to individual actions, we need to face the fact that poverty is substantially a result of society's choices and Government's policies.

What would you like to see done to address child poverty?

Solutions need to be focused on decent incomes, decent services and decent childhoods. This means tackling unemployment, making sure jobs pay decent wages, are family-friendly, and have adequate parental leave and pay. We also need decent benefits that don't plunge families into poverty, including child benefit that makes a better contribution towards the cost of having children; we need high quality, affordable childcare, decent health and education services and the right information, help and support families need when they are struggling and under pressure.

How have the Government's recent statements on the definition of child poverty and behaviours such as substance use as a cause of family poverty affected overall outcomes and your work?

The danger is that Government rhetoric about drug and alcohol abuse fuels the popular assumption that all poor families are somehow to blame for their own circumstances. Whilst devastating for those affected, the numbers are simply too small for substance use to be a major driver of child poverty.

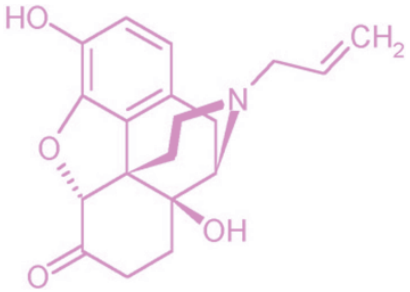
The reality is that causes lie in the nature of our economy, high unemployment, low and stagnating wages, high prices, low benefit rates, poor health and education and limited life chances. The solutions lie in political decision-making – the answer is in our own hands.

The Child Poverty Action Group campaign for a society where all children can enjoy their childhoods and have fair chances in life to reach their full potential.
www.cpag.org.uk

8 Institute of Education, *Improving parenting does not level school playing field*, December 2010

9 R St Clair, K Kintrea and M Houston, *The influence of parents, places and poverty on educational attitudes and aspirations*, JRF October 2011

Averting tragedy: overdose intervention



Alan McGee explains the success of a project using a 'heroin antidote' to reduce overdose deaths

Drug misuse has an enormous impact on the lives of family members and loved ones, and one of the most tragic outcomes is a loss of life through an overdose. However, a recent recommendation from the Advisory Council on the Misuse of Drugs (ACMD) could mean that fewer families have to go through this kind of tragedy. It has been recommended that naloxone, sometimes referred to as the 'heroin antidote', be made more widely available .

Given as part of an emergency response, naloxone can reverse the effects of a heroin or opioid overdose, significantly increasing the chances of successful resuscitation and the ability to save a life. It is administered by injection and has an almost instant effect, meaning there is time to call an ambulance or get to hospital for further assistance without the person dying or suffering brain damage from lack of oxygen.

Naloxone has been used in healthcare as an emergency resuscitation medicine for over forty years and has an entirely safe clinical history. The drug does not have harmful effects if accidentally taken inappropriately. However, until relatively recently it has only been available for use by medical professionals. The ACMD's recommendation would see access expanded considerably, both to individual drug users themselves and to their family and loved ones.

This is already starting to happen in some areas of the country. In Merseyside, the health and social care charity CRI (Crime Reduction Initiatives), in collaboration with Sefton Primary Care Trust Public Health Pharmacist, is now promoting an initiative to enable the supply of naloxone along with a programme of comprehensive training to those at risk of drugs overdose.

> parents felt they had a measure of control by being able to intervene in an overdose

The project has been operational since June 2011, and commissioners and health and social care partners across Sefton have been supportive of the project from the outset. Over one hundred staff, service users, volunteers and carers in Sefton have accessed training in overdose prevention, emergency response techniques and naloxone administration.

Within weeks of take-home supplies being made available, the first successful administration of naloxone was reported by a member of Sefton Service User Forum. The forum member, having successfully completed the training programme, was able to administer naloxone to an overdosed heroin user, saving the individual from almost certain death.

Alan McGee is Project Manager at CRI Sefton Integrated Recovery Service and produced and delivered the training events across Sefton. He says: "I have spoken personally with the Forum member who administered this life saving injection and have nothing but praise for their actions. I can't begin to tell you what a difference being able to successfully administer naloxone has made to him, his confidence and his sense of self-worth".

He added that the training gave the parents of drug users a feeling of empowerment and confidence: "they felt that they now had a measure of control by being able to intervene in an overdose, whereas previously they had felt powerless".

Naloxone: the basics

Naloxone is one of a number of drugs called opioid antagonists. These substances all have a high affinity for some of the same receptors in the central nervous system that opioids (including heroin) target. This means that if naloxone or a similar drug is administered it will automatically displace the opioid in these receptors, thus radically diminishing its effects. As well as being used medically to bring patients around after anaesthetic, opioid antagonists can be used for people who have accidentally overdosed on heroin. This would then provide enough time for the overdose victim to be taken to hospital and treated fully. Naloxone is typically administered intravenously.

The Advisory Council on the Misuse of Drugs' (ACMD) *Consideration of Naloxone* document concludes that 'naloxone provision is an evidence-based intervention, which can save lives. [It] fits with other measures to promote recovery by encouraging drug users to engage with treatment services, and ultimately, keep them alive until they are in recovery.'

It also stresses the importance of proper training for those who would be given take-home naloxone before concluding that 'naloxone should be made more widely available, to tackle the high numbers of fatal opioid overdoses in the UK'.

READ MORE

- **Advisory Council on the Misuse of Drugs *Consideration of Naloxone* (2012)**
- **National Treatment Agency *The NTA Overdose and Naloxone Training Programme for Families and Carers* (2011)**
- **Scottish Drugs Forum *Take-Home naloxone: reducing drug deaths* (2010)**
- **www.naloxone.org.uk provides a variety of facts and information about naxolone and other overdose resources.**

Your organisation – top 5 resources

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

1 Commissioning for better outcomes

Family Strategic Partnership

This report aims to identify barriers to voluntary sector involvement in local authority commissioning processes for family services: highlight examples of good practice: and recommend policy and practice solutions. The overall conclusion is that 'competitive tendering is an enormous resource challenge' for voluntary services, and one which many are struggling with; reasons cited include the 'moral imperative' to support families in need which overrides considerations of profit, and the 'resource-intensive' nature of bidding for contracts. The report recommends the development of standardised commissioning forms to increase efficiency for both commissioners and potential providers; more openness to creating quick partnerships amongst voluntary sector organisations; and the involvement of local families themselves in determining what services are available.

www.familystrategicpartner.org

2 Review of the Charities Act 2006

Minister for the Cabinet Office

Lord Hodgson's extensive review examines all aspects of charity governance and the voluntary sector's role in society, including chapters on charity history, fundraising, complaints and redress, the Charity Commission, regulation and social investment. It presents a number of recommendations and who would be responsible for enacting them: for example, that large charities (those with income above £1million) should be able to pay their trustees without permission from the Charity Commission; businesses should explore loaning or seconding staff to charities; all charities with an income below £25,000 should be officially registered as 'small'; and sanctions for the late filing of accounts should include the withdrawal of Gift Aid.

www.cabinetoffice.gov.uk/content/charities-act-review

3 Taking nothing for granted: a research report into what charities think a model grant-maker looks like

nfp Synergy

Grant-making trusts, this report asserts, are a 'hugely important part of the funding landscape' because they provide significant support for charities which do not have the skills and financial resources to raise money directly from the public, or which do not have widespread popular appeal. After setting out the basics of grants, including how they fit into charities' mix of incomes, how they are found and applied for (including a breakdown of costs and success rates) and what happens after they are secured, the study looks for insight into what an ideal funder might look like from the charity's perspective and how they can both move forward together.

www.nfpsynergy.net/

4 Surviving the transition guides

Adfam

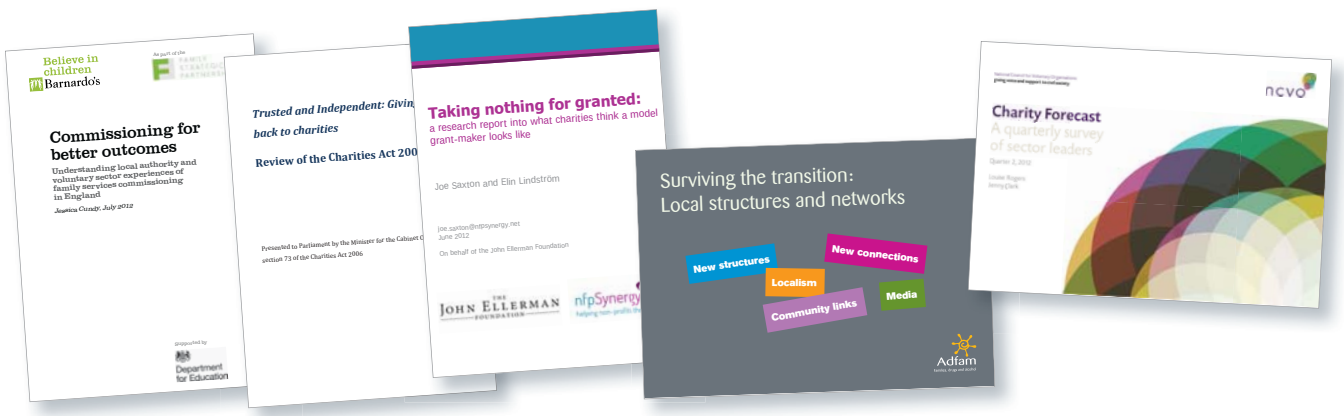
In response to a changing and challenging environment for family support services, Adfam has published two new guides to help organisations survive the financial, administrative and political transition. *Surviving the Transition: Organisational Health* sets out the basic things organisations need to have in place to be legal, healthy and robust. This includes a wealth of advice and information on governance, recording and measuring impact, business planning and strategy, policies and procedures, and much more. *Surviving the Transition: Local Structures and Networks* helps family support services navigate the complex changes happening in local commissioning, responsibility and accountability, including who they should be talking to, what the big issues are in drugs and alcohol, and how they can successfully build good relationships with a range of partners. The guide also looks at how family support fits into some other key agendas, including public health, crime and disorder and children's services.

www.adfam.org.uk

5 Charity forecast: A quarterly survey of sector leaders

NCVO

This forecast is based on quarterly snapshot surveys of charity sector leaders, the majority of whom reported that the financial situation of their own organisation had worsened over the previous year; they expect it to worsen over the next year; they predict the expenditure of their organisation will decrease or remain static over the next year; they do not plan to increase the extent of the services they offer; and they will continue to have a substantially negative confidence in the economic state of both the voluntary sector and the UK as a whole.



In Focus **The Workforce**

THE 'workforce' in drugs, alcohol and family support is a broad term. But chances are if you're reading this, you're part of it. So in many ways this issue is dedicated to you – your skills, your experiences and the history and future of your career.

A key challenge for anyone working in drugs and alcohol is that the success of your own work is often judged by the behaviour of others. What changes have you supported people to make? Has their quality of life improved? This puts a great deal of responsibility on support workers, but many would also say that this is precisely the reason they got into it to start with – to help people make positive changes, and often to give something back too.

So in this issue of *Families UpFront* we try to address some of these key questions: what makes a good worker, how do you find out, and how do you replicate success? Can good work be done with no professional background, or is it better to make things a bit more 'official' with qualifications and accreditation? How has the workforce developed over time, and how is it now changing? We have collected a wealth of information from a number of expert sources and hope to shed some light on these issues.

Families often feel that others who have 'been through it' can provide the most understanding, empathetic support. But with increased recognition of the family's role in recovery, we may see an enhanced role for integrated family support delivered by the existing treatment workforce. This may bring its own set of challenges, and at Adfam we're committed to ensuring that families can access support regardless of where the user is in their recovery. Whichever source it comes from, as long as families are properly involved in service design, delivery and development, we hope to see improvement in both the availability and quality of services for families affected by drugs and alcohol.

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

ISTOCK PHOTO

What changes have you supported people to make? Has their quality of life improved?

Setting the scene

A short summary of the key issues affecting the drugs and alcohol sector workforce.

What's the point of workforce development?

Clearly work cannot be done without a workforce. The work of supporting people with serious drug and alcohol problems through a process of recovery is challenging, as is supporting the children, parents, siblings, partners and friends of these substance users who are often profoundly affected by years, or decades, of stress, financial worries and sometimes abuse.

Family members often describe the help and advice given to them by family support groups as 'a lifeline' or a 'godsend' – an oasis of calm and understanding in times dominated by worry and hardship. The workforce that provides these essential services need to know what they are doing, and the purpose of workforce development is to ensure that they do. Whilst many will be doing a fantastic job already, elements of workforce development such as qualifications, accreditations, National Occupational Standards and training all exist to ensure that they can continue doing so, get recognition for the skills they have and that those practitioners and managers that need a bit of support can get it.

Historically the substance use and family support workforce has been very varied, with no one clear route into the work and a high level of people with personal experience of substance use (either directly or as family members) becoming practitioners. For a workforce that, unlike social workers or midwives for instance, lacks a legally required qualification or 'gold standard' these elements of workforce development are essential in supporting practitioners who may have come from quite different backgrounds and possess quite different skills and experiences. There has always been a large number of volunteers in the drug and alcohol sector, with many people motivated by their own experiences of substance use, whether personally or through family members, to work to improve life for individuals and families. Adfam's own research with practitioners found 25% of respondents identifying themselves as volunteers and it's essential that workforce development plans take into account the many volunteers working hard around the country.

The policy context

The official Government line on drug use is contained in its most recent drug strategy of 2010. It makes clear the Government's views on the importance of the workforce as a key tool in achieving the aims laid out in the title – '*reducing demand, restricting supply, building recovery*' – and dedicates a section to the importance of an 'inspirational, recovery orientated workforce' which can work with and motivate drug users towards recovery. The drug strategy of 2008 speaks more explicitly of the matter, and states that 'developing a competent substance misuse workforce…is crucial to ensuring a high standard of service delivery'.

The National Treatment Agency for Substance Misuse (NTA) is currently responsible for implementing the aims of the drug strategy and facilitating recovery, and has produced workforce resources and guidelines over the years. These include information on equality and diversity, the 'Routes to recovery' mapping tool and clinical guidance on specialist areas of knowledge.

With the creation of Public Health England and the abolition of the NTA not far away on the horizon (April 2013), the Department of Health (DH) recently conducted a consultation to inform the development of a strategy for the new public health workforce. Adfam submitted evidence to this consultation, and the DH will produce a full strategy later this year.

Organisations and alliances

The Federation of Drug and Alcohol Professionals (FDAP) is the membership body for the sector which accredits drug and alcohol practitioners, family support workers and counsellors. Practitioners who wish to gain accreditation must submit a portfolio of evidence to prove their competency against a set of National Occupational Standards.

Partnerships within the sector are also important in helping to support the workforce. The Skills Consortium is a sector-led, wide ranging partnership of organisations in the drug and alcohol sector which works to equip practitioners (including managers) with the skills they need, creates initiatives to attract and retain people into the workforce and in general supports the workforce to promote recovery for service users, their families and communities. Currently supported by the NTA, the Skills Consortium will become completely 'by the sector, for the sector' in 2013-14 with funding awarded to a partnership of DrugScope, Adfam and FDAP. With the NTA ceasing to function at the end of March 2013 the consortium will more than ever be essential in representing the needs and wishes of the workforce to Government.

The Recovery Partnership is another consortium within the sector which can play a similar role. Composed of the Skills Consortium, Recovery Group UK and DrugScope, the partnership 'seeks to be a new collective voice and channel for communication to ministers/Government on the achievement of the ambitions in the drug strategy' and could play a useful role in furthering workforce development work.

Further information

- **FDAP www.fdap.org.uk**
- **NTA www.nta.nhs.uk**
- **Skills Consortium www.skillsconsortium.org.uk**

Workforce development: what really counts?

***Phil Harris** looks back at the evidence base for interventions with drug users, and presents some challenging conclusions for practitioners.*

FAMILY services are increasingly recognised in national policy and funding, which brings new challenges. They must now operate within the requirements that come with mainstream funding, which demands they meet three levels of accountability: they must show what monies have been received; where it was spent; and what has been achieved with it. This third requirement is difficult but critical in workforce development that must orientate itself to maximising treatment gains and demonstrating its success. Emerging research has demonstrated how this is possible but it challenges orthodoxies within the treatment field.

In the 1970s there was increasing debate regarding the amount of public spending on psychological therapies which provided scant information on whether or not they worked. To address this, the field adopted an approach that had been successful in medicine: the Randomised Control Trial (RCT). In these studies, clients with similar problems were randomly assigned to different types of 'gold standard' therapies. In RCTs, clinical teams are trained by leading practitioners, and client sessions manualised and even filmed to ensure fidelity to the original model. Treatment outcomes are then compared between therapies to see which is most effective, with the winner deemed as 'evidence based' and promoted to the field.

There are problems with this approach. Firstly, trials are conducted on 'singular diagnosis' clients – people with complex needs are excluded for the sake of comparison. Clients cannot be filtered like this in everyday practice. Secondly, they involve intensive training and supervision that is not possible in everyday practice. Thirdly, research subjects can be paid to attend assessment days, which can improve their outcomes by default. All considered, it is impossible to replicate treatment from a Randomised Control Trial in everyday settings. However, the most critical issue is that the outcomes of therapies in these trials are always the same *regardless of modality*: an 'evidence base' was created but it didn't show that one type of intervention was better than another. This is called the 'dodo bird effect' from Alice in Wonderland, when the Queen announces that everyone is a winner and prizes for all.

> ***The improvement a client feels in the first three sessions predicts their long-term outcomes regardless of problem, diagnosis or social support.***

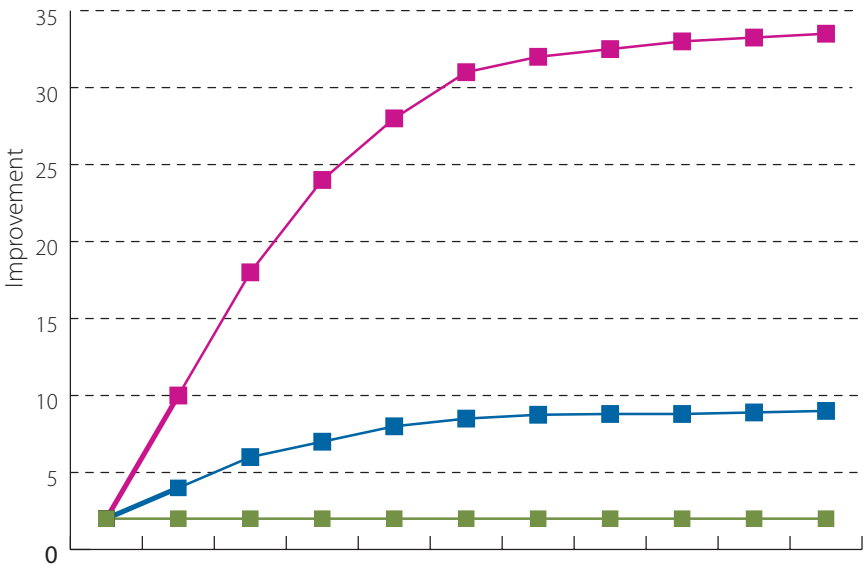
Analysis of treatment effects suggests that the type of therapy only accounts for 1% of overall outcomes: the majority of outcomes are located in extra-therapeutic factors which describe the client's own personal resources and account for 80-83% of their gains. Treatment factors account for the remaining 17-20% of outcomes, of which the most critical factor is the working alliance between the practitioner and the client *regardless of therapeutic style*. This alliance comprises a strong **bond**, working towards **goals** the client values and uses **tasks** that the client perceives as helpful. This is not to suggest we do not need models of intervention: directionless treatment produces the worst outcomes. But it does suggest that it is the 'goodness to fit' of the model with the client that is essential, not the worker's expertness in itself.

Sixty years of research has continually identified that these alliance factors drive outcomes, and studies also reveal that practitioners' outcomes remain the same from the first to the last day of their working life. A poor practitioner does the same damage to everyone they treat, most practitioners achieve an average range of response, and 'master' practitioners continually produce the highest outcomes regardless of client complexity. These outcomes are not improved by qualifications, training, manuals, supervision or clinical experience. External supports can nudge practitioners' outcomes into their upper range but they do not break the glass ceiling of their outcomes.

To understand this demands a deeper knowledge of treatment outcomes. The other key finding from sixty years of research is that these outcomes are always predicted by the early subjective improvement in the client: the improvement a client feels in the first three sessions predicts their long-term outcomes regardless of problem, diagnosis or social support. Clients who do not improve by the third session will not experience any improvement with that approach. This is known as the 'rush-trickle effect' (*see graph opposite*).

The 'rush trickle effect' give us important insight. The results of

Randomised Control Trials are always similar because they are not measuring *how fast* therapies change people: they are measuring how fast people can implement change, and this is not modality specific. There is an upper limit on how fast clients can implement change, which caps this rate. 'More,' 'better' or 'accredited' treatment will not add to these gains because people cannot change any faster. However, research shows that it is easier for practitioners to do the wrong thing and reduce a client's outcome than maximise it. Qualifications, training, manuals and supervision add new skills, techniques and perspectives to support struggling clients; however they do not eliminate the *unhelpful* elements of practice that ultimately determine the treatment curve.



Client A experiences no early subjective improvement
Client B experiences a low rate of early improvement
Client C experiences a high rate of early improvement

Master practitioners seek routine feedback from clients and adapt their practice based on this information

Research into master practitioners' outcomes supports this distinction. Firstly, master practitioners are highly adaptable in forging alliances with diverse populations. Secondly, they utilise routine feedback: the treatment field has long promoted self-reflective practice, but self-reflective practice that does not operate on objective feedback is merely theoretically informed speculation. Master practitioners seek routine feedback from clients and adapt their practice based on this information, which gives them the ability to identify and eliminate unhelpful elements of their own practice. It is this pruning process that allows them to break the glass ceiling and achieve optimal outcomes.

These considerations were built into the development of the Drug and Alcohol Family Support (DAFS) service in South Wales. Good recruitment was followed by comprehensive training in the Parents and Carers Training (PACT) approach, which was then supported with ongoing group supervision. This was the preferred model to ensure clarity in the model being delivered, establish consistency of application and promote peer learning; it was also an opportunity to understand, evaluate and respond to outcome data as part of daily practice.

The PACT programme was then delivered with a routine feedback system. Every client completes two simple, validated assessment tools (available from www.scottmiller.com). The Outcome Rating Scale has four lines 10cm long that asks clients to rate how well they are doing in themselves, close relationships, wider relationships and overall: adding these scores together allows us to chart whether the client improves at an expected rate and intervene early if they are not. At the end of each session, clients complete a Session Rating Scale, which again consists of four lines 10cm long but this time rates the quality of worker patient bond, importance of goals and relevance of tasks and how the session went overall. This measures the strength of the alliance that is so critical to outcomes. Where the client rates a session poorly, we invite feedback and the practitioner adjusts accordingly.

Through this process, every concerned other has commented on every treatment hour of the PACT programme, which informs their treatment but also identifies general patterns in outcomes and gives immense insight into how the programme might adapt. This has led to the evolution of a complete, integrated treatment pathway for concerned others that has been replicated all over the UK, based not on theoretical principles but determined by clients telling us what is most effective for them. These outcomes tools also allow us to statistically demonstrate the significance of our clinical outcomes, which reveals that the 85% of PACT clients achieve the highest rates of clinically significant change.

The drug and alcohol workforce must personify the values it espouses and develop itself. This requires sacrificing established traditions in light of robust and incontrovertible evidence; otherwise it simply replicates the very problems it hopes to avert. It must recognise that outcomes are simply not related to loyalty to a model, an accreditation process, a qualification or a treatment manual: instead, it must replace these historical preoccupations with a loyalty to the client's response to these interventions. Only when their voice is encoded into these processes will the workforce truly develop.

Phil Harris has worked as a practitioner, manager, supervisor and trainer in substance misuse for 20 years. He is involved in the strategic development of integrated treatment services for drug and alcohol users across the UK, including specialist services for concerned others. He has published several books including Empathy for the Devil *(2007) and* The Concerned Other: Clinical Manual *(2010).*

The Skills Consortium: history and future

IN SPRING 2012 Adfam's Chief Executive, Vivienne Evans OBE, was elected Chair of the Substance Misuse Skills Consortium. *Families UpFront* hears her thoughts about her new role in supporting workforce development.

The Skills Consortium has its genesis in the recovery movement and a suggestion by the National Treatment Agency (NTA) in 2009 that the drug and alcohol sector should create its own workforce development initiative through partnership between its key stakeholders. It represents an attempt to create a single, over-arching body to encourage practitioners, managers and commissioners to build their skills and develop a confident, competent workforce delivering high-quality services to substance users and their families. The Consortium also forms part of the Recovery Partnership alongside DrugScope and the Recovery Group UK, meaning it regularly communicates the views of frontline organisations to Government.

"The creation of the Skills Consortium", Evans explains, "was driven by the need to make the workforce fit for purpose to deliver recovery-orientated practice" and a desire to "harness the ideas, energy and talent from within the treatment workforce to help more drug and alcohol users recover". She thinks "the key is that we have a body within the sector made up of people from within it: experienced practitioners are naturally going to be the best people to enhance the skills and competencies of the workforce and make sure it's geared up for recovery".

According to the Consortium's business plan, 'its strength is founded on bringing together a broad group of organisations...to build consensus and support the sector'. This inclusivity, Evans believes, is vital: "executive members cover the key bases of professionals coming into contact with people affected by substance use – the Royal Colleges of General Practitioners, Nursing and Psychiatrists, voluntary and statutory treatment providers and even higher education bodies to ensure that the next generation of the workforce can take and build on what we are learning. Our Vice Chair, Jason Gough, is also a service user representative". This mix is borne out in the Consortium's membership, which lists over 250 organisations across a spectrum of treatment providers, professional bodies and membership organisations.

The Skills Hub

The crown jewel of the Consortium is the Skills Hub: an online library of manuals, guidance, training information, key competencies and the wider evidence base for interventions with substance users and their families, from engagement and preparation for treatment through to community reintegration.

"The great benefit of the Skills Hub is that its content is to a certain extent user-generated – if practitioners feel there are crucial resources missing they can submit them", Evans explains, so it is constantly evolving and developing. This results in a pool of knowledge that draws from the expertise of the workforce it is designed to support – a virtuous circle where the more the Skills Hub is used, the better it becomes.

Families and the workforce

Evans is optimistic about the implications of the Skills Consortium for supporting families: "it's good to be leading this workforce development initiative from a family perspective, and ensuring that they don't get left behind"; she adds that "it will be part of my role to show that interventions for – and involving – families are effective, and I hope we will see the availability and quality of support for families increase across the country".

Challenges

With the changing architecture of the drug treatment system and the need to bring in more and more partners to fulfil meaningful recovery goals, is there a risk of 'too many cooks' in the Skills Consortium, and might it be even harder than ever to secure any kind of consensus? "Building consensus is exactly the challenge and what we've got to do", Evans responds: "we've got to work very hard to make sure we identify the points that we all do all agree on". After all, she continues, "no one can argue that we don't need quality practitioners!"

"The recovery agenda is undoubtedly a broad and challenging one, and we want to make sure the workforce is ready for it", Evans says. "Recovery involves a wide range of partners spread across different organisations and providing various services, depending on their expertise and what is best for the service user – so it's not about calling for one type of treatment or intervention over another, but about ensuring that all work is based on the best available evidence and delivered by a workforce as good as it can be".

Future plans

In terms of immediate plans for the future, Evans says, "we're helping to develop a comprehensive framework for all the qualifications and training that exist in the substance use sector as part of the Skills for Justice project, and we are also putting on a series of Autumn road-shows to talk to current and potential members about what they need the most and driving workforce development from the bottom-up".

Though originally funded through the National Treatment Agency, when this is dissolved in April 2013 management will pass to a partnership of Adfam, DrugScope and the Federation of Drug and Alcohol Professionals to ensure it continues. So after intensive support from the NTA in the opening stages, the Consortium aims to be financially self-supporting by 2015.

If you would like to become involved in the Skills Consortium please email **policy@adfam.org.uk.**

In praise of policy?

Adfam looks at the positive role of workers behind the front line in supporting people affected by substance use.

THE workforce in the drug and alcohol sector is much larger than the fraternity of frontline treatment workers and counsellors: some professionals do not, and may never, come into daily contact with people affected directly by substance misuse.

Many whole organisations exist outside the realm of direct services; indeed these are often widely quoted in the media and beyond, for example Alcohol Concern, DrugScope and Adfam. Others, including Addaction and Turning Point, have dual roles split between delivering frontline work and performing policy and campaigning functions. As far as families are concerned, more famous names enter the fray – such as Grandparents Plus, Children England, Carers UK and the Family Rights Group – with significant policy roles.

Many of these organisations refer to their activities with terms such as 'campaigning', 'lobbying', 'promoting good practice' or 'influencing policy'. But how does this work influence and reflect the daily realities of frontline practice? Do policy officers or directors of public affairs take an equal seat at the table with drug workers, counsellors, psychotherapists and family support workers?

'Nothing about us without us'

A legitimate source of frustration might arise if frontline workers felt their concerns and experiences were not being reflected in 'high level' debates of immediate relevance to their own practices, clients and even livelihoods. What really matters, then, is that those in policy and campaigning positions properly understand the views of the people they claim to represent. Many of those affected by substance use already feel disenfranchised from 'the system'. Policy debates which do not account for – or worse, act contrary to – their views and interests only risk alienating them further, along with the practitioners working to support them on a daily basis.

Undoubtedly there will always be difficulties in translating the competing perspectives of different individuals and groups – especially in the drug sector, where strong opinions are almost a given and consensus can be hard to establish.

Horses for courses?

We need a skilled frontline workforce to support change on an individual level amongst their clients; but we also need a knowledgeable, well-connected and representative policy workforce to push for the replication of frontline success on a more systemic level.

This is not to say that some practitioners would not make fine debaters at Parliament or that people more used to research and report-writing would necessarily struggle upon coming face-to-face with a client group they experience mainly at arm's length. It is more a case – ideally at least – of playing to one's strengths, and a logical division of labour with each group performing the role they are best at and want to do.

There is an element of symbiosis here, in that there would be nothing to debate in policy circles without a frontline workforce; and frontline workers would have limited capacity to present their views and experiences to decision-makers without other professionals dedicated to precisely this role. The interests of the policy and practice workforces, therefore, should not be presented as divergent, but rather two parts of the same whole.

Partnership

Practice should inform policy work: to use an example close to home, Adfam's 2010 Manifesto was produced on the back of a series of consultation events in all nine regions of England, and would not have been possible without such a process. Conversely, policy drips down into practice: large-scale research work such as *Hidden Harm* has had a great impact on how services and professionals operate in respect to parental substance use. Both sides have a great deal to learn from each other.

As Nicola Singleton, Director of Policy and Research at the UK Drug Policy Commission (UKDPC), states: "we might think of researchers, policy analysts and advocacy organisations as 'thinkers', but no one has a monopoly on knowledge: practitioners, individuals with drug problems and their families should not be forgotten". And frontline practice does not exist in a vacuum either: "policy makers, politicians and civil servants provide the environment, set the direction and deliver resources for the work on the ground".

Measurement and success

There is another prescient question about policy work as charities the country over are being pushed to account for their funding and demonstrate their success: when is it successful? This hinges on whether it has represented the views of those it claims to effectively, and if it has influenced the right people or organisations in a way which makes things better for a particular group – for example families affected by drugs and alcohol. Producing a big report, giving yourself a pat on the back and thinking the work is done cannot be satisfactory: as Singleton agrees, "research and analysis needs to be translated into insights and knowledge that has practical value to those on the ground or developing policy". For the UKDPC, this has included work on employer attitudes, stigma and the needs of families – work which would not have been conducted without a dedicated, dispassionate policy focus.

Though as Singleton notes, the irony is that in a period of austerity, policy work may be seen as a luxury at just the time when sharing good practice and ensuring money is spent on the most effective, properly evaluated work is more important than ever.

A brief history of the drug and alcohol workforce

***Carole Sharma** from the Federation of Drug and Alcohol Professionals gives her views on the evolution of practitioners in the sector.*

THE history of the people working in drug and alcohol treatment in the UK is not one that has been well documented. Even now the workforce is incredibly varied, with no one standard route into drug or alcohol treatment – this was doubly so in the years before workforce development began in earnest for the sector, with the creation of DANOS (Drug and Alcohol National Occupational Standards) and the emergence of the National Treatment Agency (NTA). Adfam spoke to ***Carole Sharma*** who's been involved with the drug and alcohol sector, and specifically its workforce development, from the early 1980s, and currently the Chief Executive of the Federation of Drug and Alcohol Professionals (FDAP).
She told us about how the workforce has changed, what has improved and what still needs to be done.

"Workforce development really started, formally I mean, in 2000, when Skills for Health and DrugScope started work on DANOS, which went on to become the standard for everyone. The NTA also got involved with DANOS in 2001/02 but prior to this formal stuff nothing had really been done. In 2002, the NTA did a big piece of work, a national training needs analysis which was really useful, though it only covered England. They covered various elements of the workforce, including for the first time career structure, qualifications and demographics.

Back in the 70s and early 80s the workforce was largely in the NHS, with some non statutory services in the bigger cities. It was still taking shape, still creating itself, but in terms of qualifications and training we had by the early 80s some post-grad courses in drugs and alcohol for nurses, quite a lot of one- or two- day training courses, some degrees and masters but no recognised qualifications.

In terms of who was actually doing the work then, it was mainly nurses and doctors, plus ex-service users, the odd social worker, probation officers, psychologists, and some other enlightened individuals who were just prepared to try.

> *when I started there weren't drug services in every city – people would move to London or Birmingham or Liverpool because there wasn't anything else in the smaller places*

I tell you what made us all start thinking was HIV. It made us think that people needed to know what they were doing and that moved us on a bit. In the 80s we had a burgeoning heroin problem across the country; it was taking off in the working class areas, people were starting by smoking then moving into injecting and because of HIV we knew we had to work on those people injecting because they were of course at risk of blood-borne viruses. Suddenly we had to have drug services everywhere to help these people – when I started there weren't drug services in every city – people would move to London or Birmingham or Liverpool because there wasn't anything else in the smaller places. Liverpool had a massive heroin problem, as did Scotland, and the demographic of clients changed – heroin use in London used to be a middle class and upper class thing but that changed when we got smokable heroin at the start of the 80s.

Things have really changed since the early days. I was advised when I was a nurse and I made it clear that I wanted to go into alcohol as a specialism – they said that I was throwing my career away. Some of the psychiatrists I worked with were seen by their colleagues in similar way: they used to almost operate outside the 'normal' system. Now, all the steps forward have been seeds that have helped start the idea that working in drugs and alcohol

is a legitimate career. The biggest change has been the establishment of a national understanding of standards of professional expertise – what we need to do is turn it into a national understanding of levels of expertise which goes along with a whole career and structure, and ensure that we all work to agreed standards and not just do what we think might be good or what we've always done.

I do think, largely, that we're managing to hang onto our sense of innovation that came out of those early days. A key reason for this is that the people who work in drugs and alcohol tend to be personally motivated to really love it. Cranfield University, when the NTA commissioned them to do some work in 2003, said that they'd never seen a workforce that was so psychologically wedded to what it did. I think that's fantastic and we, as workforce people, need to capitalise on it.

Maybe as more money has come in, there has been a greater degree of accountability to commissioners, with people feeling almost more 'statutory'. If money comes from charitable trusts maybe there is a greater degree of freedom, but we all should be accountable really – we all have to make sure that the client group is served as best as possible and linked in with housing, mental health and domestic violence services. As ever, we've just got to find that middle ground between independence and accountability!

TOP TEN TIPS FOR WORKFORCE DEVELOPMENT

1. **QUALIFICATIONS AND ACCREDITATION provide practitioners with a personal and portable demonstration of their worth.**
2. **NATIONAL OCCUPATIONAL STANDARDS provide a ready-made set of competencies you can use to build role profiles, analyse performance and demonstrate efficiency.**
3. **SECTOR SKILLS COUNCILS are the bodies which provide workforce development for the various sectors. Skills for Health, Skills for Justice and Skills for Care are the relevant ones for the drug and alcohol sector.**
4. **MEMBERSHIP BODIES can provide practitioners with a code of practice, an ethical framework and a recognisable stamp of quality. They can also help in disputes.**
5. **For WORKFORCE DEVELOPMENT ideas and inspiration look at other, longer established sectors such as social work.**
6. **'BY US, FOR US' – true development for the workforce has to be driven from within the sector itself. Organisations can contribute by joining the Skills Consortium.**
7. **Look widely for RESOURCES AND PUBLICATIONS – there's a wealth online, including the Skills Hub (www.skillsconsortium.org.uk/skillshub.aspx).**
8. **EFFECTIVE SUPERVISION AND SUPPORT benefits everyone – make sure there is a structure in place in your organisation which allows managers to have regular contact with the people they manage.**
9. **BE OPEN TO NEW LEARNING OPPORTUNITIES – nobody is too experienced to learn!**
10. **VOLUNTEERS ARE IMPORTANT – include them and listen to their experiences.**

Professional accreditation for practitioners supporting families affected by drugs and alcohol

Adfam and the Federation of Drug and Alcohol Professionals (FDAP) have jointly developed an accreditation for practitioners supporting families affected by drugs and alcohol.

This new Adfam/FDAP accreditation is specifically designed for work with families, after consultation with the sector and the development of a unique role profile.

Benefits include:

- A professional competency-based accreditation, mapped to National Occupational Standards (NOS)
- A role profile and a code of practice to work to
- Ongoing support from FDAP and Adfam, including priority invites to events and an e-newsletter
- 6 month subscription to *Families UpFront* magazine

The accreditation is offered at the registration level. Practitioners will, as a minimum, require their employers to attest to their competence in each of the national occupational standards outlined in the Role Profile. Practitioners will be required to develop a portfolio of proof of competence which may be asked for by FDAP as part of random sampling and which will allow them to demonstrate continued professional development in order to re-accredit at the end of the three years. To become accredited by FDAP practitioners must be members.

Introductory offer including the accreditation and membership of FDAP for a year is available now for a £75 fee.

Please contact FDAP if you are interested in the accreditation at *office@fdap.org.uk*

fdap Adfam

Mutual benefits

*Adfam spoke to **Mark Gilman**, the National Treatment Agency's Strategic Recovery Lead, to discuss mutual aid and 'recovery champions' from a workforce perspective.*

THE idea of recovery as 'contagious' is a key feature of mutual aid, and more recently has made its way into official policy: a key tenet of the 2010 Drug Strategy was that the Government would 'support local communities to build networks of 'Recovery Champions' who will spread the message that recovery is worth aspiring to and help those starting their journey'. These champions would be placed throughout the system at strategic, therapeutic (that is, within services) and community levels; the creation of a recovery-orientated system and the role of recovery champions, therefore, are inextricably linked, at least in the eyes of Government.

"The overall thinking behind recovery champions", Gilman states, "is that there's more to treatment and recovery than just the medical and clinical parts – it's like a game of two halves." Continuing the analogy, he says "the treatment community are well-versed in evidence-based treatment, so we can get you into half-time 1-0 up; and the role of recovery champions is to ensure that people realize that's only half way." But before examining where the recovery champions fit into the overall system, Gilman explains the three different types of champion as set out in the Drug Strategy.

Strategic recovery champions, he argues, should be "as high up as you can get – start with the Directors of Public Health and work down...they could be directors of adult services or even councillors and elected members. We're working on it".

The role of the **therapeutic champion** is to put the strategic recovery focus into practice within services and make sure that people leaving treatment are linked in to other sources of support: "so you've finished treatment or you're well on your way, and it's about sustaining the recovery status". These can be existing members of staff within treatment services, including those who had previously hidden their recovery status for fear of stigma. The idea here, it seems, is to act as a bridge between treatment and the community; indeed at this point, Gilman continues, service users can be introduced to a **community champion** – someone in recovery themselves, with the requisite links within the local area, and who can support work on the five ways to wellbeing *(see box right)*.

Where do they fit in?

So by and large, strategic and therapeutic recovery champions are part of the established workforce; community champions, however, seem much harder to pin down. How are they selected, and on what grounds; who are they accountable to, if anyone; and who are they responsible for? Are people watching to see if they will fail or relapse themselves, and what if they do?

But posing these questions may be an attempt to over-define recovery champions and place an administrative or bureaucratic burden on something that is essentially organic; as Gilman states, "if you say you're in recovery, then you are – the same principle could apply to champions... they can be essentially self-appointed". He explains that recovery champions are partly "unofficial and cultural; it's about kinship", and that there are "thousands" out there in networks such as the UK Recovery Foundation and Wired Into Recovery.

For the community, then, recovery is more a state of mind than a title; indeed, there seems to be a clear conflict in subjecting recovery champions to rules and regulations as the more they are managed or institutionalised, perhaps the less true to the ethos of recovery they become. Recovery, Gilman believes, is an "ungoverned, and mainly ungovernable, arena", both in its fellowship model and its basic recognition that recovery is different for each individual. He stresses that recovery champions aren't meant to tell people what to do: "they might guide you towards certain places, but you also have to be an adult about it and make your own, adult decisions, which are what recovery is about".

Conflict and barriers

In terms of quantifying the number of recovery champions, there is also an argument that if the aim is to make recovery as visible as possible, then the more recovery champions the better, and the more people in recovery who can be brought under the umbrella of

MARK'S FIVE KEYS TO WELLBEING

1. **CONNECT: 'you *must* connect with others – it's crucial for recovery'**
2. **ACTIVE: 'you can do an awful lot for recovery just by being physically active – anything from a stroll to a triathlon'**
3. **GIVE: 'volunteering helps raise self-esteem, and it doesn't have to be in a drug service'**
4. **KEEP LEARNING: 'follow passions and find them out – you might have spent a long time being passionate about crack, so now get passionate about pottery'**
5. **TAKE NOTICE: 'yesterday is history, tomorrow is a mystery; we only have now, so be mindful of that and live in the moment'**

the 'champion' term, the greater the number of examples of success and the higher the level of cumulative ambition. However, as well as putting a great deal of pressure on sometimes vulnerable individuals who feel obliged to keep up perfect appearances of a life transformed for the better, could an expanded role for high numbers of community recovery champions located outside the realm of 'treatment' also realign the whole system away from a workforce of fully trained, accountable, experienced and professionalised workers? I ask, then, what the barriers are to successful partnership between recovery champions and the treatment system, and whether there could even be conflict between the different sections of the workforce.

Gilman is adamant that "if you're in the treatment workforce and you've never been to a mutual aid meeting, you're missing exposure to a crucial part of treatment...it's as preposterous as being a bricklayer without a trowel". In order to minimise any potential conflict between 'rival' sections of the workforce, it's important, he says, to "take the 'zen' out of mutual aid and demystify it", and end any scepticism amongst drugs workers. For frontline practitioners to gain this awareness, he identifies a need to "support managers to insist that their staff go, and develop active links between mutual aid and formal services".

Gilman believes that becoming familiar with mutual aid and recognising the positive role it can play all fits into a worker's duty to be "genuinely aspirational and ambitious for your patients"; treatment alone cannot represent or accommodate 100% of this ambition. Gilman uses another analogy: "if you discovered a lump on your body, you'd be assertive in going to see a GP, and if you had the money you'd probably pay to see a specialist – you wouldn't take two ibuprofen and hope for the best". Being truly pro-recovery, then, includes a desire to marshal all the resources and support available both within treatment services and out in the community. In his own work facilitating workshops on 12-step alongside people in long-term recovery, Gilman has noticed that "people can be tetchy to start with but you can see them physically change once it starts" and become much more positive, so making the first step can be crucial.

New and different?

This all sounds very positive, but mutual aid has been around for a long time; Gilman notes that the first Alcoholics Anonymous meeting in 1935 predates what we now understand as 'treatment', which began with methadone in 1964. Similarly, to some extent 'recovery champions' have always existed too, in the form of anyone visible and proud of their recovery. So the 'newness' of the recovery champion initiative seems to rest more on a point of emphasis; as Gilman puts it, the difference is about making an "*assertive* linkage of the two halves of treatment and mutual aid to make a whole".

Gilman is supportive of a re-emphasis on the benefits of mutual aid, many of which cannot be provided by treatment alone. Firstly he identifies "the ability to challenge" and address ambivalence in mutual aid settings, in which case the lack of constraint and of accepted clinical models works in favour of mutual aid and recovery champions, rather than being used as a criticism. Gilman explains: "part of the orthodox therapeutic worker-patient relationship is that the worker is non-judgmental and non-directive – but I might go to an NA or AA meeting and someone would tell me to shut up, which I might need to hear but don't want to". Mutual aid provides something that "treatment can't do, and isn't really meant for", in "having the courage and the love to tell you something you don't want to hear. You don't get that in treatment". The "defining feature" of recovery, he asserts, "is the authentic relationship" that isn't necessarily there in treatment settings. He also notes that mutual aid is available "immediately and 365 days a year: you can be in recovery in half an hour – not tomorrow, not in three weeks. Now."

So by implementing a joined-up system whereby service users are referred directly from treatment to a community champion from their own therapeutic champion within, this ability to challenge is added to the treatment journey almost automatically, and immediately; or to follow Gilman's analogy, the game doesn't stop at half time.

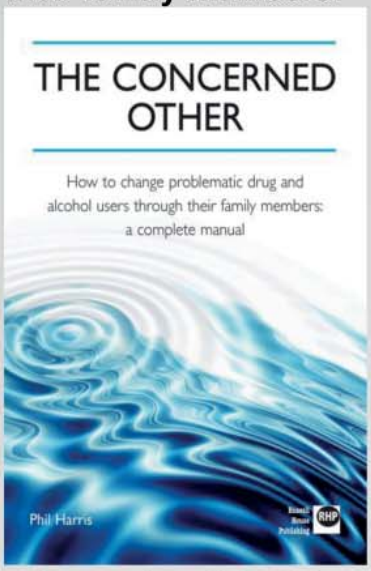
Future and family

The future of recovery champions remains to be seen; *Druglink* magazine recently examined what happens if those held up as exemplars of success relapse and what support is available to them in this situation[1]. The recovery champion initiative "allows them to be proud, which is fine", Gilman says, but you need to "create the environment in which they're comfortable", so there must be some element of organisation and structure – treatment provider Addaction has a defined system of training and support in place, for example – to make the most of the motivation on offer. There could also be interesting parallels to be drawn with family support – could there be family recovery champions? Do they already exist in the form of family members who have sought or set up support, improved their own quality of life as a result, and who could coordinate such a scheme? Indeed, Gilman points out that "recovery is becoming a whole, fully functioning human being and part of a family" and believes that "if you want to judge someone's recovery, don't ask the individual: ask their family. It's about actions and doing the right thing, not just words".

1 H Shapiro (2012, July/August) Walk the line. *Druglink*, 8-12.

Supporting Families Affected by a Loved One's Problem Use?

The Concerned Other: How to change problematic drug and alcohol users through their family members.



The Concerned Other is a **complete treatment manual** for working with those affected by a family member's drug or alcohol use.

Section One: Provides a detailed review of research that demonstrates why and **how families can affect change**, historical and contemporary interventions for families and provides a comprehensive thematic review of the treatment manual.

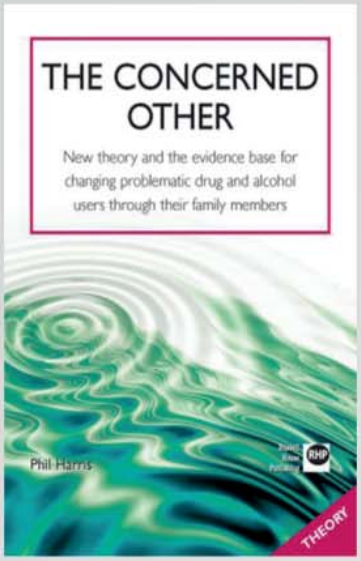
Section Two: Provides **a complete treatment programme** including **comprehensive assessment** & **care planning**, outcome measures and worksheets with detailed guidance. This skill based programme will assist concerned others to:

- Get their unmotivated loved one into treatment
- Reduce the stress and pressure the concerned other is under
- Improve the quality of the concerned others own life
- Help the concerned other support their loved one once in treatment.

Anyone who registers their purchase with RHP may request all the manual's worksheets in PDF format for free.

A4 Bound	302 pages	978-905541-48-5	2009	£49.95

The Concerned Other: New theory and evidence base for changing problematic drug and alcohol users through their family members.



This major new theoretical work explores the extensive research that demonstrates **why and how families** can effect change. This book explains:

- How addiction and family hardship interact to produce change
- The history of family intervention approaches
- Challenges the validity of concepts such as co-dependence
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Essential reading for substance misuse workers, family workers, youth workers, counsellors, policy–makers and students who want to bring themselves up-to-date with current thinking but do not want to purchase the full clinical manual.

A5 Paperback	136 pages	978-1-905541-66-9	2010	£16.95

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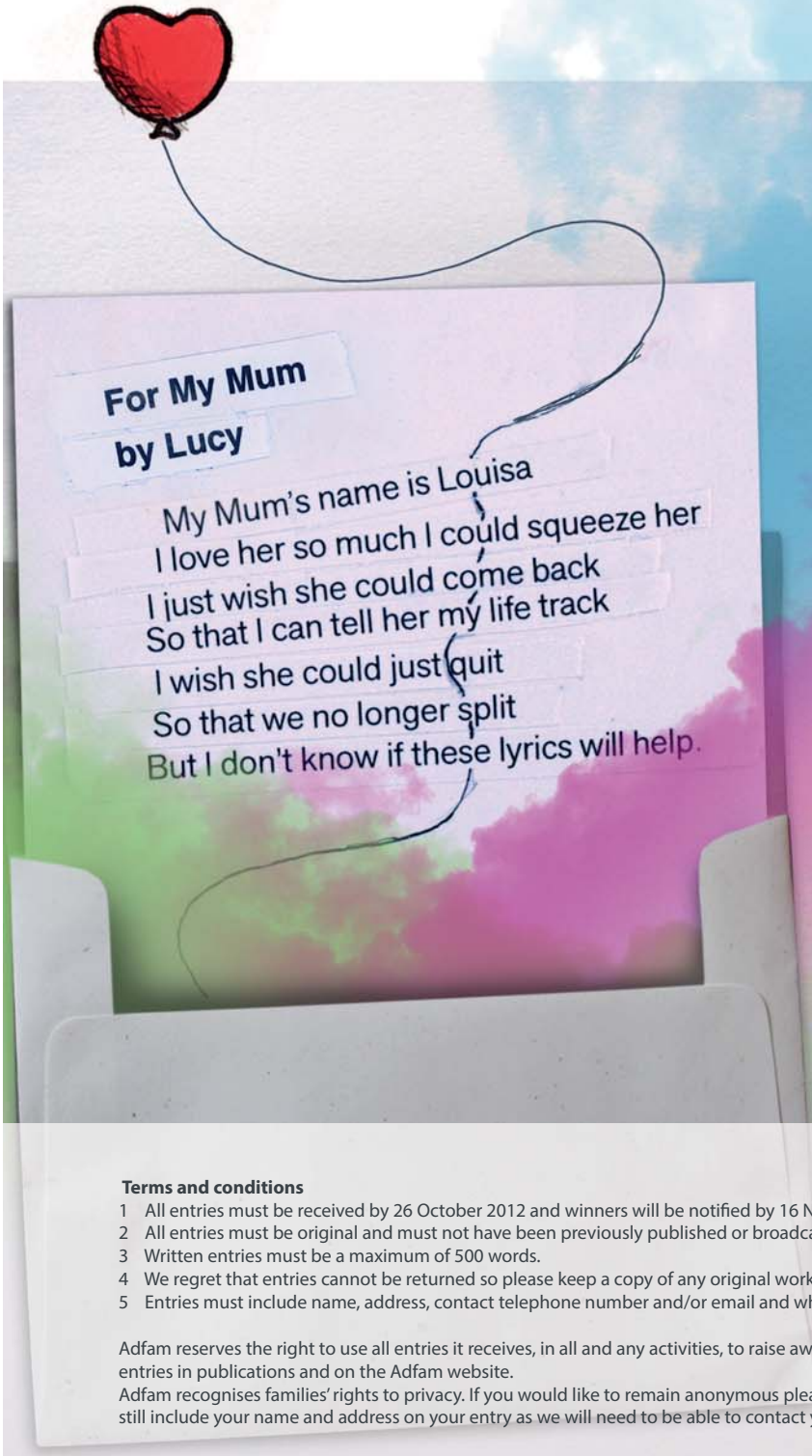
Join the National PACT Network from Sophia.ali@kwads.org.uk

You don't have to use drugs to be affected by them.

Adfam's Family Voices competition

Adfam
Families, drugs and alcohol

Have you been affected by someone else's drug or alcohol use?
Would you like to be able to tell your story?
With Adfam's Family Voices competition, you can make your voice heard.



Prizes: First prize £150
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Plus an invitation as a guest of honour to Adfam's Candlelit Carol concert on 6th December 2012, where you will have the opportunity to meet celebrity guests and have your story read out. All travel to London and overnight accommodation costs for the winner and runners up are included in the prize.

What to enter

A piece of writing or a poem of up to 500 words

How to enter

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

Terms and conditions

1 All entries must be received by 26 October 2012 and winners will be notified by 16 November 2012 - the judges' decision is final.
2 All entries must be original and must not have been previously published or broadcast. All submissions become the property of Adfam.
3 Written entries must be a maximum of 500 words.
4 We regret that entries cannot be returned so please keep a copy of any original work.
5 Entries must include name, address, contact telephone number and/or email and where you heard about Family Voices.

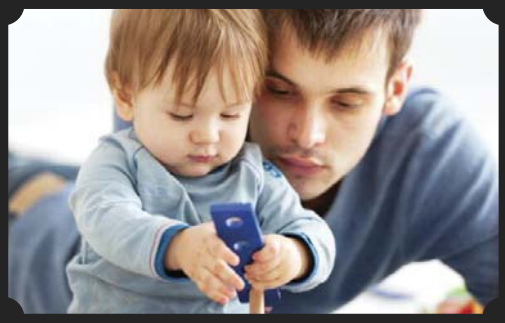
Adfam reserves the right to use all entries it receives, in all and any activities, to raise awareness of our work. This may include reproducing entries in publications and on the Adfam website.
Adfam recognises families' rights to privacy. If you would like to remain anonymous please let us know and we will respect this, but you must still include your name and address on your entry as we will need to be able to contact you if you win.

Families First

The first Adfam/DDN family conference








While addiction can tear families apart, family support can be a huge factor in driving the successful recovery of both the individual and the whole family.

This conference will bring together family members – many of whom are providing support networks around the country – along with policy-makers and professionals.

The aim of the event is to demonstrate to family members that they are not alone, and there is support available. It will also reenergise individuals involved in the daily stresses of dealing with the consequences of a loved one's drug and alcohol problems, and offer hope and inspiration by showcasing the work of family support groups around the country.

This one-day event will allow agencies to hear from some of the most inspirational advocates for better treatment and support, and will encourage working partnerships between family members and treatment providers to help whole families' recovery journeys.

Adfam
Families, drugs and alcohol

DDN
Drink and Drugs News

Putting families at the centre of recovery

This is a must-attend event for family members affected by substance use and for all agencies and organisations who genuinely want to support them

Early bird delegate rates for bookings before Friday 14 September
Family members £80 + vat
Professionals £135 + vat
(An additional £10 will be added to bookings made after this date)

Full programme and online booking on

www.drinkanddrugsnews.com

e: conferences@cjwellings.com t: 020 7463 2081

Thursday, 15 November 2012 – BIRMINGHAM