



***National Treatment Agency  
for Substance Misuse***

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## **Supporting and involving carers**

September 2006

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# 1 Introduction

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The aim of this guide is to ensure that all drug action teams and crime and disorder reduction partnerships, referred to in this guide as “partnerships”:

- Commission consistent, effective and quality services for carers and family members affected by someone else’s drug use
- Involve carers and family members effectively in their planning.

The guide is designed to be used in conjunction with We Count Too (2005). It also builds on the following documents:

- Commissioning Drug Treatment Systems: Resource Pack for Commissioners (2002)
- Commissioning Standards for Drug and Alcohol Treatment and Care (1999)
- Young People’s Substance Misuse Treatment Services – Essential Elements (2005)
- Models of Care for Treatment of Adult Drug Misusers: Update 2006 (2006)
- NTA guidance on user and carer involvement, including specific guidance for completing the planning grids for the 2006/07 treatment plan.

In addition to these documents, the guide draws on the input of a number of partnership joint commissioning managers, service providers and NTA regional leads for carers, who contributed via questionnaires and telephone interviews.

## 1.1 Who is this guide for?

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The primary audience for this guide is joint commissioning managers for substance misuse within partnerships and primary care trusts (PCTs), and the members of their joint commissioning groups.

The guide will also be of value to:

- Carers leads within PCTs and local authorities
- Family and carer support provider services
- Drug treatment provider services
- Regional Government Office drugs teams.

It is recognised that partnerships are at very different stages of development in terms of commissioning services for carers and family members. At one end of the spectrum are a minority of partnerships that commission fully funded, comprehensive family support services; at the other are those that commission no work of this type. The majority of partnerships fall into the middle ground, commissioning a range of provision from small grants for specific short-term pieces of work, to recurrent funding for specific services or single carer and family support workers located in treatment or other agencies. This guide is designed to be of use to the full spectrum of partnerships, so each will need to select the information relevant to their situation.

For example, those who are just starting to look at this area of work will find the sections below on assessing needs, auditing provision and building capacity useful. People commissioning comprehensive services should find the information on Models of Care, assessment and care planning, and purchasing and contracting useful. Those with some basic commissioning of services in place should find the sections on strategic planning and operational planning of value.

## **1.2 Some key principles**

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The following messages underpin the remainder of this document:

### **1.2.1 Carer involvement works most effectively, when support services for carers and family members are in place**

Partnerships are required to involve carers actively in their planning processes. Without the provision of dedicated support services for them, this remains a difficult aspiration to achieve. As one interviewee for this guide commented: "If someone is in pieces, how can they contribute to planning meetings?" When carers receive effective, good-quality support, this is likely to enable them to contribute objectively and consistently.

### **1.2.2 Carers have separate and distinct needs from users**

It does not work to tag carers on to the needs of users. Carers and family members tend to focus their attention on the individual's misusing behaviour and this approach is reinforced by combining work with carers with work with users. At times, the interests and needs of the two groups coincide, but they are often in conflict. Carers and family members have their own needs and focusing on these through the provision of dedicated support services will enable them to function more effectively and provide the opportunity for users to take responsibility for their own actions. Systems and processes designed for user involvement may well not work for carers – they need systems and processes that work for them. While there are specific circumstances when joint working with users and carers can be appropriate and useful, these are exceptions to this rule and should not overtake the need to separate most work with carers and users.

### **1.2.3 Family and carer support services cannot be fitted simply into models of care for drug treatment services**

While Models of Care offers a broad structure that has some relevance to work with carers, it is designed to provide a framework for the treatment of drug misuse. Family and carer support services should be designed and commissioned with the primary aim of improving the health and wellbeing of individual family members and family functioning as a whole. This is a long-term task, requiring different and more flexible interventions than drug treatment and therefore requiring relevant and different service specifications and monitoring systems. Services should be available to all carers and family members in a partnership area, not just those where the user is engaged in treatment.

### **1.2.4 Carer and family support services need to reflect and draw on carers and family members' own experience**

The majority of services for carers and family members in this country have developed out of self-help initiatives. This is one of their strengths and needs to be valued and built on by commissioners. While personal experience is not a guarantee of quality service provision, it needs to be integrated into services commissioned for carers and family members, as without it, services will have difficulty understanding and responding appropriately to the needs and experience of their clients.

### **1.2.5 Partnerships have a lead role to play in commissioning services for carers and family members**

Carer and family support services require adequate funding to enable them to deliver consistent quality services. While partnerships are not the only potential source for this, their focus on addressing the impact of drug misuse on individuals and communities gives them a responsibility

to take the lead in identifying such funding and commissioning services. It is recognised that, in the short term, it is not realistic for all partnerships to fully fund services. However, the long-term goal should be to work towards a situation where every area has carer and family support services which are fully and recurrently funded, though a combination of partnership budgets, generic carers' funding and other sources.

### **1.3 Scope of this guide**

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This guide provides practical advice and guidance on the following areas:

- Commissioning dedicated and specific support services for carers and family members
- Carer and family member involvement in partnership and treatment service planning
- Carer and family member involvement in individual care planning for the treatment of drug users
- Some implications of all of these for the commissioning of drug treatment services.

For the purposes of this guide, "carer" is used to refer to anyone affected directly by someone else's drug use who is aiming to support and help them. This may be a family member, such as a parent, partner or sibling, or it may be a close friend. Some carers are unhappy with this term, as they feel that it runs counter to the prevailing ethos within family support services, which is to encourage family members to prioritise their own health and wellbeing, rather than remaining focused on the needs of the user. Equally, others dislike the word "families", as they feel this excludes close friends. For these reasons, we prefer to use the phrase "carers and family members" is used.

This guide focuses on services for adult carers and family members, and their involvement. This is not to deny the significant impact of drug misuse on children and young carers, as outlined comprehensively in *Hidden Harm* (2003), but simply to clarify that this is a separate area of work requiring separate attention, led through children and young people's commissioning processes.

This guide provides some advice about addressing the needs of diverse populations of carers and family members. More detail on this can be found in *We Count Too*. It is acknowledged that further work is required at national, regional and local levels, to fully identify and meet the particular needs of different Black and minority ethnic communities, and those of other groups who are less likely to gain access to mainstream services, including lesbian and gay carers and carers with disabilities.

### **1.4 Why commission services for carers?**

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There are clear messages emerging from research that support for family members and carers of substance misusers has a positive impact on:

- The engagement of users in treatment services
- The retention of users in treatment
- The outcomes from treatment and sustainability of treatment outcomes.

Copello *et al.* (2005), comprehensively demonstrate this in their review of current evidence.

*We Count Too* documented the enormous and devastating impact of drug misuse on family members and carers. The feelings and experiences encompass all areas of the carer and family member's life and include:

- Fear and loss of control

- Anger and betrayal
- Guilt and feelings of responsibility
- Shame and isolation.

These feelings are borne out in the growing body of research and consultation in this field, together with the significant negative impact on the mental and physical health and wellbeing of family members and carers. Families and carers express clear and consistent needs for the following:

- Information
- Support, in the short and long term
- Contact with others with similar experiences
- Understanding and a non-judgemental approach
- Respite
- Practical help.

Research and evaluation demonstrates a range of positive benefits from the provision of dedicated support services for carers and family members. Partnerships have a responsibility to reduce the harm caused by drug misuse to communities as a whole, including the families and carers of drug users, whether or not the users are accessing treatment.

Health and social care legislation and guidance, including that on carers, gives carers of drug users, along with other carers legal entitlements to assessment and support. All organisations with a responsibility for caring for users are required to focus on carers' needs as well. The consultation for this guide indicates that mechanisms for ensuring that carers of drug users access these rights and the associated funding are significantly underdeveloped in many parts of the country.

Carers and family members provide a valuable resource as potential volunteers and paid workers in the substance misuse field, drawing on the experience and expertise gained from living with a drug user.

## **1.5 The policy context and national guidance**

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There is a wealth of relevant policy and national guidance that, when combined, provides a strong basis for commissioning services for carers and family members affected by someone else's drug use, and for involving carers actively in the planning of partnership services. This section summarises the main relevant legislation and guidance.

- The Updated Drug Strategy (2002) states: "Parents, carers and families also need support. They experience the problems that drugs cause at first hand, and have a key role in helping ... people with drug problems overcome them. They will receive improved services and support." Carers' needs cut across the treatment, young people and communities themes of the strategy. This is the key policy driver behind this guidance
- The Carers (Equal Opportunities) Act 2004 builds on previous carers legislation, placing a duty on all local authorities to inform carers who provide "regular and substantial care" of their right to a carers assessment. Depending on the outcome of this assessment, carers may be eligible to access a carers grant (sometimes called carers support or special grant), to enable them to take a break from caring and access services that can "support them in their caring role". However, it is important to note that to be able to access funding from this source, carers needs have to meet the criteria set out in Fair Access to Care Services (2002), namely that without support. there are risks to the independence of users and carers

- Each local authority, usually via social services departments, decides how to use their carers grant, according to local conditions and annual government priorities. As this grant is no longer ringfenced, some areas may spend it on entirely different priorities. Local authority social services departments now have a specific performance indicator on carers' services, which require them to show how many carers gained access to support services as a result of their assessments. While not all carers of drug users provide "regular and substantial care", some do and even where they do not, carers are still entitled to support, as set out in *Caring About Carers* (1999), which makes it clear that all organisations who provide care, must:
  - Recognise carers' rights to have their own health needs met
  - Help carers to take a break
  - Involve carers in planning services.

In many areas, partnerships and service providers have been able to access a block of carers grant to enhance commissioned substance misuse carers and family support services (see *We Count Too* for specific examples).

- The National Service Framework (NSF) for Mental Health (1999) built on carers legislation by requiring all services providing structured care programme approach care to those with mental health needs, including dual diagnosis, to ensure that their carers receive an assessment and are able to access support. This strand of the NSF has specific targets, milestones and funding attached to it
- The Health and Social Care Act 2001 places a statutory duty on all NHS bodies from January 2003, including drug treatment services as part of PCTs or mental health trusts, to consult and involve patients and the public in its planning. This requirement is set out in more detail in a range of Department of Health (DH) guidance documents focusing on commissioning a patient-led NHS. While there is no specific reference to carers in this legislation, they represent a key group whose views need to be sought and acted upon
- The social care Green Paper, *Independence, Well-being and Choice* (2005) sets out the Government's vision for social care services. It emphasises the importance of carers and of ensuring they are "integral to the vision", including proposals for increasing support and direct payments to carers
- The NTA's Business Plan 2005/06 sets out the Treatment Effectiveness strategy for adult drug treatment services. This complements and builds on the NTA's previous work to ensure robust commissioning practice within partnerships. The Treatment Effectiveness strategy focuses on improving clients' journeys through treatment and on developing local treatment systems.

The treatment journey is divided into four overlapping phases:

- Engagement of drug users in treatment
- Delivery of treatment, with an increased emphasis on care planning and retaining users in treatment for at least 12 weeks
- Treatment completion, leading to improved outcomes in relation to drug use, health and offending
- Community integration, relying on effective systems of wider social support.

Carers and family members have a significant contribution to make to all of these phases.

- Carer and family support services are the most effective way to support and enable family members to make changes in their own engage with treatment behaviour, which can then provide a trigger to users choosing to. This is borne out by research, for example Copello *et al.* (2005)

- Research also demonstrates that involvement of and support for family members can have a significant impact on both retention in treatment and on treatment outcomes:

*“... the evidence strongly supports the notion that family involvement at various points in the treatment process can lead to improved outcomes for both the substance misuser and the family members affected.” Copello et al. (2005)*

- Carers and family members also have a key role in successfully reintegrating users into the community after treatment or when coming out of prison. This is recognised in guidance for the Drugs Intervention Programme (DIP)
- The NTA latest guidance for commissioners of young people’s substance misuse services, entitled Young People’s Substance Misuse Treatment Services – Essential Elements (2005) identifies “support for family members” as an essential service that must be available to carers and family members of young people in treatment by 2006. This is now part of the performance management of partnerships
- We Count Too was produced by the Home Office in 2005 to stimulate good practice in relation to both the commissioning and provision of carer and family support services. It includes specific examples of commissioning practice and sets out simple Quality Standards (summarised in Appendix I to this guide), which can be applied to both small and more developed services
- Drug and Alcohol National Occupational Standards (DANOS, 2003) unit AB7 covers those who “provide services to those affected by someone else’s substance use” and covers three elements: enabling those affected to explore and select options, supporting those affected to put selected options into practice, and empowering those affected to review the effectiveness of selected options. DANOS unit C1, which relates to carers and families of those with mental health needs, is also relevant
- The Quality and Outcomes Framework (2005), which has been used since last year to measure the performance of and determine levels of funding for all GP practices in England, contains a specific outcome relating to carers, which is relevant for all practices, including those involved in shared care:
  - Practice Management 9: to have in place “a protocol of the identification of carers and a mechanism for the referral of carers for an assessment of their needs.”
  - This is supported by a primary care toolkit, which supports GP practices to identify, register and refer carers.

## 1.6 Getting started

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For many partnerships, this may be the most difficult task. It is important to start by identifying someone within the team who can take a lead on work with and for carers, thereby ensuring that this is seen as a specific piece of work requiring particular skills. The following are some possible options for this role:

- An assistant joint commissioner post
- A team member who leads on community engagement
- A joint user and carer support and involvement post. However, this option has some problems, as the two sets of needs are very different and the primary focus is often on user involvement, whereas carer work includes developing and commissioning dedicated services as well as involvement
- Creating a carer development post, particularly where there is little or no existing provision for carers of drug users locally. This post can be located within the partnership team, a carer or community-based organisation, or a treatment service. If the latter option is chosen, it is

important to be clear that the focus of the post is carer work as a whole, not simply support to carers of users of their service. Such a post should be seen as relatively short term, so that the funding can eventually be allocated directly to commissioned carer and family support services

- A joint post across a number of neighbouring partnerships. This may be helpful for smaller partnerships, particularly those covering London boroughs.

Whoever is allocated lead responsibility for this work, it is likely to be useful for them to link closely with local authority and PCT generic carer leads.

There is a useful list of resources and information in chapter seven of We Count Too. Chapter four, on commissioning, includes examples of work by a variety of partnerships with their contact details for further information. NTA regional teams can also provide support and advice on this work.

## **2 Commissioning carer and family support services**

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The definition of commissioning used here is that set out in the NTA's Commissioning Resource Pack, which is seen as a cycle with the following stages:

- Assessment of needs and auditing of current provision
- Strategic planning – determining priorities and agreeing commissioning aims through a consultative and partnership approach
- Operational planning, including building provider capacity and preferred quality assurance systems
- Purchasing activities, including specifying services, identifying funding and contracting via service level agreements
- Monitoring, evaluating and reviewing contracts and performance.

This section starts by providing a brief overview of appropriate service models and assessment and care planning arrangements for dedicated carer and family support services. The remainder of the section addresses each of the stages of the commissioning cycle in more detail. It is recognised that partnerships are at different stages of development with respect to this aspect of their work, so the guidance includes suggestions designed to relate to this. It is recommended that services commissioned specifically for carers from the pooled treatment budget are included in Treatment Planning Grid 4.

### **2.1 Models of service**

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A comprehensive carer and family support service should provide the range of interventions for the range of carers and family members and situations which is captured in the menu of services set out Appendix II of We Count Too:

- Information and advice, via written publications, drop in sessions and helplines. This will include harm reduction interventions for the carer and family member, such as hepatitis and sexual health interventions
- Support groups, which are accessible to a range of carers and family members, for example partners, grandparents and siblings, as well as parents
- Respite provision and personal learning opportunities
- One-to-one support, provided ideally via both outreach and centre based provision. This includes structured counselling and can involve telephone counselling and more informal support.

In addition, it is helpful if services are resourced:

- To develop specific support in partnership with criminal justice focused services, which can be linked to DIP
- To develop specific support relating to bereavement.

While in broad terms, these types of services fall into Tiers 2 and 3, as outlined in Models of Care, much of this provision does not neatly correlate with Models of Care because the needs and appropriate interventions for carers and family members are very different from those of drug users themselves. The following principles characterise effective carer and family support services:

- They are flexible and responsive to the range of needs presented by carers and family members who access them
- They recognise that carers and family members may need long-term support and services are therefore normally not time limited, although they have mechanisms to set goals and review progress with clients who are receiving structured interventions
- They focus on improving family functioning and the health and wellbeing of clients, rather than on “curing” addictions.

The following descriptions are offered, using Models of Care as a framework, but adapting it to this client group.

#### **2.1.1 Level 1: Carers and family support services: basic advice, information and referral by mainstream services**

- Provided by generic health, social care and carers services with no specialism in substance misuse. Also provided by drug and alcohol treatment services who are not specialists in work with carers, and by community and faith organisations.

#### **2.1.2 Level 2: Open access services for carers and family members affected by someone else’s drug use**

- Services are accessed via self-referral and referral from Level/Tier 1 services and treatment services. In all cases, access to services is voluntary
- Services at this level include:
  - Advice and information about drugs and treatment
  - Drop-in facilities for one-to-one support and advice
  - Harm reduction advice in relation to health and the law
  - Harm reduction training, including on blood-borne viruses and overdose
  - Helplines
  - Support groups
  - Outreach visits
  - Respite and alternative therapies
  - Personal learning opportunities
- Services employ trained and supervised volunteers and paid staff.

#### **2.1.3 Level 3: Structured community based support and interventions for carers and family members affected by someone else’s drug use**

- Services are accessed via self-referral, a simple assessment of needs leading to a simple support plan (see section 2.2)

- Services at this level include:
  - Structured psychosocial interventions (i.e. counselling), which may be time limited, depending on service capacity
  - Telephone or outreach based structured counselling
  - Respite and alternative therapies, where this forms part of the support plan.
  - Liaison with other specialist agencies, for example social services (in relation to child protection and criminal justice services)
  - Attendance at support groups, where this forms part of the support plan.
- Structured services will be provided by fully trained staff, accredited by the relevant national bodies, e.g. BACCP for counsellors.

#### **2.1.4 Level 4: Specialist residential services for carers and family members affected by someone else's drug use**

- Services are accessed via referral from Level 2 or 3 family support services, treatment services or sometimes via self referral. Referrals will be screened and assessed by the provider
- Services at this level include short stay residential provision, providing respite and structured programmes of therapeutic intervention designed to relieve stress, raise self-esteem and identify coping strategies. Therapy may include group and one-to-one support
- Structured services will be provided by fully trained staff, accredited by the relevant national bodies, e.g. BACCP for counsellors.

Level 3 and 4 work may also include therapeutic interventions with the whole family, involving the user and other family members affected. This can be particularly helpful for interventions with young users and those living at home. This guide does not cover the commissioning of family work in detail, as this is likely to form part of a treatment service specification, and unlikely to be commissioned through dedicated carer and family support services. However, it is important that commissioners include this within their overall commissioning strategy.

## **2.2 Assessment and care planning**

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All carers who provide 'regular and substantial care' are entitled under current legislation to receive a carers assessment, which should lead to a care plan and possibly access to relevant support and funding, e.g. for respite, as long as their needs meet the fair access to care criteria. However, this is only likely to be relevant to carers of drug users with severe physical or mental health problems, as well as their addiction.

This guide recommends that services providing structured interventions for carers (at Levels/Tiers 3 and 4) should carry out a simple assessment of carers' needs, leading to an agreed support plan. While this process will not need to be as detailed as assessment and care planning for drug treatment, there is useful material to refer to in the NTA's Care Planning Practice Guide (2006). Suggested items for inclusion in a carer and family member assessment form and a support plan are attached as Appendix III. These adapt the approach in the Care Planning Toolkit for users of agreeing small incremental goals to move people forwards. The support plan should include a date when progress will be reviewed. It is important to ensure that both the goals and review period are realistic and allow sufficient time for progress to be made. It is recommended that reviews should happen at regular intervals, depending on the goals set and interventions being offered. Some suggested goals are included in Appendix III. A formal assessment is not necessarily required for carers to access Level 2 services, such as helplines, one-off advice and support, and initial attendance at support groups, as it could be off-putting, but providers may wish to do a simple assessment for those who are in regular contact with their services.

Some partnerships are currently building in carer assessments to their care planning approach for treatment service users. This is an excellent development. However, it is important to separate out the assessment of the carers' own needs leading to their own support plan, from the discussion about their contribution to the drug user's treatment plan. The latter issue is addressed in section four.

## **2.3 Assessing needs and auditing provision**

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### **2.3.1 Identifying hidden needs**

It can be challenging to identify carer needs, particularly when there are no specific services or groups for carers and family members affected by someone else's drug use in the area. However, we know that, on average, for every drug user there is at least one person directly affected and usually more, so needs exist even where they are hidden. Partnerships can use the Hickman and Frisher rating for their areas and double this to get an approximate number of carers. Where services are well developed, there are likely to be particular groups of carers who are not accessing them. The following ideas can help to identify any hidden needs:

- Work with drug treatment services to identify the number of users who are being supported by a carer and family member, via questions in the assessment process
- Contact carers and family members through treatment services, with the service user's consent, and consult them about their needs, making sure an immediate offer of help is available. Information packs about drugs, treatment and other local services are a useful starting point, but you may also be able to offer access to counselling, or to respite and alternative therapies
- Develop or build on partnerships with local community organisations, including faith groups, groups for people with disabilities and lesbian and gay organisations. Carers often get informal support through such routes and community groups will value the opportunity to discuss needs they have identified with commissioners
- Particular efforts should be made to access and understand the needs of specific communities where levels of stigma and fear are likely to be acute, e.g. Black and minority ethnic communities and travellers
- Develop links with local generic provision for carers, for example carers' centres. Many carers' centres are starting to come across carers affected by drug use and may feel ill-equipped to respond, so will value links with partnerships
- Drugs awareness training that includes a focus on the impact of drug misuse on families and carers – developed in partnership with local communities and carers organisations, including Black and minority ethnic organisations – can be used as a means to access carers and family members and to build community capacity to respond to carers' needs
- Where specific carer and family support services already exist, ask about identified needs, and work with them to develop creative ways to find out more about and try to meet the needs of groups under-represented in their current client profiles, for example male carers and people with disabilities
- Minimise the gap between conducting needs assessment and putting services in place, as community needs can change rapidly
- View needs assessment as an ongoing process, combined with capacity building.

In all of this work, it is important to remember the high levels of stigma, shame and blame that surround drug use, so go carefully and sensitively.

### **2.3.2 Auditing current provision**

In many areas, some form of provision for carers and family members affected by someone else's drug use already exists, although partnerships are not always aware of this. This may include:

- Self-help support groups and other services that have been developed by carers and family members themselves within the voluntary and community sector
- Informal support offered by treatment service providers to carers and family members, including advice and information, access to counselling sessions, alternative therapies, and other provision
- Support offered via carers' centres or other generic carers' organisations, including social services departments and PCTs
- Support provided via community organisations, such as Black and minority ethnic women's organisations. This is unlikely to be explicitly offered, due to the high levels of stigma attached to drug use, but may well form a key part of the organisation's work
- Support provided by voluntary and community sector mental health services to carers of users with dual diagnosis issues. Support to people labelled as mentally ill who may actually be substance misusers.

In conducting an audit of current provision, it is important to make contact with these services as well as more established ones, explore how they are currently resourced and assess to what extent they meet the quality standards set out in We Count Too. Where services are underdeveloped or do not appear to meet basic quality standards, there may be the potential for development work, capacity building and partnership work to address this. Where services are well established, it is helpful to encourage them to conduct self-assessments against these quality standards.

It is also useful to audit existing provision against the menu of services in We Count Too, which is reproduced as Appendix II of this guide. Even in areas with well-established and resourced carer and family support services, there may be gaps in relation to certain aspects of the menu. For example, work with grandparents, work around bereavement and work around criminal justice services.

## **2.4 Strategic planning**

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In order to move from needs assessment and initial capacity building into full commissioning of carer and family support services, partnerships should consider levels and types of needs identified, preferred models of service and local capacity to deliver these.

### **2.4.1 Determining priorities and commissioning aims**

Before proceeding to drawing up service specifications, partnerships should agree their priorities and commissioning aims for this aspect of their work. Some options are:

- Where there is little provision currently available locally, a partnership may decide that the best way forward is to undertake capacity building work (see section 2.6), or commission a development worker to do it
- Where there is a range of competing or overlapping provision, the partnership may decide that drawing up a clear service specification and inviting tenders for this will clarify the situation
- Where needs appear to be very limited locally, partnerships may wish to consider jointly commissioning provision with neighbouring partnerships

- Where generic carer provision is well developed but specialist substance misuse support for carers is not, the best option may be to develop and fund a service as part of the local carers Centre, which will involve discussion with the commissioners/management of that provision
- Partnerships may prefer to locate carer and family support workers with treatment services and DIP teams. However, there are disadvantages with this option, as it makes it considerably harder to maintain separation between provision for users and carers. If this is the preferred option, then the service specification and operational arrangements will need to be clear that carers and family members should receive services in response to their own needs. This is not only in relation to the needs of the user – these services should be open to all carers and family members, not just those of users accessing treatment.

Before determining which option makes most sense for the local area, it is important to ensure that full consultation has taken place with key stakeholders.

#### **2.4.2 Consultation and partnership working**

In developing a strategic plan for carer and family support, commissioners need to consult treatment service providers, generic carers' services and workers, and carers and family support groups focusing on drug misuse. For carer and family support services to be effective, treatment services should be in agreement with the strategic plan and willing and able to play their part in making it work. This includes providing information, identifying needs, making referrals, and valuing the benefits of partnership working with carer and family support services.

It is equally important that generic carer services and workers recognise the needs of carers and family members affected by someone else's drug use, and are willing to work creatively to meet these needs.

In some cases, where the level of demand for services is low, or there is an identified need for a specialist form of family support, for example around bereavement or family work, it may make sense for neighbouring partnerships to jointly commission a service.

Helplines are often accessed by family members and carers from outside their boundaries, and there are benefits to be had from economies of scale in relation to such services.

### **2.5 Operational planning**

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Before deciding on the preferred way forward and the process to enable this to happen, the following areas need consideration.

#### **2.5.1 Building capacity**

Where needs are hard to identify because carers and family members are not in touch with services, or where services are underdeveloped, it is worth trying out different forms of provision with the dual purpose of improving local capacity and "testing the water". At the same time, contact should be made with more carers and family members, in order to better understand their needs. This is likely to be particularly important in relation to hidden carers, including Black and minority ethnic carers.

Some suggestions for ways to start to develop provision and to build capacity include:

- Providing self-help groups and small projects with small grants initially, for the costs of rooms, publicity, information materials etc.

- Providing or funding access to training for small groups, including in-group facilitation, confidentiality, in relevant skills linked to DANOS competencies and in organisational development
- Commissioning pilot initiatives, such as facilitated support groups and helplines and promote, publicise and evaluate these fully. This enables services to develop beyond self-help and allows partnerships to test what works for their area. It is important to fund such initiatives adequately and give them long enough to be able to demonstrate effectiveness, as it takes time for the word to spread and confidence to build up amongst carers and family members to access such provision
- Commissioning targeted initiatives aimed at particular groups known to find it harder to access support, e.g. men, partners, grandparents, carers with disabilities, lesbian, gay and bisexual carers, and Black and minority ethnic carers. An outreach approach may be particularly important with respect to supporting some of these groups
- Developing partnerships with Black and minority ethnic organisations including women's groups, with travellers groups, and with other community and faith organisations, to develop confidential and responsive services for family members who are unlikely to access services publicly known to be associated with drug misuse
- Encouraging established carer and family support services to build links with Black and minority ethnic organisations and other community groups, in order to extend the provision of support to those not currently accessing their services
- Developing and providing access to networking opportunities within the partnership area and regionally, as a way to break down isolation. Bursaries for individual carers to attend relevant national conferences can be made available
- Supporting services to become compliant with the quality standards in We Count Too and other relevant quality systems, e.g. QuADS, PQASSO.

## **2.5.2 Quality assurance**

Before proceeding to purchasing specific services, partnerships need to decide the preferred quality system. The only specific quality standards for services for carers and families affected by someone else's drug use are those set out in We Count Too and summarised in Appendix I. These should form the starting point, but partnerships may also wish to require services to comply with more detailed organisational standards with systems for self-assessment. PQASSO is useful for voluntary sector organisations in this respect, particularly as they can be required to reach different levels depending on the stage of development of their organisation. Alternatively, commissioners may prefer to require services to comply with the organisational standards in QuADS. If PTB funding is being used, services will need to demonstrate compliance with the Department of Health's Standards for Better Health. However, carer and family support services only need to be compliant with relevant organisational standards, not standards designed specifically for treatment services, such as the QuADS Core Care Standards. It is also important to bear in mind that these user-focused quality systems can be quite onerous to self-assess against, and are therefore inappropriate for smaller services.

Partnerships should also require services to be able demonstrate staff and volunteer compliance with the relevant DANOS standards.

## **2.6 Purchasing and contracting**

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### **2.6.1 Service specifications**

Once commissioning moves beyond the stage of funding small, pilot initiatives, service specifications for carer and family support services should be developed. These need not be

separated into levels, as one provider organisation may be commissioned to provide a range of services required.

Within service specifications for carer and family support services, the following points need to be addressed:

- Clear aims and objectives for the service
- Realistic and measurable targets and timescales for each element of service (see monitoring and review section below)
- If compliance is required with quality standards, that these are relevant to this type of service and the specification allows sufficient time and resources to self-assess and achieve compliance
- Relationships with other providers, for example treatment services, are specified and these are mirrored in services' service specifications
- Requirements for levels of staff and volunteer competence, training, support and supervision.

Further guidance on service specifications for carer and family support is in Appendix IV.

## **2.7 Finance and funding**

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In determining the resource allocation to this element of the partnership's work, the following points need to be borne in mind:

- It may well be possible for partnerships to access other sources of funding for carer and family support services, including via carers grant. This can help to put together a realistic package of funding, without having to draw too heavily on the PTB
- Ensure that the total budget available to the service, from partnership funding and other sources combined covers the full costs of providing the services being commissioned. This means including:
  - Costs of office and service space
  - Costs of advertising and marketing services (which can be significant)
  - Full staff costs, including the costs associated with recruiting, training and supporting volunteers
  - Costs of IT required for monitoring purposes, and associated training.
- Where smaller contracts are being issued for pilot initiatives, and voluntary and community sector projects, allow for payment in advance, as it can be difficult for smaller projects to manage payments in arrears
- Where funding is coming from different sources, e.g. DIP and PTB, ensure that the expectations of each funding source are clear, and that the total funding available is sufficient to deliver the range of services specified
- Try to avoid frequent changes in funding sources, as this impacts on service focus and mitigates against strategic planning.

## **2.8 Contracting process**

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Where a positive relationship has been built up by partnerships with a local provider over time, possibly through capacity building work as outlined in section 2.5.1, it makes sense to take a "preferred provider" approach and commission them to carry out the service specification.

When a contract is put out to tender, it is important to bear in mind the following points:

- Providers need to be able to demonstrate comprehensive understanding and experience of the impact of drug use on families, carers, and local communities
- Providers demonstrate how they will ensure clear separation between provision for carers and family members, and provision for drug users (this is particularly relevant for tenders from drug treatment service providers)
- Partnership tenders will be welcomed, for example between substance misuse focused services and generic carers services
- Smaller voluntary sector organisations may have very limited experience of submitting tenders, but be able to deliver high-quality services. The invitation to tender could helpfully be supported by advice about where to get support for this process, including local councils for voluntary services
- It is useful to involve local carers and family members actively in the contracting process, as long as they can demonstrate an ability to give advice that is independent of any particular provider who is submitting a tender.

### **2.8.1 Service level agreements**

Service level agreements (SLAs) should follow the NTA's commissioning guidance and include the relevant conditions, contractual framework and reference to legal requirements and policies and procedures (see commissioning section of [www.nta.nhs.uk](http://www.nta.nhs.uk)), depending on services' capacity and the scale of investment in them.

For example, if funding is less than £100,000, requirements should be less onerous than for services funded at over £200,000. Chapter five of *We Count Too* includes a list of policies that all services should have in place and all SLAs should also include the following points:

- Responsibilities on both sides, e.g. include support and involvement opportunities being provided by the partnership
- Sufficient notice of contracts ending to allow services to seek alternative funding or make the necessary organisational changes
- Contract duration, which should ideally be at least three years for fully funded services, subject to annual review
- Monitoring requirements and arrangements for regular reviews.

### **2.8.2 Monitoring and review**

In agreeing measures and setting targets for carer and family support services, against which their progress will be monitored, partnerships should ensure that these relate to the types of service being provided and the services' capacity to gather and provide the data required. The following points should be noted:

- Measures and targets designed for treatment services are, on the whole, inappropriate for carer and family support services. For example, while it is known that users who stay in treatment for 12 weeks or more have significantly improved outcomes, the same is not known for carers
- The amount and level of monitoring and detail of targets should relate to the level of investment in the service, e.g. limited requirements for services funded less than £100,000 per year
- Providers may not hold detailed information on all clients who access Level/Tier 2 services. They should be able to provide numbers, relationship to user and basic demographic

characteristics, but for example they may well not record the ethnicity or addresses of helpline callers

- As carer and family support interventions may be more open ended and long term than treatment interventions, targets and measures need to reflect this.

Areas where service providers should be able to provide data and where targets can be set include:

- The number of carers and family members in contact with services and targets for new contacts, although this is not sufficient information on its own
- The number of repeat contacts, and levels of ongoing support provided, e.g. through support groups
- Self reported progress from clients in relation to physical and mental health, reduced medication and improved family relationships
- Increased knowledge and understanding of the impact of substance misuse and treatment service and modalities, measured through feedback from clients on information provided, advice given, and training and information events attended
- Specific targets for increasing take up of services by particular groups, e.g. grandparents, men, and particular communities of interest

Process targets can also be set in relation to organisational developments, which the partnership wishes to see in carer and family support services, including:

- Self-assessment against and compliance with quality standards
- Staff and volunteer training and appraisal systems
- Partnership working with treatment, criminal justice or other services.

While carer and family support services' effectiveness should not be measured by the engagement with or impact of treatment on the user, it may be helpful to gain information about and from the links with treatment services, including:

- Feedback from treatment service providers about the impact on users of their carers and family members receiving support, as part of the review process
- Supporting services to establish electronic monitoring systems, which will record where referrals have come from and whether the user is in treatment, e.g. BOMIC
- Data from such systems can be used to encourage treatment providers who are not referring to start to do so.

Service reviews should be, at the least, carried out at six-monthly intervals, be realistic in terms of the data requirements from services and include:

- Feedback from service users (carers and family members)
- Feedback from treatment and other partner services, e.g. criminal justice if work is being undertaken in that field
- Staff and members of the management committee in the case of voluntary sector services
- An opportunity for the service to raise issues about capacity and ideas for future development work
- A robust discussion of the targets and areas where these have been met, exceeded, or not met, with discussion of reasons for this and agreement on action to address these.

## **3 Carer involvement**

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The NTA requires partnerships to include information in their treatment plans about how they are going to improve carer involvement. In 2006/07, the user and carer involvement self-assessment and planning grids were separated for the first time and detailed guidance provided to support their completion.

This section sets out some further information about how to involve carers and family members effectively and meaningfully in partnership planning and commissioning. The NTA guidance for user and carer involvement makes it clear that partnerships need to develop a coherent involvement strategy, which includes every level and stage of planning. This guidance starts from the premise that the best way to ensure effective involvement is to have robust carer and family support services in place. Such services are required in order to provide support for carers, thereby enabling them to participate objectively and actively in involvement opportunities. Involvement strategies need to recognise and address this as their first priority. However, where services are not yet in place, some of the suggestions in this section can still be adopted.

### **3.1 Why involve carers?**

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Partnerships need to be clear about why, when and how to consult and involve carers and family members. If the only reason it is happening is that the NTA says it should, then more thought is required. Good reasons for involving and consulting carers are:

- They have direct, personal experience of the impact of drugs on families and communities and views about what action and services help and what do not. Therefore, they can make a useful contribution to assessing the needs for treatment and identifying the best options to respond to them
- They care about what services and responses are available in their areas to respond to the impact of drugs, not just in relation to themselves, but also others, and are willing to give their own time to advise on this
- Assuming that carers' views are listened to and, where appropriate, taken on board, ownership and trust in plans and services will be increased. This is in keeping with the patient and public involvement requirements of recent legislation and guidance across health and social care.

It is important to give feedback on the outcomes of any consultation and involvement. Otherwise, carers and family members will not feel valued and will be unlikely to respond to invitations for involvement in the future.

### **3.2 How to involve carers**

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Carer involvement needs to be designed to be meaningful and accessible. This means developing a strategy and range of opportunities that are not about fitting carers into the partnerships' existing system or into systems designed for user involvement, as neither of these options necessarily works for carers and family members. The following points should be considered:

- Start by asking how they want to be involved, being prepared to offer options
- Have a systematic approach to carer involvement and responding to issues which carers raise
- Provide opportunities for a collective input from carers to decision making. This can be done by inviting senior managers to attend meetings of carers on their "home turf", rather than always doing the opposite
- Involve carers throughout the commissioning cycle, as outlined at the start of section two

- Identify opportunities to consult and involve carers and family members on specific issues which they are interested in and have a contribution to make to, for example:
  - Design and development of services for carers and families
  - Design of care co-ordination and care pathways
  - Aftercare and reintegration work
  - Liaison with social services around child protection issues.
- Focus on tasks that carers can contribute to, for example, production of information materials or directories of services and ensuring they benefit from this work
- Use a variety of methods to gain input, including questionnaires and surveys, one-off consultation meetings and special sections of standing meetings dealing with issues carers' views are sought on
- Set up a carer forum or pre-meetings where carers can be briefed about the issues to be discussed at forthcoming consultation events, and agree points they want to make and questions they want to ask in advance
- Give carers the opportunity to put their own issues on the agenda of standing groups they are attending
- Develop buddying systems, so that single representatives on strategic groups have some support and company
- Ensure that involvement is built up on the basis of what is meaningful and accessible to carers themselves, starting low key so as to avoid overwhelming carers with bureaucracy and formal meetings
- Only combine user involvement with carer involvement when it makes sense and carers and users are happy with this. For example, consultation about care planning arrangements should be undertaken separately, as carers and family members and users have very different perspectives on this. However, work to compile a local directory of services could be done jointly
- Recognise and be prepared to work with the chaos that is the reality of carers and family members' lives. This means accepting that representation at meetings will need to be flexible and allow for different people to attend at different times, depending on what else is happening in their lives
- Consult groups of hidden carers, for example Black and minority ethnic carers, separately by going to them, thus protecting confidentiality and taking positive action to ensure inclusion of their views
- Ensure there are a range of ways different carers can input their views, so that one or two vocal individuals do not dominate
- Involve carers in the development of services and in the tendering process for services
- Ensure a two-way feedback – ensure partnerships at strategic level are informed about issues carers raise and carers are informed about the former's response
- Explore the possibility of appointing carer advocates.

### **3.3 Offering something in return**

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While it may not be the partnership's policy to pay carers for their involvement, there are many ways that partnerships can ensure that carers benefit from making a contribution:

- The best reward is to have their views heard, valued and acted upon

- The provision of good-quality services for carers and family members in their own right is a key way to value them, as well as the most effective and representative way to access their collective views
- All expenses incurred should be paid, including childcare and transport
- The direct provision of practical support such as transport can be helpful, particularly those with mobility difficulties or those living in rural areas
- Partnership support for a local carers' forum, or funding for local carers and family support services to facilitate such a forum, will ensure good preparation and show that their input is valued
- Regular feedback from consultation and involvement is essential and shows respect for their views
- The provision of free training for carers, for example on drugs awareness and treatment systems, harm reduction and other issues
- Ensuring that carers have access to relevant job opportunities, careers advice and skills training to equip them to work in substance misuse services
- It may be possible to pay carers for discreet pieces of work and set up payment schemes in partnership with HM Revenue & Customs, as has been done with respect to mental health carers in some areas.

### **3.4 Other things to think about**

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In addition to the points in the previous section, the following points will help to ensure meaningful, informed and effective carer involvement:

- Provide training for carers so they understand the systems you are asking them to become involved in and ensure this is complemented by training for commissioners and treatment providers about the impact of drug use on families and carers
- Minimise the use of jargon at meetings. This is good practice for all involved, not just a concession to carers
- If carers wish workers in their services to act as advocates in involvement, allow for this, but do not assume that this is the same as full carer involvement or replaces it, although many such workers are or have been carers themselves
- Ensuring that the timing of meetings suits carers. For example, it may be helpful to organise some meetings in the evenings in order to make them accessible to working carers
- Consider locations of meetings, particularly in rural areas or those covering a large geographical patch. This could include holding meetings in a central location, moving meetings around or repeating them 2-3 times in different places
- Link carer representatives into the NTA's regional carers' networks, rather than relying on worker representation only at these
- Ensure there is good two-way feedback between national level meetings, regional and local meetings.

## **4 Carer involvement in care planning**

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The final section of the guidance focuses on carer and family member involvement in the process of assessing the needs and agreeing a care plan for the drug user. The consultation for this guide identified mixed views on this issue and the best ways to involve carers appropriately. However,

there was a general consensus, supported by research, that if handled appropriately, carers and family members can make a very helpful contribution to successful treatment outcomes for users and equally if it is ignored, they can have a negative impact.

#### **4.1 From total responsibility to informed support**

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Typically, carers and family members are very focused on the user when they first seek support. They see treatment for the user as the only solution to the distress and chaos they are experiencing. This means that carer involvement in care planning needs to be handled carefully, as it is important to ensure that users, rather than carers, take primary responsibility for treatment engagement and outcomes. The following points can help with this:

- Encourage treatment services to give carers and family members plenty of information about drugs and their effects, treatment modalities and services, including the cycle of change and likelihood of relapse. Where local carer and family support services exist, this may best be provided by them, but it is always useful for treatment services to have stocks of information targeted at carers
- Ensure that treatment services ask users to think about where their support comes from and consider the support their carers and family members may need. This should form a standard question on all user assessment forms (triage, comprehensive and DIP assessments), along with a question about whether the user wishes the carer and family member to be involved in their care plan
- Ensure that treatment services, preferably in conjunction with carer and family support services, consult carers about whether they wish to be included in the user's care plan, if the user has given consent for this. Make it clear that this will be for specified support and is not about taking responsibility for outcomes
- Clear agreements need to be drawn up with the user and carer about confidentiality and identifying what information can be shared with whom, with the user's wishes at the centre. This could take the form of a three-way meeting between the user, carer and the treatment lead worker or care co-ordinator. The publication *Carers and Confidentiality in Mental Health* (2004) provides some useful guidance on this matter. Particular care is needed when issues of child protection and domestic abuse are identified in the care plan
- The user's care plan should identify any input from the carer and the latter should indicate their consent to this. It should be clear that the carer is not accountable for the success of the care plan
- Carer involvement in care plan reviews should be agreed in advance, again with the user's wishes to the fore
- Carers and family members' contributions needs to be considered when designing care pathways, particularly in relation to aftercare and reintegration
- All of these are particularly important in relation to young users, but also users living at home
- It is important to remember that carers are a diverse group, as are users, so a flexible and case-by-case approach needs to be used
- To ensure that all of the above happens effectively, treatment service staff need good training in carer involvement.

## 5 Treatment service issues

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In order for the commissioning of carer and family support services to form an effective part of the whole treatment system, family and carer issues should be built into Models of Care work with adult and young people's treatment services, and into their service specifications. This section does not address these issues in detail, but does set out some points to consider here:

- Treatment services should be encouraged to think in terms of the whole family, both in relation to the impact of drug misuse on others and carer and family contributions to addressing it
- Standard questions should be included in drug user assessments about carers
- Treatment services should offer all carers identified in this way information and a referral to carer and family support services
- Treatment services should be encouraged to build relationships with carer and family support services. They may be able to offer a base for some activities, or swap training on drug treatment with family awareness. Where there is spare capacity in the former, they may agree to provide some of this to the latter, for example counselling sessions, access to alternative therapies, and use of space
- All treatment service staff should receive training about the impact on families and carers of drug use and on the provision that carer and family support services offer.
- Carer involvement in care planning and in service reviews should be built into all treatment service specifications.

## 6 References

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Copello AG, Velleman RDB, Templeton LJ (2005). Family Interventions in the Treatment of Alcohol and Drug Problems. *Drug and Alcohol Review*. London: Taylor & Francis.

ADFAM (2005) *'We Count Too' – Good Practice Guide and Quality Standards for Work with Family Members Affected by Someone Else's Drug Use*. London: ADFAM.

Substance Misuse Advisory Service (1999) *Commissioning Standards for Drug and Alcohol Treatment*. London: Substance Misuse Advisory Service.

National Treatment Agency (2005) *Young People's Substance Misuse Treatment Services – Essential Elements*. London: NTA.

National Treatment Agency (2006) *Models of Care for Treatment of Adult Drug Misusers: Update 2006*. London: NTA.

Advisory Council on the Misuse of Drugs (2003) *Hidden Harm: Responding to the Needs of Children of Problem Drug Users. The Report of an Inquiry by the Advisory Council on the Misuse of Drugs*. London: Home Office.

Home Office (2002) *Updated Drug Strategy 2002*. London: Home Office

Department of Health (2005) *The Carers (Equal Opportunities) Act 2004 (Commencement) (England) Order 2005*. London: The Stationery Office.

Department of Health (2002) *Fair Access to Care Services – Guidance on Eligibility Criteria for Adult Social Care*. London: Department of Health.

Department of Health (1999) *Caring About Carers: A National Strategy for Carers*. London: Department of Health.

Department of Health (1999) *National Service Framework for Mental Health: Modern Standards And Service Models*. London: Department of Health.

*Health and Social Care Act 2001* (2001) London: The Stationery Office.

Department of Health (2005) *Independence, Well-being and Choice*. London: Department of Health.

National Treatment Agency (2005) *Business Plan 2005/06: Towards Treatment Effectiveness*. London: NTA.

Skills for Health (2003) *Drug and Alcohol National Occupational Standards*. The full range of competences are available at [www.skillsforhealth.org.uk/danos](http://www.skillsforhealth.org.uk/danos)

Health and Social Care Information Centre (2005) *Quality and Outcomes Framework, 2004/05*. London: HSCIC

National Treatment Agency (2006) *Care Planning Practice Guide*. London: NTA

SCODA, Alcohol Concern (1999) *Quality in Drugs and Alcohol Services (QuADS)*. London: SCODA, Alcohol Concern

Royal College of Psychiatrists and The Princess Royal Trust for Carers (2004). *Carers and Confidentiality in Mental Health: Issues Involved in Information-Sharing*. London: Royal College of Psychiatrists

National Treatment Agency (2002) *Commissioning Drug Treatment Systems: Resource Pack for Commissioners*. London: NTA

## **Appendix I: Quality standards for services for family members and carers affected by someone else's drug use**

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The quality standards summarised below are set out in more detail in chapter five of We Count Too and are divided into two sections:

### **A Five essential requirements**

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The organisational processes necessary to deliver quality services:

- Family members affected by drug use are actively involved in the organisation
- The service works in partnership with other relevant local organisations and services
- The service is clear about its principles, aims and focus and how these will be achieved and monitored
- The service has in place policies, procedures and protocols covering confidentiality and its legal responsibilities
- All service staff are appropriately trained and supported.

### **B Seven basic quality standards for family support services**

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Quality standards focus on the outcomes for family members who use the services.

- Confidentiality and safety
- Offering choices
- Accessibility
- Supporting family members to look after themselves
- Non-judgemental and caring approach
- Clear boundaries
- Being informed and informing.

## **Appendix II: The good practice menu of services**

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We Count Too lists good practice guidelines and quality standards for work with family members affected by someone else's drug use.

The menu is designed for groups and services to use as a checklist against which progress can be measured and new ideas generated.

- One-to-one support services
- Information
- Personal learning opportunities
- Telephone helplines
- Support groups
- Support to help family members work together
- Services that provide a break (respite)
- Services for grandparents
- Services for partners
- Services for children and siblings
- Services for people with a family member going through the court system or in prison
- Services for family members bereaved by drug use

Further detail can be found in chapter six of We Count Too.

# Appendix III: Notes on assessment, support planning and support plan review

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## 1 Assessment

As stated in section two of this guidance, formal and recorded assessment of carers and family members seeking support is not required for Level/Tier 2 services, although it may be useful in some cases. However, it is strongly recommended for anyone seeking Level/Tier 3 services – structured interventions including counselling. Carrying out a formal assessment is only recommended where the service has the capacity to meet needs that may be identified, as it is unhelpful to assess people and then be unable to provide a response.

Clients of carer and family support services often start by being totally focused on the user. The purpose of a carer and family member assessment is to focus on their own needs, so discussion about and information on the user should be kept to a minimum in the assessment process and on the assessment and support forms.

Assessment should be carried out by a paid member of staff, who is trained to and confident in undertaking this responsibility. It can be done in one discussion, or over a series of meetings. Services need to put in place a form which records the assessment process and which the carer and family member can read through and sign. The assessment process is designed to lead to an agreed support plan, detailed in the subsequent section.

In addition to basic personal and contact details, including any information required for monitoring purposes, the assessment should cover the following areas:

- Levels of knowledge about substance use, relevant harm reduction measures (e.g. safe sex for partners), treatment services and criminal justice system
- Client's relationship with the user, including whether the user is living with them and how well they communicate
- Impact of drug use and user's behaviour on client's feelings and personal functioning, including:
  - Physical and mental health
  - Level of own medication
  - Social life
  - Work (where applicable)
- Impact of drug use and user's behaviour on relationships with other members of the family and close friends
- Whether there are domestic violence or harassment issues
- Whether the family and carer has been involved with the criminal justice system
- Any child protection issues (if these are identified, services need to act in accordance with their child protection policies)
- A discussion of the client's goals for the next six months in terms of the issues identified through the above assessment
- Once clients are aware of the range of services they can access, it is important to agree which of these will be helpful in terms of achieving their goals.

It is also likely to be useful to record the following information:

- Referral source
- Client's GP and any other services or workers whom they may be receiving support or input from
- Details of the user and a summary of their drug use and treatment, where relevant
- Any previous involvement the client has had with the service, e.g. Level/Tier 2 interventions such as attending a support group, receiving an information pack etc.

## **2 Support plan**

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From the assessment previously describe, a simple support plan can be drawn up that sets out which elements of service provision the client will receive over the next period of time. The support plan should include a date when progress is to be reviewed, which will normally be between three and six months.

The support plan should include some agreed goals. It is important that these are realistic and focus on areas where clients feel they want to make progress. Some examples might include:

- More understanding of the effects of drugs on the user
- Learning how to minimise harm, e.g. in relation to blood-borne viruses
- Fewer arguments with other family members
- Reduced medication for stress from the doctor
- Going out to meet friends more often (or at all)
- Fewer sleepless nights
- Not paying for the user's drugs
- Changing the locks and only allowing the user in the house when they are calm
- Attending a further education or training course
- Going back to work.

The point of the goals is that they need to focus on helping clients to regain some control over their own lives.

## **3 Review**

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The review meeting should focus on the goals set in the support plan and cover:

- Which services and forms of support have been most useful, for example support groups, one-to-one counselling, information, training courses, respite, and alternative therapies
- Where has progress been made in relation to the goals set and what has made that possible
- Where progress has been slow or what things have got worse, with a discussion of why this is
- A revised support plan, if the client wishes to continue to receive support from the service
- A date for the next review.

It is worth noting that worker feedback from these reviews will be useful to the service as a whole in terms of shaping future developments. For example, if few people are finding a particular element of service useful, but everyone is finding something else helpful, then priorities in the

future could shift. Commissioners could usefully encourage providers to capture this information and feed it back as part of whole service reviews.

## Appendix IV: Service specifications for carer and family support services

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There should be a clear service specification drawn up for all carer and family support services, based on the identification of local needs and using the menu of services (see Appendix II of this guide and, for more detail, We Count Too).

Partnerships may commission one service to provide all elements of the menu or a number of different services to provide different elements. If the latter option is chosen, then each specification should spell out clearly the expectations around joint working. For example, a local Black and ethnic minority community organisation may be commissioned to provide support groups and one-to-one work with family members and carers in their local community. However, it is likely to be helpful for them to undertake some joint work with other providers of carer and family support services in the area, such as respite events, training and work around bereavement.

Service specifications should broadly follow the model set out in the NTA's Commissioning Resource Pack and include these elements:

- Definition of the service being specified, relating it to the levels or tiers of intervention to be offered
- Aims and objectives of the service
- Client groups served, including the geographical area covered, whether the service is for carers and family members of users of all substances, or just particular drugs, and specific population groups targeted, e.g. grandparents
- Eligibility and exclusion criteria, which in relation to carer and family support services is likely to be all adults affected, but will usually exclude under 18s. Exclusion should also be made for anyone demonstrating unacceptable behaviour towards staff, volunteers or other clients
- Access and referral to services. In most cases this will be open, allowing for self-referral and referral by others, but where this is not the case, referral routes should be specified
- Assessment and support planning requirements, particularly with reference to Level/Tier 3 services (see Appendix III)
- Description of services and interventions to be provided. This will be the main part of the specification and needs to set out clearly each specified element being funded, including advice, information, support groups and harm reduction interventions
- Staff training and competencies required
- Service principles, which include the requirement that providers demonstrate they have a full understanding of the impact of drug misuse on families and carers, requirements around partnership working, the principle of separating work with carers from work with users and requirements to ensure accessibility of services to diverse groups, for example translation and interpreting, and physical access
- Policies and protocols. This section includes reference to quality standards that providers need to demonstrate they are working towards, lists policies that providers need to have in place and sets out general requirements about policies – these include processes for regular review, named lead people for each policy, and processes to ensure that all staff and volunteers are aware of policies and implementing them
- Monitoring and review. This section will make reference to how any targets set out in the final SLA will be monitored, the need to have in place recording systems and the process and frequency of service reviews.