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SUBSTANCE USE AND DISABILITIES: EXPERIENCES OF ADULTS' SOCIAL CARE PROFESSIONALS AND THE IMPLICATIONS FOR EDUCATION AND TRAINING

Abstract

This paper draws on data from a national survey of social workers and social care practitioners in England undertaken in 2010-2011. It focuses on practitioners working in services for adults with either learning or physical disabilities and, in particular, their experiences of responding to alcohol and other drug use among their service users. Based on secondary analysis of survey and focus group data from the earlier study, the paper outlines the extent to which workers in these areas of practice encounter alcohol and drug problems and discusses the key challenges this poses for them. The findings show that between 4% and10% of adults' practitioners' service users have alcohol and drug problems depending on the nature of the disability. Regardless of the type of disability, practitioners reported difficulties in talking about substance use with their service users as well as identifying tensions around lifestyle choice and risk management. They also reported the need for education and training in a number of areas. Social work education and subsequent training in working with substance use problems needs to be available to adults' practitioners and it needs to address the specific issues and needs in different areas of social work practice.

Key words

Learning disability, physical disability, alcohol, drugs, social work, education,, training

Introduction

The overlap between substance use issues and a variety of social problems is well known. In the context of social work and social care practice, research in England has addressed, in some detail, the impact of alcohol or other drugs (hereafter AOD) on parenting capacity (see for example Cleaver, Unell, and Aldgate, 2011) and in relation to people with mental health difficulties (see Crome and Chambers et al, 2009). Much less research is evident in relation to substance use among people accessing social care services because of disabilities.

The analysis reported here draws on data from a national survey of working with AOD problems in social work and social care (Galvani, Dance and Hutchinson, 2011) and focuses on the experiences and training needs of those working with adults with disabilities who also have problems with alcohol or other drugs.

The paper begins by considering what is known about the nature and extent of AOD problems among people with disabilities before moving on to discuss the findings of our secondary analysis and the implications of these for education and training for practitioners in social work and social care.

Physical disability

The extent to which adults with physical disabilities experience difficulties with AOD use is not entirely clear. Certainly data concerning disability are not routinely collected by the National Drug Treatment Monitoring System (NDTMS) in England (NTA, 2009). Neither was detail about disability collected by the US National Survey of Substance Abuse Treatment Services in 2011 (Substance Abuse and Mental Health Services Administration, 2012). However, evidence from both England and the USA suggests that rates of AOD problems are elevated for people with a physical disability (Hoare and Moon, 2010; Smith and Flatley, 2011; Glazier and Kling, 2013). In the USA research has reported on the prevalence of AOD problems among people with physical disabilities as being at twice the level of those without disabilities (Krahn et al. 2006). It should be noted though that establishing the prevalence of problems in this field is severely limited by the ways in which both substance use and disability are variously defined in different studies.

Beddoes and colleagues (Beddoes, Sheikh, Khanna, and Francis, 2010) in a review of the UK literature suggest that, for the most part, AOD use by people with physical disabilities appears to be increased use of alcohol and sometimes use of cannabis to manage pain. Further they identify isolation and exclusion, social pressure, mental health problems, poverty,

communication difficulties and self-medication as factors which can disproportionately affect disabled people and increase the risk of their turning to AOD as means of easing or managing distress.

However, it is also recognised that physical disability can often result from pre-existing AOD use, Galvani (2012:213) outlines the following ways in which AOD use and disability may be related:

1. Disability resulting directly from substance use: e.g. brain damage from use of the substance or amputation following infected injection sites.

2. Disability stemming indirectly from substance use: accidents that occur while intoxicated and result in disability.

3. Disabilities prior to substance use: e.g. someone born deaf or with muscular dystrophy who chooses to use substances.

4. Substance use as a way of coping with disabilities: e.g. people with mental distress, trauma or physical disabilities whose use of substances serves to temporarily ease difficult feelings and experiences.

5. Disabilities stemming from someone else's substance use: e.g. children born with foetal alcohol spectrum disorder.

The relationships between AOD use and physical or sensory disabilities can therefore be complex and disabled people who have AOD related problems are far from a homogenous group. The disability itself may present in any number of ways and, for those who have difficulties with AOD, their relationship with that may take a number of forms.

Learning disability
The extent to which people with learning disabilities experience problems with AOD is far from clear. Learning disability[1], in contrast to physical disability, appears relatively straightforward to define:

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[1] Learning disability is a term used particularly in the United Kingdom, American writers for example often use terms like mental retardation or cognitive impairment to identify groups or individuals with these difficulties.

A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) along with a reduced ability to cope independently (impaired social functioning). The onset of disability is considered to have started before adulthood, with a lasting effect on development. This definition includes IQ and functional aspects that make it distinct from the use of the term "learning difficulties" which has a far wider application in education (Department of Health, 2001).

Learning disability (LD) is usually discussed as being 'mild', 'moderate' or 'severe/profound'. However, the degree of impairment in either intelligence or social functioning can vary widely and, sometimes, independently of each other. Some individuals with LDs are able to integrate well and live independently; others require significant support and sometimes need residential care.

Taggart and colleagues (Taggart, Mc Laughlin, Quinn and Milligan, 2004) have conducted research and literature reviews in this area and comment that problems with definitions and varying research methodology complicate any attempt to estimate rates of AOD problems although the consensus appears to be that people with LDs are less likely to use AOD than the general population. However, what is clear from the literature is that there is increasing concern about the risk of more people with LDs developing problems with AOD as a result of the ongoing move towards encouraging and supporting their independence and inclusion. Concerns here relate to increased opportunities to participate in social activities – which, in England, often means going to 'the pub' or social drinking. One of the main reasons that this is seen as a risk concerns the perception that people with LDs may be more likely to develop dependence because of suggestibility and tendency to develop patterned behaviours which they are resistant to change (McGillicuddy, 2006). A body of international research focussing on adolescents with learning disabilities and/or learning difficulties has presented a contradictory picture with some studies showing higher rates of some forms of AOD use (Maag et al, 1994, Mallett 2009) while others show the young people with "higher IQs" as more likely to drink or smoke at an earlier age (Molina and Pelham 2001). Again caution is needed in drawing conclusions from such studies due to the limited evidence and the varying definitions of LD used.

Also evident from previous research and the wider literature are worries about the risk of exploitation by others while intoxicated and the extent to which people with LDs are able to

assess how much they have drunk or understand the implications of that (Dance and Allnock, 2013). That said, some authors have cautioned that the use of alcohol by people with LDs and the cultural participation that implies should not be over-pathologised (Simpson, 2012).

Overall, it can be seen that there are legitimate reasons to explore the experiences of social care practitioners working in these two specialist areas of practice. There are a variety of ways in which problematic AOD use might develop and/or impact on the well-being of these two groups of service users. It is however important to bear in mind that the degree of limitation, and therefore need, associated with either physical or learning disability can vary widely and it is likely that it is those experiencing greater levels of difficulty who will be accessing, or trying to access, a social care service. This is particularly true when thresholds for services are high and will usually require that need is assessed as at least 'substantial' if not 'critical' (Department of Health, 2010). For example, Emerson and colleagues (2012) suggest that only about 21% of adults with a learning disability were known to learning disability services.

It is also the case that AOD problems will probably be only one of many problems for those known to local authority services. Furthermore it is unlikely to be a primary need, but it might be a problem which hinders progress in other areas.

As outlined above, the aim of the current research was to explore the experiences of social care practitioners when working with people with physical or learning disabilities who have problems with AOD - and thereby inform our understanding of their specific education and training needs.

Methodology

Methods: the original survey and the focus groups
The findings discussed in this paper emanate from a secondary analysis of a subset of data from a mixed methods, cross-sectional survey of social work and social care practitioners which focused on their experiences of working with people affected by AOD. Full details of the survey methodology and findings are available in (Galvani et al, 2011). In brief, the original survey was completed on-line by 597 front line social work and social care professionals (response rate - 21%) employed by 17 statutory adults' or children's services in

England. The survey questionnaire included both open and closed questions designed to explore

- the extent to which practitioners encountered AOD problems when working with service users

- practitioners' responses to working with AOD issues and the challenges presented

- practitioners' knowledge about, and attitudes towards, working with alcohol and drug use among service users.

- the extent of training received in AOD use and current training needs and

- experiences of working with specialist substance use agencies.

The focus groups were organised around a pre defined practice scenario which aimed to steer conversation through the same areas of interest to add depth to our understanding of the issues and how they impacted on practitioners.

Both the survey and the focus groups were therefore relatively structured and focused on the identification and description of issues and experiences encountered by practitioners.

The current study

This current study comprised secondary data analysis of quantitative and qualitative data collected from a subset of the 597 respondents mentioned above, who were working with adults who have either physical or learning disabilities (n=114). The analysis aimed to address the following research questions:

i.   To what extent do practitioners working with adults with disabilities encounter AOD problems among their service users?

ii. What are the challenges faced by these specialist practitioners when working with people with AOD issues?

iii. What is the extent of training received in AOD use and what are practitioners' current training needs?

Sample

Of the 114 practitioners 25 were learning disability practitioners (LD), 27 were working with 'working age' adults with physical/sensory disabilities (PD) and 62 were working in physical

disability teams which provided services for adults of all ages - including older people (PD(OP)). Some data were missing on a number of variables, this was particularly the case in relation to training questions and is especially noticeable among the PD(OP) group. Between 70% and 80% of respondents in each group contributed responses to open questions. There were two focus groups held with learning disability practitioners and one focus group with practitioners working with people with physical disabilities.

Data Analysis

The aim of the analyses was to identify issues related to working with AOD that were specific to the three areas of practice. The approach taken with quantitative data from the survey was to examine the data for shared and non-shared experience (similarities and differences) across the service user groups. Given the relatively small, and disparate, group sizes quantitative data are used descriptively.

The analysis of the qualitative data was triangulated across data collection methods by initially conducting separate analyses for open survey questions and focus group data and also separating data for each group of practitioners. The coding was then compared across service user groups to identify the common and distinct themes and then across methods. For both datasets (the responses to open survey questions and the focus groups) data were coded separately by two researchers. The two sets of coded passages and attributed themes corresponded well, although no formal inter-rater reliability tests were applied in either case. .

The quantitative data were analysed in SPSS, and the qualitative data were managed and coded using NVivo 9.

Ethics

Ethical approval for the original survey included University-level and Local Authority-based ethics committees or research governance panels. All participation was voluntary and the on-line survey allowed respondents to skip questions that they did not wish to answer. Focus groups were audio recorded (with permission) and transcribed. The survey was conducted anonymously and all identifying information was removed from transcribed material before storage and analysis.

As can be seen from table 1, there were variations in the profile of staff groups although these were minor for the most part and there were no systematic differences observed for most factors. The exception to this was the number of cases where practitioners had encountered AOD issues over the course of their careers. Here, in comparison with practitioners working with people with physical disabilities, very few of those working with learning disabled clients reported having worked with 40 or more cases over their careers.

Table 1. Sample characteristics

	PD (OP) (n=62)	PD (n=27)	LD (n=25)
Sex (% Female)	84%	93%	68%
Age:			
Under 34	23%	12%	16%
35-44	19%	31%	44%
45-54	34%	42%	32%
55 and over	24%	15%	8%
Ethnicity			
% White British	94%	96%	91%
Staff permanency			
% on permanent contract	97%	100%	100%
Social Work qualified?			
Yes	47%	78%	64%
No	48%	18%	28%
Current SW student	5%	4%	8%
Ever worked in a specialist AOD role?			
Yes	15%	19%	8%
No	85%	81%	92%
N of cases worked with over career where there were AOD concerns			
Less than 20	42%	33%	80%
Between 20 and 39	28%	26%	12%
40 or more	30%	41%	8%

Findings

The Extent to Which Practitioners Encountered Substance Use Problems

The difference observed above in practitioners' overall experience of working with AOD problems was mirrored in participants' reports of their current work experience. People working with adults of working age with physical disabilities reported that, on average, there were AOD issues for about 10% of their current caseload, while those working with older

people with a physical disability reported an average of 6% and those working with LDs reported just 4%. Similarly, table 2, which illustrates the number of practitioners reporting frequent encounters with different types of drugs, again shows the lower rates of reported AOD contact for practitioners working with learning disabled people.

Table 2: The types of AOD problem encountered 'often or very often' according to primary service user group

Service user group	Alcohol Often or very often	Illicit drugs Often or very often	Prescription drugs Often or very often
PD (27)	30% (n=27)	9% (n=24)	21% (n=24)
PD (OP) (62)	20% (n=61)	8% (n=55)	21% (n=56)
LD (25)	0* (n=25)	0 (n=24)	0** (n=23)

Notes to table 2: Available responses for encounters with each type of substance were:
- Often/very often (weekly or almost daily), sometimes (once every 2-4 weeks), rarely (less than once a month/never)
- *16% sometimes; **13% sometimes

Overall then, these data show that rates of encounters with substance misuse for adults' social care practitioners are nowhere near as high as is the case for child protection workers for example (Galvani et al, 2011). Nevertheless, those working with people with disabilities do encounter AOD problems, although this occurs less often for those working with people with learning disabilities as opposed to physical disabilities. It is of note though, that whilst AOD problems for learning disabled service users were relatively low, practitioners in this field reported an average of 6% of current cases where there were concerns about the AOD use of someone close to the service user (possibly a carer).

The data also show that alcohol is the substance most frequently encountered overall, rather than illicit drugs. But frequent encounters with misuse of prescription drugs were also reported by one in five practitioners in physical disabilities teams. Within focus group discussions there were occasional references to people with LDs sometimes making mistakes with their medicines, and concern from all groups about the risks of mixing medications and alcohol, However a comment by one focus group participant, who said '*Probably we're not looking for people that are actually abusing prescribed drugs*' suggests that this type of AOD misuse was not routinely thought about.

In thinking about the extent to which practitioners in each of these specialist practice areas came across service users with AOD problems there was quite a distinction between the groups. Learning disabilities practitioners discussed how, because of eligibility and threshold criteria, many of the people they worked with would be unlikely to independently access alcohol or other drugs. In their experience it was people with mild disabilities who would be more likely come into contact with substances and potentially develop difficulties. Concerns were nevertheless expressed about the potential vulnerability of those with milder learning disabilities to a) being drawn to use of AOD to 'fit in' and b) being vulnerable to exploitation by others – financially or otherwise.

Practitioners working with people with physical or sensory disabilities in contrast perceived an increase in the number of people needing a service as a result of alcohol related injury or illness and also mentioned the risks of people developing a substance use problem as a result of 'self-medicating' to manage their disability with either alcohol or drugs (be they prescribed or illicit).

Challenges in Working with Services Users Whose AOD Use is Problematic
There were three broad, but inter-related, practice challenges which speak directly to preparation of practitioners for their role: the management of risk; the need for a trusting relationship with service users; and issues of capacity, rights and life-style choice.

Management of risk:
Risk is a word that appeared frequently in the transcripts of the focus group interviews and in the responses to open survey questions. The context in which this was discussed was one in which service users did not necessarily acknowledge that they had a substance use problem and did not wish to engage with treatment services or change their behaviour. Participants also indicated that they often felt isolated: other services had declared they were unable to help and there were several comments about social care being 'the last port of call' or being 'left holding the can'.

> *We're seen as the last throw of the dice for this person and are almost*
> *expected to wave a magic wand and cure this person, where every other*
> *service has failed. And I think sometimes that you're working without a*
> *great deal of knowledge, you're winging it basically on a daily basis, and*
> *managing the risks. So these referrals come from [other services], they're*
> *always passing the buck because they've failed, I'm sure they feel how we*

feel but ... we can't close things as easily as other services can, so we tend
to get left managing things. That's one thing that always strikes me.

<div align="right">Physical disability focus group</div>

Perhaps not surprisingly then, there was a real sense of felt responsibility and anxiety in the words of many practitioners, which highlights that substance use problems can be a significant issue in adult safeguarding.

For a lot of the time, until they really want to accept some help, it's like
managing it, it seems weird but you just kind of put risk management plans
in place to deal with the potential risks that are going to come up while
they're drinking and making sure that you know exactly, that it's all
documented. Sometimes it seems like a paper exercise but it's really
important to just have them all documented in a plan, so that you know
what could happen and they know what could happen but ...

<div align="right">Learning disability focus group</div>

For the most part the risks being discussed concerned people's physical safety – worries about falling while intoxicated, or mismanagement of mobility aids leading to accidents or concerns about fires starting for example. There were also concerns about the impact of drinking (or use of other substances) on the support networks (formal and informal) that service users relied upon. Examples were given of both family support and paid carer support being withdrawn as a result of service user behaviour which again increases the level of risk that service users are exposed to and increases the challenge for practitioners.

Worker-client relationships and talking about AOD
As mentioned above, one of the major constraints for practitioners that contributed to anxiety about risk was that service users were not ready to engage with treatment services. Further, many practitioners felt they were 'on their own' in helping clients to manage the risks that their AOD use posed.

Our data revealed that practitioners tended to rely on observable signs of substance use problems, such as mood swings, aggression or poor self-care. And some were hesitant or resistant to asking questions about AOD use. One reason given for this was the difficulty of broaching the subject without having developed a trusting relationship with a client. One of the findings from the current study was that there were differences between PD and LD

practitioners in terms of their addressing AOD issues with service users: those working with physically disabled people reported asking about AOD use much more frequently than those working with learning disabled people. As mentioned previously, this may well reflect the fact that many users of local authority learning disability services may not be sufficiently autonomous to access AOD independently and therefore rates of problematic use would be expected to be lower. However, as observed by one participant there remains the possibility that an assumption about low rates of AOD use might lead to problems being overlooked:

> *Work within Learning Disability presents few of the above issues [AOD problems] but issues could be missed if ignored.*
>
> Learning Disability Survey Response

Capacity, rights and life-style choice

The tensions around service users' right to choose how to live their life and what risks to take were particularly live for practitioners in LD and PD services. In the field of disability the promoting and supporting of independence, autonomy, privacy and inclusion as far as possible are fundamental principles. With alcohol in particular, its consumption in social settings is a normative activity for many groups in society and practitioners participating in the study wrestled with striking a balance between respecting individual rights and promoting healthy/safe choices.

> *Our team's about capacity, hugely, we talk about that all the time, use the Mental Capacity Act and if someone's got the capacity to make that decision, even though it's an unwise decision, you can't do anything about that. All you can do is guide and say "this is the step you need to take, I can't do this for you, if you really want to address this then this is the place you could try" and just keep trying to encourage but you can't force somebody to get help,*
>
> Learning Disability Focus Group

Participants contrasted the issues they faced with those faced by children's social workers for example, where substance use by parents impacts negatively on child-care resulting in a safe-guarding/child protection concern. The role when working with disabled people was seen as

one of support rather than monitoring or policing and participants talked about not having a right to ask questions about AOD.

> *Ultimately though I'd only become involved with somebody's alcohol problem if they felt they needed the help or if it was affecting somebody else's life, I wouldn't go in there and think "you're drinking too much, you shouldn't be doing that", I'd be thinking that that's their choice, I'm not going to be pointing fingers at people, perhaps they don't have five veg a day as well, how far do you go? It's not my business.*

Learning Difficulty Focus Group

Participants from learning disabilities teams in particular also mentioned occasional concerns about carers using AODs, possibly as a way of coping with the demands of caring, However, they felt that their role was to assess support needs and facilitate access to services, not to question carers about their own behaviour. Furthermore, the assessment forms used would not naturally encourage discussions about these issues.

Training for Working with AOD Problems

The extent of training that practitioners had received for working with AOD problems was a major focus of the original survey (Galvani et al, 2011). The findings of that survey were that generally levels of AOD training were low. Only 27% of the whole sample had received more than 32 hours (4 days) training in total (including qualifying and subsequent training opportunities) with workers in adults' services generally faring less well than children's services workers. Interestingly in one of the LD focus groups, where people referred to their training experience as they introduced themselves, it was striking that only two of nine participants reported having received any training on substance use issues.

Thinking specifically about practitioners working with people with disabilities, the majority of those working in PD teams felt that training in working with alcohol and drugs was 'very or extremely' important (PD 77%, PD(OP) 53%). The same was true for fewer people working in LD teams (21%). However, despite differences in the extent to which training was felt to be very important, there were similarities across the groups in terms of the aspects of AOD practice for which more training would be helpful. The areas in which there was most need are illustrated in table 3, which shows that (with one or two exceptions) around 60% of practitioners working with people with disabilities wanted more training about interventions,

assessment of risk, working with specialist agencies and how to talk with service users about AOD concerns.

Table 3. Proportions of respondents who desire more training by areas of AOD practice

	LD % (n=19)	PD % (n=22)	PD (OP) % (n=47)	All % (n=88)
Types of intervention and treatment available	63	55	77	72
How to assess risk relating to drug or alcohol issues	79	73	66	67
Working with/referring to specialist alcohol or drug workers	63	68	60	62
How to talk about drug or alcohol issues with service users	53	59	66	60

This indicates that there is recognition of AOD problems and a desire to be better prepared to work appropriately with these issues

Discussion

Overall, our data suggest that practitioners in disability services are working with service users with substance use problems, albeit less frequently than colleagues in children's services. The average proportion of cases featuring AOD concerns was higher for PD practitioners than was the case for LD workers. The literature suggests that, as a group, people with LDs are less likely than the general population to use substances but to be at higher risk of problems should they choose to do so (see Taggart et al., 2004). It is also the case that only a proportion of people with learning disabilities, those with high levels of need, are likely to be in touch with services (Emerson et al., 2012). A similar situation is likely to be the case for those with physical disabilities.

While reported levels of use were relatively low, it is important to question whether this was a true reflection, given the reservations practitioners had about talking with service users and carers about their AOD use. It is also pertinent to question the fact that much of the data concerned alcohol use rather than illicit drugs or misuse of prescribed medications. This,

along with the reliance on observable signs of the impact of misuse in order to identify problems does raise questions about practitioners' concept of AOD misuse.

It is worth noting that misuse of prescribed drugs did not feature very much in the qualitative data, particularly since over 20% of survey respondents working with people with physical disabilities identified this as a frequently occurring issue. Evidence shows that prescribed drug use is one of the least covered topics within qualifying social work programmes - alongside ethnicity and gender in relation to substance use (Galvani , Dance and Hutchinson, 2013). There is clearly a need for more attention to be paid to this issue. When practitioners did encounter service users who they recognised as having AOD problems serious concerns could be raised. Practitioners' experience was frequently with people who did not wish to engage with treatment services or change their behaviour. In these circumstances practitioners appeared to feel powerless to intervene other than to put risk management plans in place which often did little to allay their anxieties.

There are clear indications here that practitioners need to be provided with the skills and techniques to work with AOD issues in order to manage their own, as well as their clients', well-being. Practitioners need the confidence to intervene when possible and to be able to accept situations when their service users' informed choice to use AODs places them at ongoing risk of harm.

However, this presents a challenge. In England there is no current requirement for professional social work qualifying education to include teaching on AODs. Evidence from qualifying programmes (Galvani and Allnock, 2014) and from social workers' reports (Galvani et al, 2013), show that the delivery of AOD education within qualifying programmes is hugely variable from none to programmes with dedicated modules or units. The evidence also indicates that even where there is some AOD education, its quality and quantity is questionable (Galvani and Allnock, 2014). It also shows that those following children's pathways through social work education and employment fare far better than their adults' pathway colleagues.

The three key concerns of these adults' workers that need to be addressed by education and training included the management of risk, talking to people about their AOD use and the debate about capacity and rights. With the exception of talking to people about their AOD use, the others are topics that are embedded in the social work curriculum in England. Even talking to people about sensitive subject matters as part of assessment or support is a core

feature. What is new, however, is the consideration of these topics in relation to AOD use. Social work education needs to do better at drawing explicit links between social work skills and knowledge and working with substance use although this relies on the educators being confident and knowledgeable enough to do so.

Interestingly, although issues of autonomy, capacity and choice were mentioned frequently in both the open survey questions and in the focus groups, there was relatively little comment as to whether there was a role for social workers or social care practitioners in supporting service users towards a readiness to change behaviour. This suggests that there is a need for wider discussion and greater clarity about the role of social work and social care in relation to promoting well-being (Dance and Allnock, 2013:50; Galvani, Forrester, Glynn, McCann et al et al. 2011:53; Cecil, 2012).

Finally, it is important to consider that the findings presented here emanate from a survey of practitioners (many of them qualified social workers) operating in local authority social services departments in England. In a climate where, increasingly, social care is provided by workers without formal qualifications and by people working outside of the LA context (NMDS-SC and Skills for Care, 2012), thought needs to be given to how professional education and training can be made available to all who might need it.

Conclusions and Implications for Social Work and Social Care Education

This analysis of the experiences of practitioners working in adult disability services suggests that many participants were unsure of their role in relation to working with AOD problems, were hesitant – or resistant – to talking about it and under-prepared to be able to engage effectively in direct work to support service users with their AOD problems.

Practitioners' experiences were that when clients had problems with substance use this could generate high levels of risk for the service user and high levels of anxiety for the worker. The latter was often accentuated because of difficulties in engaging clients with other services.

There appears to be a very clear need (if not a duty of care) for institutions responsible for delivering qualifying and post qualifying education to begin to develop the knowledge and skills required in practice. Delivering such education would meet the needs of both the practitioners as identified here and, importantly, deliver a better service to the service user.

This requires commitment from qualifying social work programmes and a recognition that this is an important part of developing responsive and competent practitioners. This early education needs to be built upon by employer led training and career development for social work and social care practitioners. We have provided above and elsewhere (Galvani et al, 2013) an indication of the AOD related topics that practitioners feel they would like to learn more about. We take this opportunity therefore to emphasise some general principles that can be drawn from the findings of the current study which provide pointers as to how such education and training opportunities might helpfully be developed:

1. Basic education in substance use knowledge and assessment skills at professional qualifying levels for adults' and well as children and families social work and social care students.

2. Employment-based training needs to be available to all groups of practitioners whose work brings them into contact with service users or carers with substance problems. This means thinking creatively about how continuing professional development in particular can be developed to take account of the demands on practitioners' time.

3. Education and training needs to be context specific. Different challenges are faced by different groups of practitioners, for example, adults' practitioners may need to learn more about prescription drug use and misuse than children's practitioners as they are often working with older populations or with disabled people where prescription drug use is higher.

4. Education and training needs to build workers' confidence and skills in working with people at all stages of the cycle of behaviour change (pre-contemplation, contemplation, preparation, action, maintenance) but particularly those in the pre-contemplation stage.

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