ALCOHOL RESEARCH UK

University of Bedfordshire

Tilda Goldberg Centre for social work and social care

Building capacity and bridging the gaps:

Alcohol and other drugs in social care practice, education and employment-based training

Summary report: Strands 1-3

June 2013

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Strand 1 – Existing Dataset Analysis: Older People, Physical Disabilities, Learning Disabilities

The first strand of this study was only possible because of the participation of the people who facilitated and responded to the original survey and focus groups (Galvani *et al*. 2011). We are very grateful for the interest of, and support from, the research coordinators, senior managers and practice managers within the local authorities involved. We are particularly grateful to the social work and social care practitioners who took time to share their views and experiences.

Strand 2 – Qualifying Social Work Education Survey

We are very grateful to the group of academics from Scotland and Wales who helped us with the piloting of the survey tool and to those academic friends of the PI who gave additional feedback on it. We are extremely grateful to the social work programme leads and colleagues who completed the survey and/or consulted with colleagues in its completion. We would also like to thank Joint Universities Council Social Work Education Committee and the Association of the Professors of Social Work for encouraging colleagues to complete the survey.

Strand 3 – Local Authority Workforce and Learning Development Survey

The following people have assisted us greatly in the development, piloting, analysis and write up of this strand and deserve our thanks: Anne Connor, Sefton Council Workforce Development Manager, for reviewing our final draft report and, in her role as Chair of Learn to Care, for including our survey in the Learn to Care newsletter; Louise Kearney, Sefton Council Learning and Development Officer, for her advice and consultancy in developing the survey tool and in deliberations on its dissemination, and for reviewing our final draft report; Jo Neale, University of Bedfordshire, and James Blewett, Kings College London, Coordinators of Making Research Count, for allowing us to promote and disseminate the survey at a London regional event and for providing advice on the survey tool and report; the Workforce Development professionals who took part in the survey and participated in the knowledge exchange event.

Glossary

AOD	Alcohol and other drugs
AS	Adults' Social Care Services
CS	Children's Social Care Services
CPD	Continuing Professional Development
QSWP	Qualifying Social Work Programme
JTD	Joint Training Department (AS and CS combined)
KE	Knowledge Exchange
LA	Local Authority
LD	Adults with learning disabilities
NTA	National Treatment Agency
OP(MH)	Older people, including older people with mental health problems
PAG	Project Advisory Group
PD	Adults with physical/sensory disabilities up to age 65
PD, OP	Adults with physical/sensory disabilities including older people
PG	Post graduate
PLO	Practice Learning Opportunity (formerly known as Placements)
PSUG	Primary Service User Group
UG	Under graduate
WLD	Workforce Learning and Development

Project Advisory Group

A small project advisory group (PAG) was established at the start of the project to help the research team in their development of the three project strands. The advantages of establishing a PAG include bringing additional relevant expertise to complement the project team, ensuring the research reflects, wherever possible, the views of a range of professional/personal perspectives, and ensuring the research remains grounded in the experience of those being researched. The group also act as critical 'friends' and can advise on dissemination of projects in their various fields of practice. Two physical meetings were held in April 2012 and October 2012 with further contact as required throughout the project. The PAG also read and commented on the findings and draft reports in February and March 2013. The PAG comprised:

- Liz Allison, Social Worker
- Rosie Buckland, Social Worker
- Lucy Jordan, PQ Course Leader and Lecturer, Southampton University
- Wulf Livingston, Senior Lecturer, Glyndwr University
- Ian Paylor, Head of Social Work and Senior Lecturer, Lancaster University
- Marcus Roberts, Director of Policy and Membership, DrugScope

In addition, Louise Kearney from Sefton Borough Council's Workforce Development Team acted as an adviser and consultant for LA survey strand in its development and piloting stage.

Background

In 2010, the research team undertook a national survey of social work and social care practitioners in England. The survey focussed on their experiences of working with people who use, and have problems with, alcohol and other drugs (AOD). The survey was the first of its kind in the UK and explored the practice experiences of respondents as well as their training experiences and current training needs (Galvani *et al*. 2011). The survey data were supplemented by focus groups with a range of adults' and children's social care practitioners.

Two particular findings from the survey underpinned the rationale for this project. First, the survey found that the training and educational experiences of social work and social care professionals were, at best, limited, and at worst, non-existent. Social workers fared slightly better than other social care professionals but nevertheless more than one third (36%) had not received AOD education during their professional training, a further 17% had four hours or less, and a just over a quarter (27%) had between 5-16 hours of AOD education. Further exploration of social workers' training experiences post qualification again showed that almost a quarter (23%) had no in-house training, 8% had four hours or less, while a slightly more optimistic 38% had between 5-16 hours of AOD training.

Second, practitioners in Children's Social Care (CS) fared better on education and training (albeit limited anyway) than most Adults' Social Care (AS) practitioners. CS practitioners were far more likely to encounter, and ask about, AOD use than their AS counterparts. While, for CS practitioners, there were clear links between AOD use and safeguarding issues, the AS practitioners had not yet reached this same conclusion. What the survey suggested was that AOD education had to consider the particular practice context in which the social workers worked and the particular needs of those practitioners and their service user group. However, this needed further exploration.

As a result, the findings raised questions for the research team including how to support AS practitioners better and to do this required further analysis of the survey and focus group responses of practitioners in AS user groups. In addition, it was important to determine whether the picture painted by the practitioners in relation to their AOD education and training was accurate, and whether a more solid evidence base could be gleaned from triangulating the data through additional evidence from qualifying social work educators and those leading local authority workforce development and learning departments. These questions led directly to the aims and objectives of this project.

Overall aims and objectives

The primary aims of this research project were to:

1. establish the particular challenges faced by practitioners working with the following service user groups; older people, people with learning disabilities and physically disabled people,
2. determine the nature and extent of education on alcohol and other drugs on social work qualifying programmes in England,
3. explore the nature and extent of training on alcohol and other drugs provided by employers for those working in children's and adults' services in England.

Following advice from the Project Advisory Group (PAG), two of the aims were modified slightly. Initially we had included 'looked after children' as a group for further analysis. These were dropped as a group from aim no. 1 as the PAG felt that, given the dearth of research in the area of AOD use and adults' service user groups, older people, people with learning disabilities and physically disabled people should be the focus of further research. They pointed out the greater availability of existing research on looked after children and children in need more broadly.

Second, the social work education survey initially included questions about post qualifying (PQ) social work education as well as qualifying programmes. Formal PQ education has traditionally been run by universities to meet requirements set by the governing body of social work (until recently the General Social Care Council). However recent years have seen major changes within PQ frameworks. While some formal PQ courses have been retained, employers and social care practitioners are increasingly accessing a wide range of post graduate training and qualification opportunities including those not specifically targeting social workers. Such courses range from one day conferences to full time degree level courses in a huge range of subjects from management and leadership to substance use. It was not possible to survey all such PQ training and education opportunities available to social workers given the scale of this study and therefore this group was dropped from the research.

These three broad aims formed the three strands of this research project – each strand numbered according to the aims set out above:

- Strand 1 – Existing dataset analysis (PI: Cherilyn Dance)
- Strand 2 – Qualifying social work education survey (PI: Sarah Galvani)
- Strand 3 – Local authority workforce learning and development survey (PI: Aisha Hutchinson)

This report presents the key findings of each strand and includes a discussion of the cross cutting themes together with implications and recommendations.

Full project reports for each strand are available (Allnock and Hutchinson 2013; Dance and Allnock 2013; Galvani and Allnock 2013).

Knowledge Exchange Event

Before completing the project's analysis and report writing the research team committed to holding a Knowledge Exchange (KE) event with a selection of participants from each of the three strands of the project. The purpose of this KE event was to ensure that the outputs of a study reflected the perspectives of all potential beneficiaries of the research. It took place at a point in the research so the responses and participation of the beneficiaries could be reflected in the project outputs, and the event was conducted in the spirit of discussion and debate about the data (and sometimes the methodology!). KE events are not conferences but rather a two way exchange of information. As part of our consultation with the recipients and participants of each strand of this research, a KE event was held on 24th January 2013 in central London (see appendix 1). The event was invitation only to ensure that only those professionals with relevant experience in relation to the three strands of the project were present. Thus, invitations were sent to adults' social care practitioners, particularly those working with older people, learning disabilities and physical disabilities, workforce development officers/managers within local authorities, and social work educators and academics. More than 50 people attended the event (see appendix 2) and took an active part in discussing not only the findings, but also solutions to some of the challenges and barriers the findings raised. It was a very successful event and feedback from attendees showed they valued highly the interactive nature of the day. Summaries of the information collated at the KE event are included within each strand's report.

Strand 1 – Existing Dataset Analysis

Authors: Cherilyn Dance, Debbie Allnock

Key research findings

- On average, across all groups, practitioners reported approximately one in 20 (5%) service users on their caseloads as having AOD problems (this ranged from 3.7% for practitioners in learning disability services to 9.9% for those working with physically disabled clients under the age of 65).
- In all three areas of practice more workers reported frequent encounters with alcohol than was the case for illicit drugs (with 0-30% of practitioners frequently encountering alcohol, and 0-9% frequently coming across illicit drugs). Just over 20% of practitioners in physical disability teams (both groups) also reported frequent encounters with problematic use of prescription drugs.
- Many practitioners report finding it difficult to identify AOD problems. In attempting to do so, practitioners rely most heavily on their own observations of evidence of social harms resulting from AOD use and its impacts on service users lives.
- There is real ambivalence about asking questions about AOD use, which often has to do with service users' rights to make their own life-style choices – where they have the capacity to do so.
- Issues around mental capacity were identified as a complex challenge in relation to work with the client and with other professionals. In all groups the difficulty of balancing human rights and freedom of choice with a duty of care was mentioned.
- Practitioners emphasise the importance a trusting relationship with service users in order to explore sensitive issues such as AOD use, but changes in service delivery mean less opportunity to develop rapport. Knowledge of skills and techniques to engage service users, even when encounters are brief, is essential.
- Challenges related to working directly with service users included concerns about threats to care packages when behaviour is unacceptable to paid carers, the reluctance of many service users to seek help change their usage patterns and the complexities of managing 'risk' in the context of maintaining the service users AOD use.
- With reference to working with specialist AOD use services, practitioners across all groups identified a lack of services appropriate to the needs of their client group. In particular there was an expressed need for services to be able to engage with service users to help them reach a decision to change their behaviour.
- Some practitioners expressed the view that they felt 'isolated' where service users had AOD problems and that social care was frequently left without adequate support from other services. This responsibility weighed heavily upon them.
- Training in AOD was identified as being 'very' important for the majority of practitioners. They were particularly interested to know about types of intervention and treatment, assessing risk, working with specialist AOD use workers and how to talk about AOD issues with service users.
- Analysis of practice with each group of service users revealed particular issues:
  - There was concern about the potential increased vulnerability of people with learning disabilities in relation to risks of developing dependence and exploitation by others if

using AOD problematically. Their ability to understand the advice about safe use and the implications of use.

- Practitioners working with physically disabled clients or those with sensory impairments identified many issues around access to, and appropriateness of, treatment services; concerns about the safe use of mobility and other aids while intoxicated; problematic information sharing – especially with regard to discovering that a disability is alcohol related and a lack of support around reduction, rather than cessation, of AOD use.
- Older people were reported to deny they have a problem and are not able to cope. There were difficulties reported in distinguishing dementia and alcohol-related dementia and problems with dementia compounding problems, e.g. the impact of dementia on appropriate use of prescription medications. Mobility problems among older people combined with drinking and the increased risk of falls was a major concern and again there were worries about the safe use of mobility devices etc. Practitioners identified a lack of support groups for older people and the view was expressed that older people are being steered away from specialist AOD use services and put in residential homes instead. There were particular concerns about the impact on carers and indeed carers' own misuse of AODs.

- Practitioners in all groups identified barriers to accessing specialist AOD services and a lack of specialist services able to offer an appropriate service to their client group.
- There were also concerns expressed about those with lower levels of need where thresholds for entitlement to a service might not be reached.
- The Knowledge Exchange event confirmed our interpretation of the issues for these groups of practitioners and discussed how practice around AOD issues was influenced by fear and taboo.
- Possible ways forward were identified by practitioners in terms of greater use of multi-disciplinary working, link workers across services, and outreach. The knowledge exchange discussions suggested greater use of mentoring and imaginative approaches to training and self-directed learning.
- The analyses presented suggest that the contexts practitioners work in and the challenges they face differ according to client group. Training needs to reflect this and be relevant to practitioners' work context.

Strand 2 – Qualifying Social Work Education Survey

Authors: Sarah Galvani, Debbie Allnock

Key findings

- 40% of qualifying social work programmes in England (n=63/157) responded to the survey.
- Of these, 94% of respondents (n=59/63) reported some teaching on alcohol and other drugs (AODs) on their social work qualifying programmes.
- AOD education remains an inconsistent and variable element of qualifying social work education.
- The priority given to AOD teaching was considered to be too low by almost three quarters of the respondents. No respondents thought it was too high.
- Among the QSWPs that include AOD education in their curricula, there are a number of approaches to delivering it.
- Integrating AOD teaching into other modules is by far the most common approach adopted. However it is important to state that there is a considerable lack of clarity about what is being taught and in what depth raising questions about the reliability of the data.
- There were few specialist AOD modules (n=13) but a higher number of specialist sessions (n=53). However, all but two programmes with specialist modules or specialist sessions also integrated AOD into other modules and teaching suggesting a greater degree of programme commitment to the topic
- On average students taking specialist AOD 'modules' received 20 hours of AOD education; for those taking specialist AOD 'sessions' the average was four hours only.
- The AOD-related topics most commonly included in teaching were the impact of AODs on physical/mental health, attitudes and values and risk assessment.
- Gender and ethnic differences in AOD use, prescribed drug use and identifying problematic drug use were the AOD-related topics least covered.
- As with Harrison's (1992) research, there was a concerning degree of mismatch between the reported topic coverage and the hours in which it was taught. In a significant minority of specialist AOD modules and in half of all AOD specialist sessions far too many topics were reported as being covered in the time available. This suggests minimal coverage or inaccurate reporting.
- Few respondents formally assessed student learning on AOD-related issues.
- Programme leads were often not aware of whether or not colleagues included AOD content in their teaching.
- It was not possible to establish the quality of AOD education being delivered and this needs further research. More AOD education does not necessarily equate to better quality teaching.
- Current social work education reforms offer opportunities for greater inclusion of AOD education on qualifying social work programmes.

Strand 3: Local Authority Workforce Learning and Development Survey

Authors: Debbie Allnock, Aisha Hutchinson

Key findings

The following points have been selected as key findings from the report. Ninety-four workforce/learning development (WLD) departments responded to the survey, representing a 46% response rate from a sampling frame of 203 departments

The extent of AOD training

- In the past year (2011-2012), alcohol and other drugs (AOD) training was provided by 77 WLD departments (83%); on average, 4.56 courses per WLD department were delivered in 2011-2012.
- However, almost one fifth (n=16, 18%) of WLD departments had not delivered any AOD training in the past year.
- Seventy-five per cent (n=58) of those who reported that they provided training on AODs additionally facilitated access to other AOD training or opportunities.
- Of the 16 departments who had not delivered training, 11 (73%) facilitated access to other training.
- AOD training was mandatory in less than one-quarter (n=15, 23%) of WLD departments.

The development of AOD training

- Just over one quarter of WLD departments (n=22, 28%) said there was a dedicated training strategy or a series of programmes on working with AOD use for social care/ work and social care practitioners; slightly more reported awareness of policies and practice guidelines for working with AOD concerns (n=30, 40%).
- Almost 60% (n=44) of WLD departments said they provided tools or resources for assessing and identifying AOD use to support social care professionals in their work.
- Representatives from Drug and Alcohol Action Teams (DAATs) and Local Safeguarding Children Boards (LSCBs) alongside social care practitioners were identified as being most commonly involved in the development of AOD training , with only a few reporting the involvement of service users or a strategic lead in AOD use.

Characteristics of AOD training

- More training was aimed at social care professionals in Children's Services (CS) than in Adults' Services (AS).
- Social workers were the target of more training than other social care practitioners.
- Most AOD courses were considered basic (n=83, 50%) or intermediate (n=68, 41%); the average course lasted just over 6 hours; and over half of courses (58%) were offered at least once a year.
- Over three-quarters (75%) of AOD training courses were externally commissioned (n=64, 39%) or provided jointly with others (n=59, 36%), with the remainder provided via in-house social care trainers (n=36, 22%) or some other way (n=5, 3%).

- Half (n=82, 50%) of all AOD training courses delivered training on all substances, including prescription medications and poly-substance use; a small number of courses focussed solely on alcohol alone, or on drugs alone.
- Most common topics covered in training were alcohol and its effects, illegal drugs and their effects, identifying problematic alcohol use, treatments and interventions available and impact on physical and mental health.
- Least common topics covered in training were related to gender, ethnicity and culture, and AOD use theory.

Changes, impacts and challenges to AOD training

- Most WLD departments report that AOD training levels remained stable from the previous year and anticipated no changes in the following year, although a small number of departments had experienced consistent decreases in training and a small number had seen consistent increases in training.
- A common barrier to provision was lack of resources; both financial and non-monetary such as the availability of experienced and knowledgeable trainers
- Respondents reported that high workloads and limited 'release time' to attend training were also common barriers.
- A small number of respondents said that competing priorities for training, a lack of strategic direction and on-going restructuring processes all constituted barriers to AOD provision.
- Resources, both financial and non-monetary, were identified as key support required to provide more AOD training.

Discussion: Building Capacity and Bridging Gaps

This research project began with three broad aims:

1. establish the particular challenges faced by practitioners working with the following service user groups; older people, people with learning disabilities and physically disabled people,
2. determine the nature and extent of education on alcohol and other drugs on social work qualifying programmes in England,
3. explore the nature and extent of training on alcohol and other drugs provided by employers for those working in children's and adults' services in England.

While each strand of the project stands alone in terms of its findings, implications and recommendations, a number of clear synergies emerge from across the three strands. These are worth highlighting and considering in terms of their implications for education, training, practice and research.

Structural/systemic issues

There appears to be a lack of joined up or partnership working between Local Authority WLDs and qualifying social work programmes in relation to education and training on AODs. While this was not a direct question in the QSWP or LA WLD survey strands, the social workers in Strand 1's focus groups commented on their lack of AOD education during qualifying education (although our original survey (Galvani *et al*. 2011) found wider variation in people's AOD education experiences). Strand 2 of the project also identified limited AOD education during qualifying education with the implication that this would need to be picked up post qualifying, through employer-led training. Strand 3, while demonstrating that some LAs were running some AOD training, found that it was predominantly basic or intermediate, more likely to be targeted at children's social care professionals, and run once a year on average. Given these findings, it appears certain that some social workers will fall through the gaps in the little education and training provision that exists. Comments from attendees at the Knowledge Exchange event suggested that there is duplication of basic training provided by QSWPs and WLDs; this was supported to a degree by the findings on the AOD-related topics most covered by QSWPs and WLDs, e.g. attitudes and values, reasons people use. Greater partnership between WLDs and QSWPs would be advantageous to all concerned. It appears, therefore, that it would be mutually beneficial for QSWPs and Local Authority WLDs to work in partnership to develop an AOD training strategy for social workers; it is likely that the benefits of such partnership would extend beyond AOD issues to other areas of knowledge and practice. Given the limited resources which both QSWPs and WLDs cite as barriers to inclusion of AOD education and training, a joint AOD training strategy could spread such limited resources more widely. However, basic training for social care professionals outside social work would need to be continued.

There were very clear messages from respondents in all strands about the organisational constraints to better engagement with AOD education and training, for example, lack of prioritising of AOD issues. For social work such constraints have long been documented as a barrier to effective practice with AOD issues. Lightfoot and Orford (1986: 754) found that social workers, significantly more than nurses, identified 'situational constraints' that

prevented them from working with "alcohol-related problems". These constraints included needing to adhere to policy frameworks that determined their work priorities, a lack of encouragement from senior staff, a belief that they should not "interfere" in people's choice to drink, lack of time to discuss alcohol problems, involvement could be justified only if others are affected, and a lack of collegial success in working with people with alcohol problems. It is somewhat depressing that these are among the reasons identified by both social care practitioners and WLDs almost thirty years on.

It was not an aim of this research to establish if such barriers were real or perceived, but what this research shows is that some WLDs and QSWPs are providing AOD education and training within similar, if not the same, constraints. This suggests there are other issues in play related, perhaps, to practitioners questioning whether AOD issues are a legitimate aspect of their work. This uncertainty, in turn, affects people's willingness to engage with it. Strand 1, along with the original research, found ambivalence among social workers and social care professionals in terms of asking about AOD use (Hutchinson *et al* 2013). This was particularly pronounced among adults' social care practitioners, many of whom felt it was not their role unless it was a crisis. Engaged leadership and management will be required to change this attitude; again something that was found lacking in Lightfoot and Orford's research. Strand 2 identified barriers of space and time as the key reason people gave for not including AOD education in the curriculum, however clearly some QSWPs are managing to achieve a balance. Strand 3 also identified a lack of resources, including financial restraints, lack of trainers, limited release time for the shrinking workforce and competing priorities as constraining too. Again some LAs were clearly doing better than others. The challenge is to support WLDs and QSWPs to see responding to AOD use as a priority for education and training, to determine if there are key policy drivers that can influence their training priorities, and to signpost them to resources that will enable easier facilitation of AOD education and training. If the organisational message is that we don't prioritise AOD issues, it is not surprising that social work practitioners are, at best, unclear about whether or not it is their job to respond.

Focus of AOD education and training

The lack of education and training targeting AS practitioners was also apparent across the three strands of the project. While AOD use among adult service user groups appears to be less than that of children's service user groups, our original survey found that on average adults' practitioners have three people on their caseloads at any one time who use, or are affected by, someone else's AOD use (Galvani *et al*. 2011). Supporting these people adequately requires a training response. In spite of the lower levels of AOD use on their caseloads, practitioners in Strand 1 stated that training on this topic was either 'important' or 'extremely important' to their jobs (with the exception of learning disabilities practitioners). Further, higher levels of use among people with physical disabilities (aged under 65 years) were also found; the association of physical disabilities and AOD use is also supported by national data (Hoare and Moon 2010). Other research has revealed strong evidence of increasing numbers of older people drinking at risky levels due to our aging population and has predicted that this may well increase if baby boomers take their current alcohol consumption into older age (Wadd, *forthcoming*).

There is certainly evidence for increased education and training tailored to those working with adults' service user groups. Strand 2 showed seven QSWPs reported AOD input

integrated into 'working with adults' modules; these are small numbers and given this was integrated teaching it is unlikely to go into any great depth. Strand 3 also shows far fewer training courses focussing on adults' service user groups than children or young people. The result is a major gap in adults' practitioners' knowledge base about working with service users with AOD problems. Strand 1 found that practitioners wanted training that was relevant to their role and practice context; for example, AOD training for CS practitioners in the context of safeguarding children is not appropriate for the AS practitioner exploring the aids and adaptation needs of an older person impacted by AODs . More tailored training is needed to ensure practitioners can relate their learning to their own working environment. As one senior LA key informant in the original survey pointed out:

> ...drug and alcohol basic awareness training is not tailor made enough to really be of any true relevance necessarily to social workers…It needs to be delivered by people who have some understanding of what the workforce needs to know, what they come across on a day to day basis.
>
> (Galvani *et al*. 2011: 124).

The data from Strand 1, and the larger sample in the original survey, found that the topics on which practitioners sought additional training included 'types of treatment available', 'how to assess risk' and 'how to talk about drug and alcohol use'. Findings from the QSWP survey in Strand 2 suggest that these topic areas are covered by specialist AOD modules and sessions and much less so by integrated teaching approaches. Given integrated teaching forms the most common delivery route for AOD education this may explain the contradiction or it may simply be that QSWPs are more recently responding to practitioner needs and therefore not reaching existing social workers. This raises the importance of WLDs picking up on the gaps in social workers' AOD education at qualifying level. However, Strand 3 shows that WLDs are not widely covering these topics either. Based on this evidence there seems to be a disconnect between practitioners' training needs and what is being taught even though there systems in place in many LAs to identify training needs. While prescription of content of social work education and training has never been welcomed by the social work academy, a degree of consistency in topic coverage would avoid such basic topics as 'how to talk about alcohol and drug use' falling through the net.

What such education and training will also support is practitioners being able to ask the right questions about AOD use in the right way. Not only would this help to identify people whose AOD use is problematic but it would also help to establish accurate levels of AOD use on adults' practitioners' caseloads. Strand 1 found a lack of confidence in asking about AOD use and concerns about doing so. As with the larger sample in the original survey, practitioners often felt they wanted to establish therapeutic relationships first and then they 'might' broach the subject of AOD use. Practitioners working with physically disabled service users were most likely to ask about AOD use and in general those with higher numbers of people using AODs on their caseloads asked about it more often[1]. It is something of an anomaly that social workers for whom assessment is a major part of their roles and responsibilities (HCPC 2012), and who ask about all sorts of personal issues when appropriate, are floundering when it comes to asking about AOD use. This appears to speak

[1] Whether these practitioners have higher numbers because they ask about it or whether they ask about it because they have higher numbers of people with AOD problems on their caseloads cannot be determined.

to role legitimacy and role adequacy concerns; that is, feeling it is a legitimate thing for them to do and feeling knowledgeable enough to do it (Hutchinson *et al*. *forthcoming)*. It is social work education and training, and subsequently practice managers, who should be supporting them to do it.

In relation to topics covered in AOD education and training, it is notable that ethnicity in relation to AOD use and gender differences are two areas minimally covered by both WLD training and QSWP education. The original survey, exploring social care practitioners' perspectives, found that these areas were among those ranked highly on current training needs. Clearly there is a connection between the two. Interestingly they were lower down the rankings for the smaller sample of AS practitioners in Strand 1 whose focus was on topics identified above. Given that the vast majority of social workers work daily with diverse groups of people, such knowledge is key to effective assessment and responses. Ethnicity, culture and religious beliefs should influence assessment decisions, for example, how and whether it is safe or appropriate to ask people about their AOD use, and what context or environments might be shameful and demeaning. There is already much criticism of the 'whiteness' of existing specialist AOD services and the need for culturally appropriate AOD service provision (Rassool 2006). Similarly understanding the differences between men's and women's AOD use and the impact on their own, and other people's, safety and well-being, should be part of holistic assessment of need and risk. It is a sad reflection on training providers that such issues are so low down the list of topics to consider in relation to AOD education and training given the importance of such personal factors to engaging and building relationships with individuals and communities. Prescribed drug use is another area that is low down on the list of topics addressed by QSWPs and WLDs yet is of particular importance to practitioners working with adult service users.

Finally the ability to work effectively with specialist services was a further cross-strand theme. The qualitative data in Strand 1 found that practitioners were often frustrated by their attempts to work in partnership with specialist services and found access to, and appropriateness of, these services particularly challenging at times. They felt there was a lack of services, particularly for those with disabilities of some kind, and that the thresholds they set for supporting people were overly high. Strand 2 found that AOD education on the topic of 'working with specialist agencies' was lower down on the list of topics covered by AOD education suggesting a lack of mutual understanding about service provision/priorities. Strand 3 however reported better coverage of the topic (64%) by Local Authority WLDs, although a third were not delivering any training on working with specialists. As with the topics identified above, the picture is one of limited and piecemeal coverage at both WLD department and QSWP levels in spite of the identified needs of practitioners.

Implications and Recommendations: Building Capacity and Bridging Gaps

There are clearly a number of qualifying social work programmes and Local Authority WLDs that have engaged with alcohol and other drug use as an important issue for their social work and social care professionals. Their models of AOD education and employer-led training could be disseminated more widely to support those who are finding it a challenge. This wider dissemination will begin with further outputs from this study including *Briefings* for social work educators and LA WLD department staff. However as the perspectives of the adults' social care practitioners in Strand 1 showed, there are clear gaps in their knowledge base that are not being filled by either learning opportunity. Both this study and the original survey have identified a list of AOD related topics that social workers have identified as their learning needs. It has also begun to outline what current education and training is being offered at during qualifying training and in Local Authority employment. What it has not shown is the quality and depth of that education and training, and the high number of topics covered in short time periods does raise concerns about quality and depth. This is clearly an area for further research.

What may help this process is for the social work profession to develop a clear position on social workers' roles, functions and responsibilities (and related competencies) for working with alcohol and other drug use. Currently there appears to be confusion and ambivalence among practitioners about whether, and how, to intervene when they encounter AOD use, and among QSWPs and WLDs about the priority they should give it. There needs to be greater clarity within the profession and it needs to be framed within national policy drivers that straddle health and social care. Similar documents have recently been developed by health colleagues targeting commissioners, providers and clinicians (Royal College of Psychiatrists and Royal College of General Practitioners 2012).

In the interim, local training agreements between LA WLDs and QSWPs would reap rewards both in terms of potential cost efficiencies and the development of a more informed social work workforce. The drivers for AOD use treatment from central Government are disappearing within the new localism agenda. Far greater responsibility for specialist service provision will be determined locally. This major shift in national policy sits alongside a new emphasis in Government drugs strategy to promote family and community involvement in supporting people with AOD problems as well as initiatives that may place more pressure on families and communities, for example, sanctions on entitlement to benefits leading to greater levels of individual and family poverty, homelessness, and increased vulnerability (H.M. Government 2010). Combined, these initiatives suggest that the future is likely to see social workers working with more people with AOD problems and with families negatively affected by them. On a more positive note, the move to greater localism within the public sector, the setting up of local health and wellbeing boards under the Localism Act 2011, and the current reforms in social work education (TCSW 2012) may provide a helpful context in which QSWPs and Local Authority WLDs can revisit current collaborative working arrangements. Of particular concern will be to ensure such arrangements do not uncritically adopt medical model approaches to working with AOD use – a challenge in what is currently a health led specialist area of practice. AOD use and its relationship to social problems need to remain just as much at the core of social care models as its impact on health and associated 'treatment' responses.

Conclusion: Building Capacity and Bridging Gaps

At the time of writing reforms to social work education and practice are underway following a number of high profile tragedies involving children (primarily) known to social services (Laming 2009). These reforms involve the revalidation of social work qualifying programmes under a new governing body, the Health and Care Professions Council (HCPC), as well as reviews of practice and recommendations around management and organisational change within social care (Munro 2011). Such reforms offer a timely opportunity for research of this kind to influence the emerging new education and training curricula as well as highlight the continuing professional development needs of a group of practitioners who have been largely overlooked in relation to education and support for working with AOD use.

This research project was both ambitious and innovative. Its ambition was to provide a strong evidence base about the nature and extent of AOD use education and training for social work professionals. Combined with the authors' previous research, which identified the AOD education and training experiences of social work and social care professionals (Galvani, Dance and Hutchinson 2011), this study sought to triangulate this evidence with the perspectives of the two key organisations involved in providing those learning opportunities: Qualifying Social Work Programmes (QSWPs) and Local Authority Workforce and Learning Development departments (WLDs). Its innovation was in its attempts to do so on a national scale and to include both adults' and children's social care directorates in its survey of Local Authorities WLDs; this has not been done before. It was also ambitious in its attempt to replicate the only previous survey of AOD education in social work qualifying programmes conducted in the UK (Harrison 1992). For both surveys the challenge was to engage respondents at a time of considerable organisational change and individual pressure. Public sector organisations are undergoing major budget cuts and reorganisation and the social work academy is, once again, in the middle of considerable educational reform.

Further, the project's focus on the perspectives of social work and care practitioners working with adult client groups was also somewhat innovative. Far greater attention is given to AOD use within children and families social care practice with adults' social care remaining a poor relation. Yet increasingly social workers report working with adult service users who have alcohol or other drug problems and feel at a loss to know how, and whether, to respond.

Strand 1 of this three strand project sought to delve further into our existing data on adults' practitioners' experiences working with the AOD use. It focussed specifically on three adult service user groups who are largely overlooked in research on this topic: older people, people with learning disabilities and physically disabled people.

The methodological challenges and limitations of this study have been outlined within each report but together they serve to highlight one of the key findings of this three strand project; the importance of organisational engagement with the topic of AOD use in effecting change and the power of organisational constraints (real and perceived) to negate or limit attempts at AOD education. Accessing the right people, in the right positions, and with the

right knowledge, for the purposes of survey completion, highlighted the complexity of organisational structures. This complexity reverberates throughout the project's findings.

The overwhelming message from these projects is that the level of AOD education and training social workers receive is primarily a game of chance. There is huge variation between qualifying social work programmes around England from no education at all to comprehensive education embedded throughout the qualifying programme (albeit few in number). There is huge variation between the amount of training provided by local authority employers in terms of both quantity and focus. And there is wide variation in the experiences and confidence levels of adults' social workers for working with AOD use depending on their service user group. If these variations were a response to locally determined need it could offer some explanation, but this is not the case. It is beyond doubt that social workers in all areas of social work practice face regular, if not daily, encounters with people using AODs. It is also beyond doubt that the vast majority are inadequately prepared for engaging and supporting those people. The challenge is finding a solution that is acceptable to all within the organisational and environmental contexts in which they work. Until that happens many services users with problematic AOD use will continue to receive a limited social care service at best, and, at worst, one that continues to fail service users, and their families, living with alcohol and other drug problems. The good news is that there are clearly attempts within practice, education and training arenas to engage with and address AOD use among social care service users. There is certainly a call from the front line to prepare them to do so. The answer may be in evaluating, developing and promoting existing models to those who are still struggling to respond.

References

Allnock, D. and Hutchinson, A. (2013) 'Building capacity and bridging the gaps: Strand 3: Alcohol and other drugs in social care employment-based learning and development.' Final Report. Luton: University of Bedfordshire

Dance, C. and Allnock, D. (2013) 'Building capacity and bridging the gaps: Strand 1: Social care practice with older people, people with learning disabilities and physically disabled people who use alcohol and other drugs.' Final Report. Luton: University of Bedfordshire

Galvani, S. and Allnock, D. (2013) 'Building capacity and bridging the gaps: Strand 2: Alcohol and other drugs in qualifying social work education.' Final Report. Luton: University of Bedfordshire

Galvani, S., Dance, C. and Hutchinson, A. (2011) *From the front line: alcohol, drugs and social care practice. A national study*. Luton: University of Bedfordshire.

H.C.P.C. (Health and Care Professions Council) (2012) *Social Workers in England: Standards of Proficiency*. Available at: http://www.hpc-uk.org/assets/documents/10003B08Standardsofproficiency-SocialworkersinEngland.pdf [accessed 22 March 2013]

H.M. Government (2010) *Drugs Strategy 2010. Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life*. London: Home Office

Harrison, L. (1992) 'Substance misuse and social work qualifying in the British Isles: A survey of CQSW courses', *British Journal of Addiction*, 87, pp. 635–42.

Hoare, J. and Moon, D. (eds.) (2010) *Drug Misuse Declared: Findings from the 2009/10 British Crime Survey England and Wales*. London: Home Office

Hutchinson, A., Galvani, S. & Dance, C. (2013) 'Working with substance use: Levels and predictors of positive therapeutic attitudes across social care practitioners in England.' *Drugs:Education, Prevention and Policy*, *forthcoming*.

Laming, Lord (2009) *The Protection of children in England: a progress report.* London: The Stationery Office.

Lightfoot, P.J.C. and Orford J. (1986) 'Helping Agents' Attitudes Towards Alcohol-related Problems: situations vacant? A test and elaboration of a model.' *British Journal of Addiction,* 81(6), 749-756

Munro, E. (2011) *The Munro Review of Child Protection: Final Report A child-centred system.* London: DfE

Royal College of Psychiatrists and Royal College of General Practitioners (2012) *Delivering quality care for drug and alcohol users: the roles and competencies of doctors. A guide for commissioners, providers and clinicians*. College Report CR 173. London: Royal College of Psychiatrists and Royal College of General Practitioners

The College of Social Work (2012) *Reforming social work qualifying education. The social work degree.* Available online at: http://www.collegeofsocialwork.org/uploadedFiles/TheCollege/_CollegeLibrary/Reform_resources/Refo rmingSWQualifyingEducation%28edref1%29%281%29.pdf [accessed 26 February 2013]

Wadd, S. (*forthcoming*) 'Alcohol Use and Related Harm amongst Older Adults: A Synthesis of UK Data.' (personal communication, March 2013)

Appendix 1 – Knowledge Exchange Event Programmme

AN INTERACTIVE KNOWLEDGE EXCHANGE EVENT

DEVELOPING BEST PRACTICE WITH SUBSTANCE USE: SKILLING THE SOCIAL CARE WORKFORCE

THURSDAY 24 JANUARY 2013, 9.30AM – 4PM

Friends House, Euston Road, London NW1 2BJ

0930	Arrival and registration
1000	**Chairs Introduction** Lucy Butler, Deputy Director, Adults' Social Care, Oxfordshire; ADASS National Lead on Alcohol & Drugs
1015	**Substance use in social work education, training and practice: a taster** Strand 1 – Adult social care practice: Cherilyn Dance Strand 2 – Social work education: Sarah Galvani Strand 3 – Local authority training: Debbie Allnock
1045	**Knowledge exchange task 1: "What findings/issues?"** In your first group, discuss what you might expect to be five key findings from your allocated strand based on your experience and knowledge.
1115	*Break (with refreshments)*
1135	**Feedback from two groups followed by Findings presentation** **i) Adult social care practice** **ii) Social work education**
1255	*Lunch*
1345	**iii) Local authority training**
1425	**Knowledge exchange task 2: "Solutions and good practice"** In your second group, with reference to the issues identified in the morning, discuss the specific guidance you want and/or the resources needed to help develop better education, training and practice. (*There will be a chance to get a coffee to take to your group during this session.)*
1515	**Plenary discussion and debate** Feedback from each group of educators, training professionals and practitioners.
1545	**Chair's summary**
1600	**Event ends**

Appendix 2 – Knowledge Exchange Event – Delegate List (with permission)

Adult social care practitioners		
Emmanuel Addo	Tower Hamlets	Senior Practitioner, Adults Health & Wellbeing Directorate
Michael Arch	Camden	Senior Practitioner
Melissa McAuliffe	East London	Asberger's Specialist Social Worker
Liam Benson	Havering	Social Worker
Dowrin Bernard	Hounslow	Social Worker Children & Adults Services/ Learning Disability Team
Amy Christie	Sutton	Social Worker Community Social Work Team Adults Generic Team
Maria Foldvari	Sutton	Senior Residential Practitioner
Caroline Groves	Lewisham	Social Worker, Adults with PD and Older People
Sacha Ikeme	Independent	Independent senior social worker/ adults and older people
Lucky Mashinge	Southwark	Senior Manager
Paul Meadows	Thurrock	Consultant Practitioner, Substance Misuse
Patricia Mukherjee	Brent	Substance Use Care Manager
Denise Mustafa	Hounslow	Social Worker Children & Adults Services/ Learning Disability Team
Antony Rejo	Birmingham	Social Worker in the Adult and Communities Directorate
Melissa Russell	Brent	Social Worker
Sally Savers	Havering	Social Worker
Julie Stace	Bromley	Senior Care Manager, Substance Misuse
Laura Starkey	Hull	Service Manager
Susan Wainaina	Brent	Social Worker
Heather Wallace	Independent	Social Worker
Social Work Educators		
Fern Basnett	University of Staffordshire	Senior Lecturer
Stefan Brown	Royal Holloway University	Teaching Fellow in Social Work
Zuzia Goddard	University of Derby	Lecturer
Anne Keeler	University of Chester	BA Programme Leader
Mick McCormick	The Open University	Head of Department, Social Work
Karen Mills	University of Hertfordshire	BSc and MSc Lecturer
Chris Penney	University of Portsmouth	Senior Lecturer in Social Work
Jane Reeves	University of Kent	Director of MA Studies
Penelope Welbourne	University of Plymouth	MA Programme Leader
Learning and Development/ Local Authority Group		
Julia Bradley	Hertfordshire	Learning and Development Officer
Paul Cefaz	Redbridge	Provision and Change Management
Louise Kearney	Sefton	Learning and Development Officer
Douglas Maitlin-Jones	Enfield	Learning and Development Manager
James Meehan	Sutton	Parental Substance Misuse Development Manager
Claire Sowerby	Leicestershire	Senior Learning & Development Manager, CYPS
Robert Spencer	Poole	Workforce Lead with Poole DAAT