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The extent and nature of practitioners, encounters with alcohol and other drug use in social work and social care practice.

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Abstract

This article considers the extent and nature of social work and social care practitioners' experience of working with service users whose lives are affected by the problematic use of alcohol or other drugs (AOD). It draws on the findings of a national study of 'working with alcohol and drug use' which was conducted in England in 2010-2011.

The study reported here comprised an online survey of front-line practitioners (n=597), complemented by 12 practitioner focus groups and interviews with 21 key informants from participating local authorities and substance use treatment services. This paper focuses primarily on data from one element of the survey. Findings indicate that the great majority of staff encountered service users who are affected by AOD problems at some level, although there were differences between groups of practitioners in the extent and nature of AOD problems for different groups of service users. The differential experiences of staff according to their client groups underlines the need for education and professional development not only to provide training on working with AOD but to ensure that training is contextualised and relevant to practitioners across the range of social work and social care services.

Keywords

Substance use, alcohol, drugs, social work, social care.

Introduction

The problematic use of alcohol, illicit drugs and sometimes prescription medications (AOD), is a problem that has a long history: consumption of wine and other potentially addictive substances has occurred throughout human history and White (1998) traces treatment approaches as far back as the 1750s. The nature of society's concerns about problematic AOD use has changed over time, as different patterns of use of various substances, by different groups in society, have come and gone over the years, each raising different social concerns.. That society is concerned about these problems relates to the human and financial costs associated with them. Traditionally, these have been particularly recognised at a societal level in relation to crime and health expenditure. At an individual level the dangers or harms associated with misuse vary according to the substances used, the way in which they are used and how frequently they are used, but misuse, particularly over a period of time is likely to lead to negative consequences for an individual in terms of both health and social well being.

Problems with AOD use alone are unlikely to be the primary reason for people having contact with social work or social care services but where AOD use is impacting on a person's functioning, particularly the capacity to care for dependants, other social difficulties are likely to arise which may indeed lead to contact with services. At the same time the sorts of problems that bring people into contact with social work may well lay the conditions that can lead to use of substances to in an attempt to escape, manage or cope with those problems. This is not restricted to problems with drug or alcohol use impacting on parenting capacity, which is one area that has received a good deal of research and policy attention (Advisory Council on the Misuse of Drugs [ACMD], 2007; Cleaver et al., 2011) but can play out in a variety of scenarios. Indeed, Paylor and colleagues put it this way:

> *'Whatever the form or type of social work intervention, ever since early days of the profession, social workers have been confronted with personal and social problems caused by service users' use of drugs and alcohol.'* (Paylor, Measham & Asher, 2012, p.1)

Knowledge of the nature and type of difficulties faced by users of social work and social care services using AODs is essential in order to ensure that practice and services are able

to respond appropriately. Quite a lot is known about the prevalence of AOD problems in the context of child protection work. In England this issue has been highlighted in the findings of serious case reviews, and the Munro Review (Brandon et al., 2013; Munro, 2011), but it is far from being just an English problem. Although there are many important differences between countries in population profiles, patterns of AOD use and arrangements for service delivery (Forrester & Harwin, 2006) concern about this issue is evident worldwide (eg Traube, 2012; Dawe, Harnett & Frye, 2008). However, knowledge about the extent to which practitioners in other areas of practice encounter similar problems is rather patchy. Research has addressed the overlap between AOD use and mental health problems but a review published in 2009 indicates that much of this has been undertaken from a medical, rather than a social or social work perspective. Furthermore, the same authors note that the majority of the research emanates from North America and does not necessarily translate to a UK context (Crome & Chambers et al., 2009).

In similar vein, whilst there is a lot of research, and indeed policy attention, focused on young people's use of AOD, very little of this explores from a social work perspective – even though it is recognised that young people leaving care – as a group - are at higher risk of developing AOD problems than their counterparts in the general population (Dixon et al., 2006; Ward, Henderson and Pearson 2003).

With regard to AOD problems among users of Adults' Social Services one or two UK studies have explored prevalence and the social work perspective on working with these issues as they affect people with learning disabilities (e.g. Taggart et al., 2004) and the needs, in relation to alcohol use in particular, of older people using services has recently begun to be recognised (Royal College of Psychiatrists, 2011).

In general, the studies identified above have focused on relatively small or purposive samples and have usually been concerned with 'the problem' or the service user, rather than the practitioners' experience. To our knowledge, no previous study has sought to establish the extent to which AOD problems are to be found on practitioners' caseloads across the range of social work and social care services in England. This paper attempts to fill this gap in order to inform the evidence base with regard to the significance of AOD problems in social work and social care and to highlight the implications in relation to professional training opportunities.

Research Design

This mixed methods study utilised an on-line survey to engage a range of social work and social care practitioners working in the 'front-line' of service delivery in adults' and children's local authority social services to establish their experience in working with AOD problems. In-depth exploration of the research questions was achieved through a series of 12 focus groups with participants representing a variety of roles in either children's or adults' social services. These front-line experiences were complemented by semi-structured interviews with key informants. We draw to a limited extent on some of the qualitative data to provide context and examples for some of the findings discussed but it is the survey data that are the main focus of this paper, specifically data which considers the frequency with which practitioners encountered AOD problems and the type of problematic use they encountered.

The Sample and Methods

The sampling strategy aimed to ensure representation of the variety of local authorities in terms of their administrative arrangements (county councils, boroughs and unitary councils), their geographic location within England and levels of affluence/deprivation. Children's and Adults' Services directorates were approached separately[1]. Where a directorate was not in a position to participate a second, with similar characteristics was approached.

The final sample for the study was drawn from 17 social care directorates (10 children's and 7 adults') from 11 local authorities in England. Lead contacts within each participating directorate agreed to distribute invitations to all social work and social care practitioners with case work responsibility to complete the survey. It should be noted that differing systems of communication networks within agencies inevitably meant that there were variations between authorities in terms of which groups of workers received the invitation.

Response rates to the survey varied across directorates with as few as 12% of potential participants responding in one and as many as 56% in another. A total of 646 practitioners responded from a range of adults' and children's social care roles (21% of all those

[1] In England although both Children's and Adults' Services are ultimately administered and delivered through individual local authorities, within each authority they are operated and managed separately. Each arm of service is also subject to its own governance and legislative framework managed by different government departments: Adults' Services being within the auspices of the Department of Health whilst Children's Services are the remit of the Department for Education.

approached) across all directorates surveyed, however, 49 of these were working in specialist alcohol or drug roles at the time of completing the survey. For the purposes of this paper data for these individuals are excluded since the interest here is specifically in the experiences of practitioners in other specialist social work and social care roles. The effective sample size for the survey is therefore 597.

The bulk of the items in the survey questionnaire was study specific. Embedded within the questionnaire was an adapted version of the Alcohol and Alcohol Problems Perceptions Questionnaire (Galvani and Hughes, 2010). The version used here aimed to capture practitioners' levels of knowledge about, and attitudes towards, working with issues associated with both alcohol and other drug (AOD) use (Galvani, Dance & Hutchinson, 2011). [See also Hutchinson, Galvani & Dance (2013) for further discussion of these findings]. The survey questionnaire included both open and closed questions.

The 12 focus groups were drawn from participating agencies and were organised around primary service user groups – for example practitioners working with older people, people with physical disability, young people, or children and families.

Key informants were individuals in senior positions within directorates who had a role in strategic planning and/or service commissioning in relation to AOD services within their authority. Participants included managers from both social care and drug and alcohol service settings.

Ethics

The project design and methodology was approved by the ethics committees of the originating university, the Associations of Directors of Children's Services and Adults' Social Services (ADCS and ADASS), and the research governance committees of the participating directorates where applicable. All data were collected with informed consent, data were treated confidentially and stored appropriately, and the anonymity of both individuals and agencies was respected.

Sample Characteristics

The characteristics or the profile of the sample is important to consider, particularly in relation to the type of work undertaken by participants and the context in which it is

performed, since this is likely to have considerable bearing on the extent and nature of alcohol or drug problems which might be encountered.

The sample was predominantly female (82%) and there was a relatively flat age distribution, both of which are consistent with the patterns reported elsewhere (Skills for care 2013 and HSCIC (Health and Social Care Information Centre) 2014). However, in comparison with the same source, minority ethnic groups were under-represented in our sample (only 8% of our sample classified themselves as being of minority ethnic origin in comparison with 16% and 10% across the children's and adults' social care workforces respectively.

Table 1: Professional and post-related characteristics of the sample (n=597)

Characteristic		N=	*%*
Directorate	Children's Services	357	*61*
	Adults' Services	240	*39*
Current role	Support role	129	*22*
	Qualified practitioner	337	*56*
	Managerial or senior practitioner role	125	*21*
	Missing	*6*	*1*
Type of qualification	Social work qualified	369	*62*
	Social work student	27	*4*
	Other professional qual.	49	*8*
	NVQ3 or equivalent[2]	47	*8*
	NVQ 4 or equivalent	76	*13*
	No qualifications	19	*3*
	Missing	*10*	*2*
Time in current post	Less than a year	144	*24*
	1-4 years	238	*40*
	5+ years	207	*35*
	Missing	8	*1*
Time in social care sector	0-4 years	118	*20*
	5-9 years	148	*25*
	10+ years	315	*53*
	Missing	*16*	*2*

Table 1 illustrates the profile of the sample in relation to participants' service setting and role. As is clear, there were more participants from Children's Services than Adults'

[2] NVQ refers to National Vocational Qualifications which recognise different levels of work-related competence achieved. There are five levels of qualification available, the highest of which (Level 5) indicates a depth of knowledge broadly equivalent to a doctoral degree but without the original research contribution. (NASWE (National Association of Social Workers in Education, online; Ofqual, (Office of Qualifications and Examinations Regulation) online)

Services, with the former accounting for just over 60% of the whole sample (although this is to be expected as more Children's Services Directorates were surveyed). The majority of respondents described themselves as a qualified practitioner, but support and senior or managerial roles were also represented.

Over 60% of participants were qualified social workers and a further four percent of participants were in the process of training to become a qualified social worker. The majority of the remaining third of participants held qualifications in teaching, nursing, youth work and occupational therapy to name a few, as well as in various NVQ 3s and NVQ 4s[3] in different aspects of social care.

Respondent characteristics in terms of both time in post and time working in the social care sector indicate that the survey tapped the range of experience. An important consideration in relation to working with AOD problems was previous experience of working in a specialist setting. Of the sample of 597, 89 had such experience – either through training placement opportunities or in previous posts. Overall the demographic and professional characteristics of those with and without experience of working in a specialist alcohol or drug setting were largely similar. Importantly though, it tended to be social workers and those with other professional qualifications rather than those with NVQ or no qualifications who had alcohol and drug work experience ($\chi 2 = 13.7$, $df=5$, $p<0.02$).

Identifying Primary Service User Groups (PSUG)

One of our major interests in this piece of work was to be able to describe the experience of practitioners in different areas of social work and social care practice. Our final categorisation of the various specialist areas was necessarily somewhat rudimentary in order to reduce the large number of groups sufficiently to permit quantitative analysis. Nevertheless, the final groupings do permit a more detailed understanding of the range of experience across the statutory service sector. The sample of practitioners was divided into those whose service users (or clients) were adults (Adults' Services, AS) and those whose services focused on children (Children's Services, CS). Each of these groups was further subdivided resulting in eight groups in total which are used in the analyses which follow. These eight areas of service are specified in figure 1 which sets out the proportions of the

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sample according to their primary service areas or 'service user groups' (please see the notes to figure 1 for detail on which areas of service are included in the groups identified in the figure).

Figure 1. Representation of service areas[4]

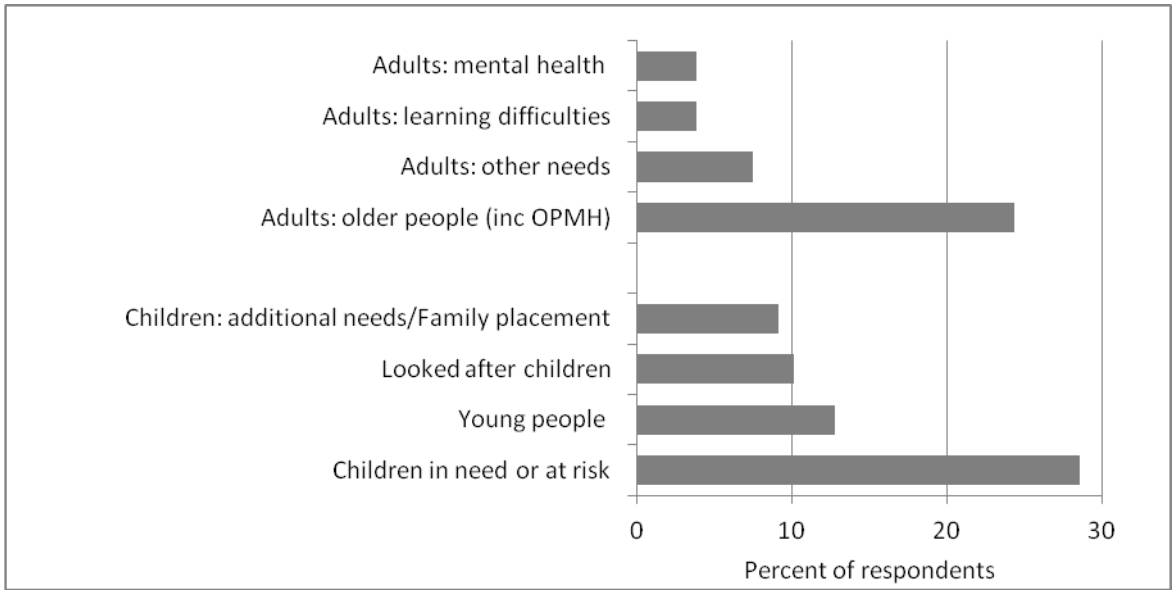


Figure 1 clearly illustrates the dominance of participants working in either older people's services (24% of the entire sample) or children and families (i.e. services for children in need or child protection/safeguarding – 29% of the whole sample). Aside from these two exceptions the distributions were fairly even across other service areas within both Adults' and Children's Services.

Findings

Defining problematic AOD use

Before proceeding further with the presentation of findings it is important to set out how survey respondents understood the term 'problematic substance use'. Early on in the survey we posed an open question which asked: 'What is it that helps you determine whether a person's alcohol and/or drug use is problematic?' Responses were received from

[4] ***Notes to figure 1****. OPMH is older people with mental health needs; 2. Adults with other needs includes those working with people with physical disabilities under the age of 65, and who have sensory impairment, other illnesses and those working with people seeking asylum 3. SM = substance misuse; 4. 'Young people' includes those working with care leavers, young offenders and young people not in education, employment or training.*

three quarters of the sample and these indicated that practitioners tended to use a social definition of problematic AOD use, one that focussed on the impact of AOD on the activities and responsibilities of service users' lives – whatever those might entail. For example, Children's Services workers tended to focus on the impact on parenting

> *How they [parent/s] function within the family unit and prioritise their own needs over their children's. Children's views on their parents drinking habits*

Adult's Services workers tended to consider impacts on the individual and their social interactions:

> *How [people are] presenting, whether [they are] managing daily functioning, personal care (self neglect), managing relationships, managing environment, attending appointments* [survey response]

It is worth noting that these illustrative quotes focus on observable signs of neglect (of self or others) or impairment. Interestingly, whilst questions about AOD use do feature in most assessment tools, some practitioners – especially in Adults' Services – felt uncomfortable about asking questions about AOD consumption:

> *I think I would initially try and broach it from a very general level because this isn't indicating that you've got any evidence either way, I'd probably want to have the kind of validity of having some kind of form with me, so they won't feel I was targeting them in any way or coming at it in a threatening manner*. [Focus group extract]

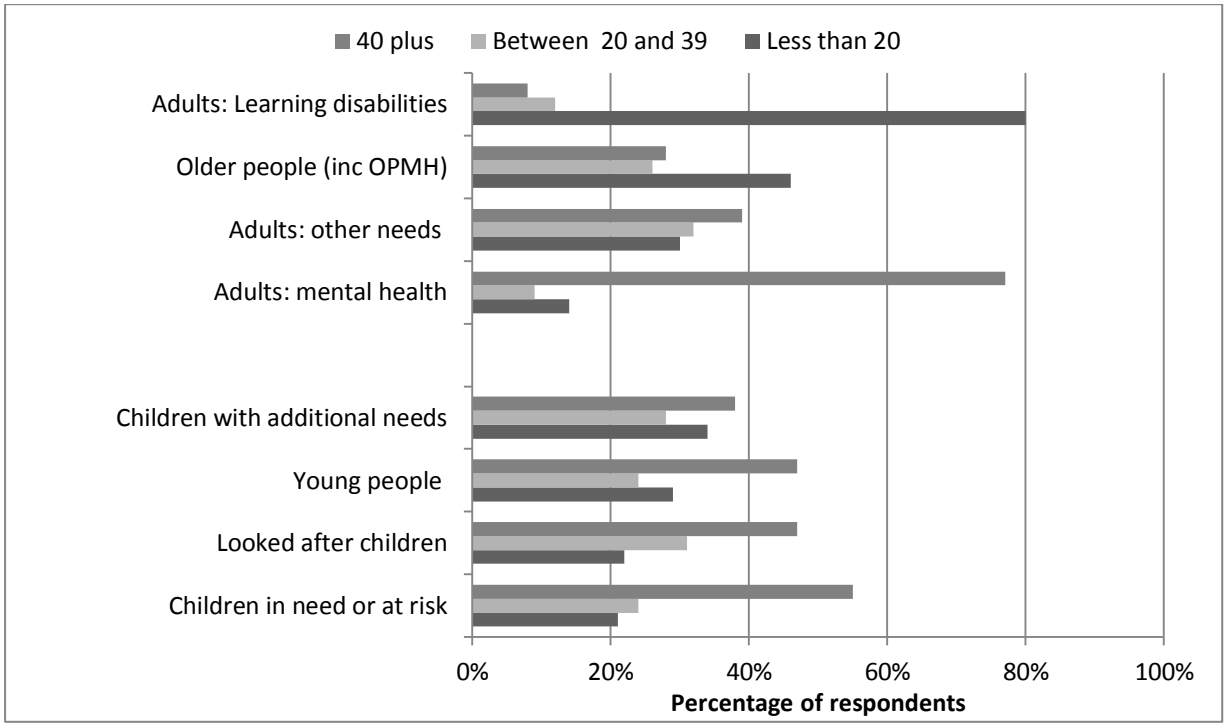
Experience in Working with AOD problems

Participants' overall experience in working with AOD problems was an important consideration for this study. One question in the survey asked participants to indicate approximately how many individuals or families (cases) they had worked with over their social care careers where AOD use had been a problem. Just under one third of practitioners (32%) reported having worked with fewer than 20 cases, 25% stated between 20 and 39 cases and 41% indicated they had worked with over 40 cases.

There were marked differences in terms of experience in working with AOD problems between CS and AS generally, and according to primary service user group. In Children's Services 49% of respondents indicated having worked with 40 or more cases while a

similar proportion (43%) of those working with adults reported less than 20 ($\chi 2 = 24.0$, *df*=2, $p<0.001$). The variation according to primary service user group elaborates on the variation by directorate and is illustrated in figure 2. As can be seen, particularly within adults' specialisms there are very distinct differences in the experience profile: the great majority (77%) of those working with adults with mental health problems reporting to have worked with 40 or more cases, whereas among those working with adults with learning disabilities the picture is almost completely opposite - with 80% reporting working with fewer than 20 cases during their career. The other two adult specialisms show a more balanced spread but it is clear that nearly half of those working with older people have relatively little experience (fewer than 20 cases). Between Children's Services areas of specialism there was less variation and in each case the majority of participants were reporting significant experience of working with substance use issues, although this is marginal in the case of those working to support children with additional needs and their parents or carers ($\chi 2 = 68.7$, df=14, $p<0.001$).

Figure 2: Number of cases with concerns about substance use over social care career by primary service user group



Experience in working with problematic AOD use was also highly correlated with age. The older the practitioner and the longer they had worked in the social care sector, the more likely they were to have worked with concerns about AOD use ($\chi 2 = 27.6$, *df*=6, p<.001 and ($\chi 2 = 48.7$, *df*=4, p<0.001 respectively). Those who were social work qualified were also significantly more likely to report having worked with these issues than those with other qualifications or no professional qualification ($\chi 2 = 34.0$, *df*=2, p<0.001).

Current Caseloads and Extent of AOD Misuse

In order to estimate the extent to which practitioners encountered AOD problems in the different areas of service we asked respondents to indicate how many people they had on their 'caseload' at the time of taking the survey (or if they have no caseload how many people they had worked with in the last week). We then asked people to state, of those current cases, the number for whom there were concerns about either a) the service user's own alcohol and/or drug use or b) the use of alcohol and/or drugs by someone close to them. These two items of information then permitted us to calculate a value for each practitioner which gave an indication of the proportion of people on their caseload for whom there were concerns about problematic AOD use.

Across this sample of social care respondents working in local authority services, there were concerns about the problematic AOD use on the part of the *service user* in an average of one in seven (14%) cases on people's current caseloads and concerns about AOD *use by someone close* to the service user (a parent, carer or relative for example) in just over one in five cases (22%). These averages however, conceal substantial differences between primary service user groups (PSUGs). An initial comparison between CS and AS revealed that average caseload proportions for *own use* were 17% for CS practitioners as against 9% for AS (*t*:-4.7, p< 0.001), while differences in proportions for *use by someone close to the service user* were even more marked at 33% and 4% for CS and AS respectively (*t*:-17.5, p< 0.001).

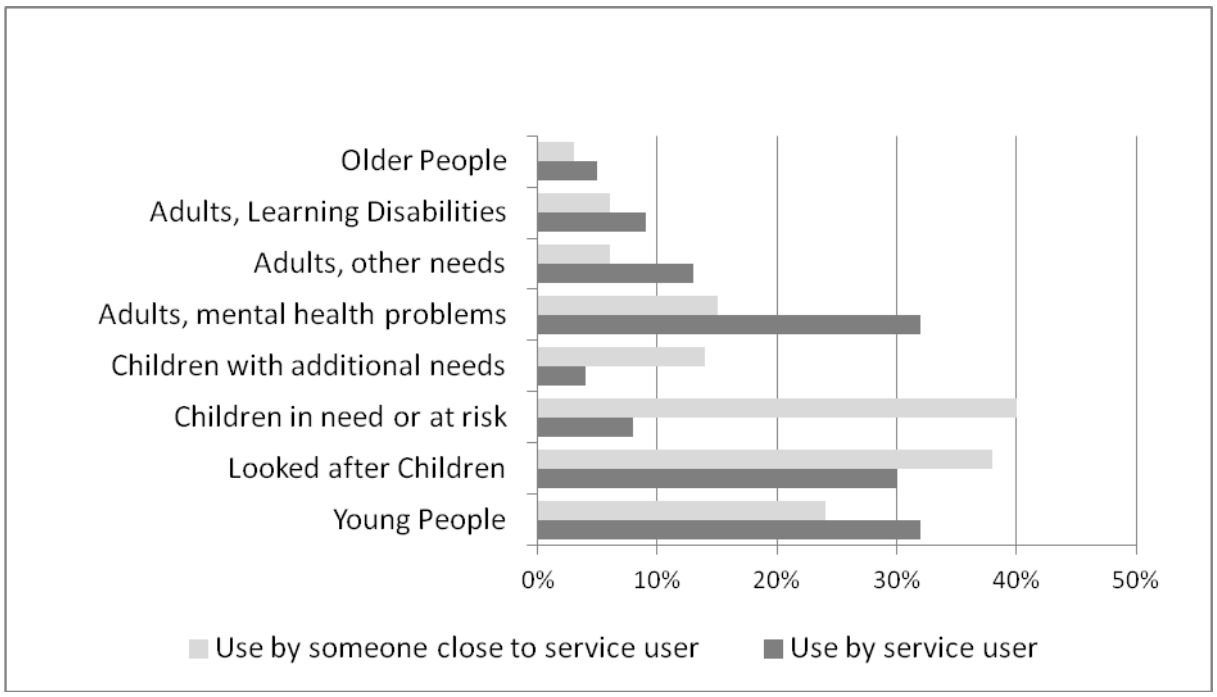
Variation by primary service user group

Taking this analysis one step further we explored the variation in the extent of AOD between the eight areas of practice (PSUG). Figure 3 provides a graphical illustration of the observed variation in the proportions of cases where there were issues of problematic AOD use for either the *service user* (the darker bars) or *someone close to the service user* (the lighter bars). The patterns seen are understandable when the different practice contexts are considered. Thus, (focusing for a moment on problematic use by the service user) among the Adults' Services groups the mean caseload proportion for those who work with adults with mental health problems was 32% while the averages for other Adults' Services groups were considerably lower (13%, 9% and 5% for adults with other needs, with learning disabilities and older people respectively).

Similarly, in relation to Children's Services groups, AOD problems for service users themselves appeared much more frequently on the caseloads of people working with young people (32%) or looked after children (30%) than was the case for those who worked with children in need or child protection (8%[5]) or those who support carers of children with additional needs (4%). A one-way ANOVA (using Tukey's HSD post hoc) confirmed that the differences highlighted above were statistically significant (F =41.6, p< 0.001).

Figure 3: Proportion of cases affected by substance use problems by service user group

[5] Note – this figure is low because it is about service users' own use and the child is the service user. It is likely that parental substance use is picked up in the caseload proportions of people who are affected by the use of someone close to them.



Turning attention to the mean caseload proportions of people affected by the problematic AOD use of *someone close to the service user* , again an ANOVA test revealed statistically significant differences ($F=208.1$, $p< 0.001$). Post hoc analysis here showed that the mean caseload proportions of those who worked with children in need/child protection (40%) or with looked after children (38%) were significantly higher (statistically speaking as well as in practice) than those whose work supported families with children with additional needs (14%) or those working with young people (24%). Post hoc analysis also indicated a significant difference in the mean caseload proportion between those who work with adults with mental health problems (15%) and all other primary service user groups in Adult Services (6%, 6% and 3%).

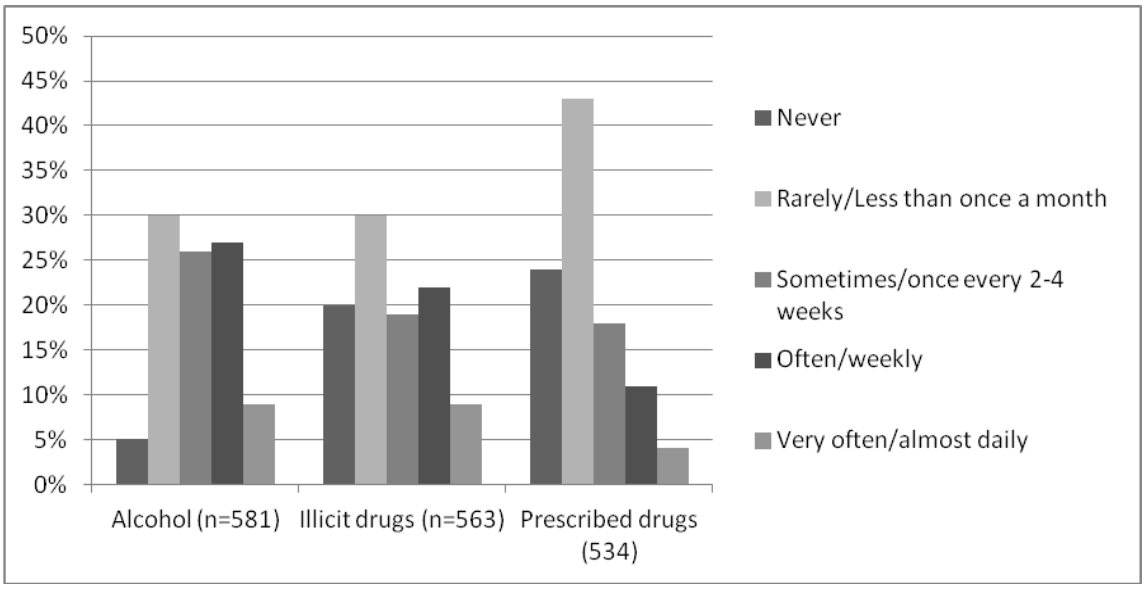
It is worth noting that 21% of participants advised that at the time of the survey they were working with fewer cases where there were AOD problems than was their usual experience - just 6% stated the proportion was higher than normal. The figures provided may therefore underestimate the extent of known AOD problems in social work and social practice.

Types of AOD Use and Frequency of Encounters

Thus far the analysis has considered problems associated with alcohol or other drugs without distinguishing between substances. Previous work has suggested that problematic alcohol use is likely to be encountered more frequently than use of other drugs (Forrester and Harwin, 2006). However, much of this evidence is focused on smaller samples of people working in child protection services. We therefore explored the experience of this larger and mixed sample of practitioners. As might be expected most (49%) did indeed report encountering mainly alcohol problems. Relatively few practitioners (just 9%) reported encountering *mainly drug use* although a substantial proportion of participants (42%) indicated that they came across a mixture of alcohol and drug related problems.

Taking this one stage further in an attempt to 'pin down' specific experience rather than rely on general impressions, survey questions asked practitioners to indicate how often they had come across problems with alcohol, with illicit drugs and with prescribed drugs in the course of the previous 12 months. As can be seen in figure 4, only five percent of the sample indicated they never came across problems associated with alcohol, whilst 65% of respondents reporting that they came across this at least 'sometimes' (every two to four weeks) and for nearly one in ten this happened on an almost daily basis.

Figure 4 - Frequency of encounters with problematic use of alcohol, illicit drugs and prescribed drugs



The frequency of encounters with illicit drugs in the last 12 months show a much higher percentage of respondents reporting 'never' and lower numbers in the 'sometimes', 'often'

or ‘very often’ categories but it is still the case that half of respondents reported meeting problematic usage of illicit drugs at least every two to four weeks. Encounters with problematic prescribed drug use are far lower with the majority of respondents reporting they ‘never’ or ‘rarely’ encountered problems with prescribed drug use among their service users but still one third of respondents came across this at least every month or so.

Again, as would be expected, there were very clear differences between respondents’ experiences according to whether they worked for Children’s or Adults’ Services. Those who worked in Adults’ Services were significantly more likely to state they worked with ‘mainly alcohol’, while Children’s Services staff were significantly more likely to work with both alcohol and other drugs and with ‘mainly drugs’ than their adult counterparts ($\chi 2=164.4$, $df=2$, $p<0.001$). Caseloads where workers dealt with ‘mainly drugs’ were relatively rare (9% of the whole sample) however, it is important to note that these cases tended to be focused in a few key service user groups including adults with mental health problems, services for young people (youth work, youth offending and care leavers) and looked after children.

Overall, it is clear that staff can face AOD problems in all areas of social care, although Children’s Services workers were more likely than those in Adults’ Services to encounter problematic use of either alcohol or illicit drugs. Reported frequency of misuse of prescribed drugs was similar in both services. For both groups, but especially for the majority of Adults’ Services staff, it was predominantly alcohol problems that practitioners found themselves working with. The survey data were supported by the qualitative data from both focus groups and key informant interviews where alcohol was identified as the primary problem and importantly there were perceived to be issues in securing alcohol treatment services which service users were prepared to engage with.

> *We think we have a high quality service for category A substance misuse, but we don't seem to get anything like the kind of service we would like for alcohol misuse and yet that is our area of biggest concern.* [Key informant, Children’s Social Care]

Of course, whether these reported rates are a true reflection of the level of these problems for service users is a moot point. We have observed previously and elsewhere that many

practitioners were hesitant, indeed sometimes resistant, to asking about people's use of AODs, preferring instead to base their assessments on observable signs of impaired functioning (Galvani, Hutchinson and Dance 2013; Dance & Allnock, 2013). Thus, the extent of AOD discussed here might be underestimated.

Discussion

As with all research, there are a number of limitations to this study. First, it was only feasible to work with a relatively small number of local authorities, however, our efforts to ensure that the sample represented a range of service settings counters this to some extent. Response rates were also problematic for this study; difficulties in achieving 'good' response rates to survey style studies in social work are reported frequently and this is an issue that we have addressed elsewhere. The low response rate means it is important to bear in mind that, while many practitioners participated in the survey, respondents only represented just over 20% of potential participants across the sampling frame and it is certainly possible that those who chose to participate did so because the subject of the survey had a particular relevance for them. We were able to address this issue to some extent by establishing that there were no systematic differences in reported experience according to the response rate in different directorates which varied substantially. Additionally, the experience reported in response to survey questions was confirmed in focus group data, which adds confidence about the findings. Finally, in self-completion survey methods there are always concerns about shared interpretations between researcher and participants: to minimise the chances of misinterpretation our questionnaire was piloted twice and we offered frequent 'open space' opportunities for respondents to clarify their responses or introduce their own thoughts.

Limitations notwithstanding, this study represents a unique attempt to establish the extent to which alcohol and other drugs feature in the day to day work of social work and social care professionals in all areas of service in England. The findings demonstrate very clearly that practitioners in all areas of social work and social care do indeed work with people who have problems resulting from AOD use. The rate of encounters with AOD, as indicated by respondents' 'caseload proportions', is compatible with findings reported elsewhere in the literature. For example Cleaver et al., (2008) in their study of six English local authorities report that 60% of child protection referrals involved concerns about

AOD – the figure of 40% of cases on the workload of a children and families practitioner working with both children in need or at risk seems in line with this. Similarly, the rate of dual diagnosis (AOD use and mental health problems) identified by Strathdee and colleagues (2005) in community mental health teams was 37% which resonates with the 32% 'caseload proportion' reported by participants here. Although rates of cases and 'caseload proportions' are not, strictly speaking, directly comparable, the level of congruence observed for the two examples given suggests that the data from the current study are reasonably reliable and valid.

The conclusion to be drawn from the data presented here is, therefore, that social work practitioners across the range of services are encountering problematic AOD use among the people they work with on a regular, and sometimes, a very frequent basis. Overwhelmingly for most it is alcohol that presents problems for their service users – although for some groups a mix of alcohol and illicit drugs is fairly common.

As might be expected practitioners in mental health teams in Adults' Services and those in family support or child protection teams in Children's Services reported much more frequent contact with problematic AOD use than practitioners in other sectors of the service. It is also these groups, along with those working with young people or looked after children, who were more likely to encounter problems associated with a mixture of substances or drugs other than alcohol.

Practitioners in other sectors of service (e.g. those working with older people or people with disabilities) reported that problematic AOD use was evident for smaller proportions of their caseloads, the range being from four to 13 percent of cases where it was the service users' own AOD use that was problematic. However, this still represents one or two in every 20 cases and there were additional cases which involved problematic use by someone close to the service user. Furthermore, it was mentioned above that many respondents indicated that the proportion of cases with AOD concern they were working with at the time they completed the survey was lower than was usual, indicating that the results reported here may well be an underestimate.

Finally, in thinking about reported frequency of encounters it is important to bear in mind that practitioners were only able to report on cases where they had identified problematic AOD use. As mentioned here earlier and elsewhere (Galvani, Hutchinson and Dance, 2013) this research has identified that social work and social care practitioners (in common

with professionals in other human services) may well not recognise signs of problematic use – at least not until the impact on health or social functioning is significant – and they may be hesitant to initiate discussion about alcohol or drug use..

Leaving aside for the moment the question of whether the reported proportions are accurate, the analyses reported here have evidenced that social workers and other practitioners in all areas of social care come across significant numbers of service users who have issues with AOD. This has obvious implications for social work education at qualifying level and for continuing professional development for all practitioners in all areas of Adults' and Children's Social Care.

Implications for social work education

Although the frequency with which AOD is encountered varies across the range of service areas, the evidence from this study indicates that all social workers and social care professionals need to have a basic understanding of AOD and know how to include relevant questioning into routine assessments in order to identify problems.

If problems are identified, it follows that practitioners need to know how to respond - again education and training provision needs to ensure that individuals are equipped with the knowledge and the support to enable them to respond effectively.

This research indicates that providing AOD education to social workers needs to be given priority in qualifying education and on-going CPD, alongside other key training needs such as safeguarding, risk assessments and mental capacity training, for example. While we know that it is impossible for qualifying training to give equal attention to every aspect of social work practice, this study provides evidence for educators who are eager to include more AOD training in their programmes.

The type of substance used and the implications of misuse for service users vary between service sectors, indicating a need for targeted or focused training in AOD which is tailored to the needs of practitioners in the context of their client groups.

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