Building capacity and bridging the gaps

Strand 3: Alcohol and other drugs in social care employment-based learning and development

Final Report – 2 June 2013

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3.1 INTRODUCTION ................................................................. ERROR! BOOKMARK NOT DEFINED.
3.2 AIMS, OBJECTIVES AND RESEARCH QUESTIONS ................................................. 9
3.3 METHODOLOGY .......................................................................... 10
  3.3.1 Methods ..................................................................................... 10
  3.3.2 Sampling frame ........................................................................... 11
  3.3.3 Pilot study ..................................................................................... 12
  3.3.4 Analysis ......................................................................................... 13
  3.3.5 Limitations ................................................................................... 13
  3.3.6 Ethics ............................................................................................ 14
  3.3.7 Presentation of findings ................................................................. 14
3.4 FINDINGS: SAMPLE CHARACTERISTICS .................................................. 15
  3.4.1 LA type ......................................................................................... 15
  3.4.2 LA setting ....................................................................................... 15
  3.4.3 LA region ....................................................................................... 15
  3.4.4 WLD department structure ........................................................... 16
  3.4.5 Target audience ............................................................................. 16
  3.4.6 Provider type .................................................................................. 17
  3.4.7 Organisational changes ................................................................. 17
  3.4.8 Individual respondent characteristics (job title and length in post) .......... 17
3.5 FINDINGS (PART 1): THE EXTENT OF EMPLOYMENT-BASED TRAINING ............. 19
  3.5.1 Amount of AOD training ............................................................... 19
  3.5.2 Mandatory nature of training ....................................................... 20
  3.5.3 Facilitating provision of AOD training outside the local authority ........ 20
3.6 FINDINGS (PART 2): THE DEVELOPMENT OF AOD TRAINING ........................................... 22
  3.6.1 Dedicated AOD training strategy ................................................................. 22
  3.6.2 Policy and practice guidelines ...................................................................... 22
  3.6.3 Tools for working with AOD use ................................................................. 22
  3.6.4 Developing AOD training ............................................................................. 23
  3.6.5 Course follow up and evaluation ................................................................. 24

3.7 FINDINGS (PART 3): CHARACTERISTICS OF AOD TRAINING ...................................... 26
  3.7.1 Target audience ......................................................................................... 26
  3.7.2 Substances covered on courses ................................................................. 27
  3.7.3 Course length ........................................................................................... 27
  3.7.4 Provider type ............................................................................................. 28
  3.7.5 Course level ............................................................................................... 29
  3.7.6 Course frequency ...................................................................................... 29
  3.7.7 Mode of delivery ....................................................................................... 30
  3.7.8 Course content .......................................................................................... 30
  3.7.9 Topics by hours of training ...................................................................... 31
  3.7.10 Topics associated with key course characteristics ................................. 31
  3.7.11 Focus of course titles ............................................................................... 32
  3.7.12 Access to materials to support course content ........................................ 33

3.8 FINDINGS (PART 4): IMPACT AND CHALLENGES TO AOD TRAINING ....................... 35
  3.8.1 Changes to provision of AOD training ..................................................... 35
  3.8.2 Barriers to provision of AOD training ..................................................... 36

3.9 FEEDBACK FROM KNOWLEDGE EXCHANGE EVENT .................................................. 39

3.10 DISCUSSION ..................................................................................................... 41

3.11 IMPLICATIONS AND RECOMMENDATIONS FOR WLD DEPARTMENTS: .................. 46

3.12 IMPLICATIONS FOR RESEARCH .......................................................................... 47

3.13 CONCLUSION .................................................................................................... 47

REFERENCES ........................................................................................................... 48

APPENDICES ............................................................................................................ 51
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We very much value the hard work and ongoing support from Kerry Lapworth, the Tilda Goldberg Centre Administrator who helped us at various points throughout this project. Finally, and by no means least, the PIs owe a great deal of gratitude to our Research Fellow, Debbie Allnock, for going above and beyond the call of duty and for providing maternity cover for Aisha Hutchinson so readily and ably. Without her skills and expertise this project would have been a far greater challenge. The three strands of the project involved a range of people and these are acknowledged separately below.

The following people have assisted us greatly in the development, piloting, analysis and write up of this project 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.

We also acknowledge members of our professional advisory group and those who piloted this survey for their time and input.
The research presented in this report is one part of a three part project exploring alcohol and other drugs in social care practice, education and employment-based training. In order to support its development, a small project advisory group (PAG) was established at the start of the project. 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 the LA survey strand in its development and piloting stage.

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 which allowed 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). It was held on 24th
January 2013 in central London. Further details of the programme and attendance at the KE
event can be found in the Summary report for the three strands (Galvani et al. 2013).
Strand 3: Local Authority Workforce Learning and Development Survey

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 in providing more AOD training.
3.1 Introduction

This final report presents findings from a three stranded project undertaken by a team of researchers at the Tilda Goldberg Centre (University of Bedfordshire), and builds on a national survey of social work and social care practitioners completed in 2010 (Galvani et al. 2011). The original survey focussed on social care practitioner’s experiences of working with people who use, and have problems with, alcohol and other drugs (AOD). The first of its kind in England, the survey explored the practice experiences of respondents as well as their training experiences and current training needs.

Amongst the key findings it was revealed that almost one third (32%) of Local Authority (LA) employed social workers and social care practitioners had not received any in-house (employer-based) training on AOD use and a further 51% had received two days or less. Just 6% had received more than three days’ in-house training on AOD use in the course of their career in the sector, which in some cases spanned several decades (Galvani et al., 2011).

As a result, the researchers felt it was important to determine whether the picture painted by the practitioners in relation to their employer-based AOD education and training was accurate, and whether a more solid evidence base could be gleaned from triangulating the data through additional evidence from local authority workforce development and learning departments. This led directly to the aims and objectives of this project and complements two other strands which a) establish the particular challenges faced by practitioners working with older people, people with learning disabilities and physically disabled people (PI: Dr Cherilyn Dance), and b) determine the nature and extent of education on alcohol and other drugs on social work qualifying programmes in England (PI: Dr Sarah Galvani). Full details of the whole project and each strand can be found in the Summary report (Galvani et al. 2013).

Local Authority WLD departments play an important role in preparing social care professionals to effectively work with service users (SWTF, 2009). Employment-based training is critical for ensuring high quality of care across the social care sector, underpinning modifications to practice and capacity of the workforce to respond to changes in values, methods and roles (Tilley et al., 2000; Manthorpe et al., 2010; Clark, 2001). It is a key responsibility of employers to establish the conditions in which well-trained professionals can be effective and deliver high quality services by equipping them to carry out their daily role as well as support continuing professional development (CPD) (SWTF, 2009; Skills for Care, 2010).

A brief literature review revealed no other studies focussed on AOD in employer-based training, in spite of alcohol and other drugs regularly appearing on social care practitioners’ caseloads. Current knowledge about social work training and preparedness has come from studies focussed on qualifying social work education programmes (see Harrison, 1992; Waterson & Morris, 2005) or views and experiences of frontline or student social workers (See Bina et al., 2008; Galvani and Hughes, 2010; Loughran et al., 2010).

3.2 Aims, objectives and research questions
The purpose of this strand was to explore the nature and extent of employer-based training on alcohol and other drugs (AOD) provided to social workers and social care practitioners working in Children’s (CS) and Adult (AS) services in England. Such knowledge can then be used to identify both best practice and barriers to such training, and guide recommendations to strengthen this area in the future.

Therefore, the research sought to answer the following questions:

1) What proportion of LA training departments provides training on alcohol and other drugs to social care practitioners?
2) For those who provide training on alcohol and others drugs to social care practitioners, what is the extent, length, provider type, coverage, target audience, level, frequency, delivery mode and content of this training?
3) What is the nature of follow up support and evaluation of this training?
4) What are the factors which impact on the provision of AOD training?
5) Have levels of training changed over the years and what are the reasons for this?
6) How are AOD training courses and programmes developed?
7) Do LA training departments have a training strategy for working with substance use and how is this strategy developed?
8) What materials do LA training departments draw upon to develop AOD training and how accessible are these materials?
9) What are the barriers to providing training on alcohol and drugs to social care practitioners?

### 3.3 Methodology

This section provides an overview of the methodology adopted for the survey of workforce learning and development departments.

**3.3.1 Methods**

A confidential online survey was developed to gather information about AOD training courses (see appendix 1). The online survey tool included primarily closed questions with a small number which were open, and was developed in consultation with the wider research team, the Project Advisory Group (PAG) and was tested through a pilot study. The survey was designed within Qualtrics, a flexible and creative online survey software ([https://www.qualtrics.com/](https://www.qualtrics.com/)). The survey included an information page and requested consent before participants could proceed to the main survey.

The survey tool included the following sections:

1. Characteristics of the Local Authority (LA) including region, rural/urban, type and; some characteristics of the respondent such as job title and length they had been in post;
4 Characteristics of AOD training including questions about course frequency, length, provider, target audience, content, level and mode of delivery; in addition, respondents were asked whether training was mandatory, whether it is followed-up with further support and evaluation; and whether the amount of AOD training had changed recently;
Development of AOD training, for example, whether there was a dedicated strategy, policies and tools for working with substance use, who contributes to training development, what materials are used to develop courses and what access trainers have to these materials, as well as barriers and enablers to the provision of training.

The survey was sent to all Local Authority workforce training departments for which the research team were able to gather contact details between June 2012 and August 2012. All Directors of Children’s Services and Directors of Adult Social Services were informed of the study prior to disseminating the survey, and workforce development staff were pre-warned that the invitation was coming. A number of strategies were implemented to encourage participation, including several reminders, a marketing campaign at a regional Making Research Count session, and contact with ‘Learn to Care’ and ‘Skills for Care’ coordinators, who encouraged members to take part in the survey via emails out to their network.

3.3.2 Sampling frame
The aim was to construct a full sampling frame of all WLD departments in all Local Authorities in England. The sampling frame was developed via an examination of Local Authority websites, Google searches, and telephone contact with Local Authorities, seeking details for WLD departments. Upon identification, these departments were contacted to both confirm and/or identify the best person to assist with the research. This tended to be a WLD manager or officer. Identifying contacts was not always a straightforward task, as Local Authorities are organised differently, with a variety of names ascribed to workforce teams.

There were 152 Local Authorities in England at the time this research was conducted operating a range of different structures for their WLD departments. Some have separate training departments for Children’s (CS) and Adults’ Services (AS) and some have one joint training department providing training to all staff across CS and AS (for ease of reading, joint departments will be abbreviated to JTD throughout the report). The implication for this research was that in some LAs, there would be two WLD departments to identify and contact rather than one. In nine LAs it was not possible to determine the exact organisation of Children’s and Adults’ WLD departments because the research team was unable to make contact with the relevant people, and thus they have been excluded from the sampling frame.

The research team worked to gather contact details of relevant staff working in the remaining 143 LAs, representing 94% of all LAs in England. Table 3.1 shows the number of separate and joint WLD departments we attempted to contact. Of the 216 known WLD departments, contact details for a relevant staff member were obtained for 203 of these. In total, the research team distributed the survey to 200 contacts, after three Directors of services declined participation.

Table 3.1: Number of known separate and joint WLD departments

<table>
<thead>
<tr>
<th>WLD departments delivering training to</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s services only</td>
<td>73 (34%)</td>
</tr>
<tr>
<td>Adults’</td>
<td>73 (34%)</td>
</tr>
</tbody>
</table>
Comparison of LAs within and outside the sampling frame was carried out using the Chi-square statistic to determine if there were any significant differences evident that may bias the sample. This was completed by LA region ($\chi^2 = 1.40, df=4, p=.845$) and LA type ($\chi^2 = 2.93, df=3, p=.403$), and there were no significant differences identified which means that the sampling frame of 143 LAs is representative of all 152 LAs.

Table 3.2 below displays information about the number of surveys returned. Of the 98 surveys, four were multiple responses from the same LA. For example, surveys were returned from a WLD staff member as well as from a staff member associated with a specialist team such as LA Drug and Alcohol Action Team (DAAT). However, both surveys provided different and unique information about AOD training that, when combined, formed a full picture of training accessed by their WLD department. Taking these multiple responses into account, we received 98 survey responses representing 94 unique WLD departments, resulting in a 46% response rate for WLDs within the sampling frame. The WLDs that provided survey data cover 80 LAs representing 56% of LAs in the sampling frame. This was considered a good response rate from LA WLD departments to a non-compulsory, web-based survey which, on average, have been found to achieve an average of 33% (Nulty, 2008). Our response rate is also comparable with an annual survey carried out by Learn to Care with LA WLD departments in England (See, for example, Brown et al., 2008; Brown & Keen, 2009).

### Table 3.2: Number of surveys returned, by respondent, department and Local Authority

<table>
<thead>
<tr>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of surveys returned</td>
</tr>
<tr>
<td>Number which were from the same department</td>
</tr>
<tr>
<td>Number of unique WLD departments</td>
</tr>
<tr>
<td>Number of LAs represented by the surveys</td>
</tr>
</tbody>
</table>

Comparisons of LAs who responded and who did not respond were also carried out using Chi-square analysis as above by LA region ($\chi^2 = 11.82, df=8, p=.159$) and LA type ($\chi^2 = 10.100, df=6, p=.121$), showing no significant differences. This suggests that the responding LAs are broadly representative of all LAs in the sampling frame by these characteristics. Similarly, responder and non-responders were compared using department structure and no significant differences were found by LA region ($\chi^2=18.78, df=16, p=.280$) or type ($\chi^2=8.08, df=6 p=.232$). This suggests that the responding departments are broadly representative of the non-responding departments.

### 3.3.3 Pilot study

A copy of the draft pilot tool and information sheet was first distributed amongst the survey team for feedback before being distributed to the Project Advisory Group (PAG). Following this initial feedback, the survey tool was amended and uploaded into Qualtrics. We piloted
the survey with 6 workforce/development leads in Wales to test the survey tool with people who would not be taking part in the main stage survey, thereby reducing bias. However, we needed to further test the survey and had to draw on an additional 10 workforce/development leads in England. Seven responses were received from the pilot, with feedback included on the survey. This feedback was integrated into the final survey design.

3.3.4 Analysis

Two forms of analysis were undertaken with the dataset. First, quantitative analyses, including descriptive and bivariate analyses, were carried out on quantitative data using a statistical analysis software package, SPSS. Descriptive statistics were run for each closed survey question both for descriptive purposes and also to confirm whether the numbers were large enough for further bivariate analyses. The characteristics of the sample were compared with the full sampling frame characteristics to identify any significant differences between groups. While the majority of analysis is descriptive, bivariate analyses were run using some key explanatory variables on a range of survey questions to assess whether there were any relationships evident. Unfortunately the data was not amenable to multivariate analysis such as logistic regression. For all analyses using Chi-square, the critical cut-off point to determine significance was p<.05. Only differences which were found to be significant below this cut-off point will be reported. Second, a simple thematic qualitative analysis was carried out on the open questions, using a qualitative data management package (NVivo 9) to manage the data.

3.3.5 Limitations

There are several limitations of the study to note. First, the study provides only a partial picture of employment-based AOD training in England. Many social work and social care roles sit outside CS and AS within voluntary and independent agencies (Eborall & Griffiths, 2008) with separate training provision, however, limited resources and time precluded the extension of data collection to these sectors. It was also recognised that a lot of AOD training is likely to be available to social care practitioners in CS and AS by agencies such as the Drug Action Team (DAT), Drug and Alcohol Action Team (DAAT) or Primary Care Trusts (PCTs). However, this provision will only have been captured if this training was known by the Local Authority (LA) Workforce/ Learning Development (WLD) departments.

Second, due to survey design, we predominantly have information about ‘traditional’ training courses and methods of delivery specifically dedicated to AODs, however there are many more creative and potentially more appropriate modes of supporting continuing professional development and learning such as action learning sets or presentations in team meetings. Coverage of AODs on other training courses such as safeguarding or mental health is unlikely to have been picked up by the survey. Third, in an effort to reduce questionnaire ‘fatigue’, the survey was constructed to request information on up to six AOD courses only. Fifteen respondents, however, said that their WLD department provided more than six courses in 2011-2012 resulting in some missing data in these cases. Finally, the survey was distributed to WLD departments in the midst of widespread restructuring and changes, within a context of austerity, which may have impacted on the time and capacity of people to respond to the survey. However, a 46% response rate for this online survey falls above the average 33% response rate for online surveys more generally (Nulty, 2008).
3.3.6 Ethics

Ethical issues were considered at every stage of the research. An information sheet was developed setting out participant rights, with specific reference to data protection and an assurance of confidentiality. This information was provided at the start of the survey, and participants were required to give their consent to take part before they were able to proceed with the survey. Questions included in the survey were only related to their professional roles and the training courses offered or accessed by their departments; no other personal or sensitive information was collected. Participants were given an opportunity at the end of the survey to withdraw and were given details of the research team so that they could withdraw at a later stage if they wished.

Given that the survey was developed and completed online, data security was of paramount importance. The survey itself was housed on the University of Bedfordshire website which adheres to a strict policy of data protection. Further, the web-survey development company Qualtrics offer a secure website for responses which are encrypted when downloading. All documents related to the project were kept on a secure drive and only the research team had access to the project files.

Ethical approval was sought and received from the Institute of Applied Social Research (IASR) and University of Bedfordshire as well as from the Association of Directors of Children’s Services (ADCS) and Association of Directors of Adult Social Services (ADASS) (May, 2012).

3.3.7 Presentation of findings

There are four different baseline figures which were used throughout the report, depending upon the focus of the analysis. Therefore, the figures vary throughout the presentation of findings in the following ways:

1) Analyses profiling characteristics of Local Authorities from which surveys were returned, such as region and type, will use 80 as the baseline.
2) Analyses profiling individual respondents and for which a full picture of training is required will use 98 as the baseline.
3) Analyses profiling WLD departments will use 94 as the baseline (excluding multiple responses by directorates) to avoid duplicating characteristics. An example would be describing whether or not WLD departments are organised jointly or separately for practitioners in CS and AS.
4) Analyses profiling AOD-related training courses will use 178 as the baseline. All AOD-related training courses described by respondents became, in their own right, units of analysis to examine overall characteristics of these courses.

Throughout the report, the baseline figure used in the analysis will be provided for ease of reading. Analytic techniques used in the report were descriptive frequencies such as averages and medians, and bivariate analyses were carried out using the Chi-square statistic to explore differences among AOD-related training courses.
3.4 Findings: Sample characteristics

This section will present characteristics of the 80 LAs, 94 WLD departments and 98 respondents represented in the sample.

3.4.1 LA type

Over a third of responders were unitary authorities, and a further third, respectively, were London boroughs. The final third comprise both non-metropolitan counties and metropolitan boroughs which is representative of LA types across England, as seen in table 3.3.

Table 3.3: Local Authority type, by Local Authorities and Workforce/Learning Development Departments in the sample

<table>
<thead>
<tr>
<th>Local Authority type</th>
<th>Number by Local Authority (n=80)</th>
<th>Number by WLD department (n=94)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unitary authorities</td>
<td>27 (34%)</td>
<td>31 (33%)</td>
</tr>
<tr>
<td>London boroughs</td>
<td>24 (30%)</td>
<td>30 (32%)</td>
</tr>
<tr>
<td>Non-metropolitan counties</td>
<td>15 (19%)</td>
<td>17 (18%)</td>
</tr>
<tr>
<td>Metropolitan boroughs</td>
<td>14 (18%)</td>
<td>16 (17%)</td>
</tr>
</tbody>
</table>

3.4.2 LA setting

Almost half of the LAs and WLD departments represented in the sample provided training for practitioners working in both urban and rural environments (see table 3.4 below), with just over a third focussing on urban issues specifically. Only small percentages of LAs and WLD departments were predominantly rural or suburban.

Table 3.4: Local Authority setting, by Local Authority and Workforce/Learning Development Departments in the sample

<table>
<thead>
<tr>
<th>Local authority setting</th>
<th>Number by Local Authority (n=80)</th>
<th>Number by WLD department (n=94)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban/rural</td>
<td>37 (46%)</td>
<td>42 (45%)</td>
</tr>
<tr>
<td>Urban only</td>
<td>28 (35%)</td>
<td>36 (38%)</td>
</tr>
<tr>
<td>Rural</td>
<td>9 (11%)</td>
<td>10 (11%)</td>
</tr>
<tr>
<td>Suburban</td>
<td>6 (8%)</td>
<td>6 (6%)</td>
</tr>
</tbody>
</table>

3.4.3 LA region

The LAs and WLDs represented in the sample are spread across all regional areas, which have been classified into five categories (derived from the nine categories used by the Census) for the purposes of analysis: the Yorkshire & Humber and North East; the East Midlands and Eastern regions; West Midlands and the North West; South East and South West; and London. Table 3.5 below illustrates the coverage of regional areas, with a third of the sample coming from the London area, and only 11% from the Yorkshire & Humber and North East regions. This pattern is representative of the regional distribution of LAs in England.
Table 3.5: Local Authorities and Workforce/Learning Development Departments by region

<table>
<thead>
<tr>
<th>Local authority region</th>
<th>Number by Local Authority (n=80)</th>
<th>Number by WLD departments (n=94)</th>
</tr>
</thead>
<tbody>
<tr>
<td>London</td>
<td>24 (30%)</td>
<td>30 (32%)</td>
</tr>
<tr>
<td>West Midlands &amp; North West</td>
<td>20 (25%)</td>
<td>22 (23%)</td>
</tr>
<tr>
<td>South East &amp; South West</td>
<td>17 (21%)</td>
<td>19 (20%)</td>
</tr>
<tr>
<td>East Midlands &amp; Eastern</td>
<td>10 (12%)</td>
<td>11 (12%)</td>
</tr>
<tr>
<td>The Yorkshire &amp; Humber and North East</td>
<td>9 (11%)</td>
<td>12 (13%)</td>
</tr>
</tbody>
</table>

3.4.4 WLD department structure

As mentioned previously, WLD departments are structured differently within LAs. Figure 3.1 below graphically illustrates the number of surveys returned from WLD departments providing for practitioners in CS only; WLD departments providing for practitioners in AS only; and WLD departments providing for practitioners in both CS and AS. There was an approximately equivalent spread (one-third each) of responses from all three directorates, which is representative of the WLD departmental structure across England.

Figure 3.1: Structure of WLD departments, by total known number in the sampling frame (n=203) and number in the sample (n=94)

3.4.5 Target audience

Almost all of the 94 WLDs provided training (not just AOD training) to social work qualified practitioners and social work students in the last year (see table 3.6 below). A significant percentage of departments provided training to social care staff and other allied professionals. Almost half of departments additionally provided training to private, voluntary and independent workers which include carers, health professionals, foster carers, housing staff, the police, probation or other members of the social care workforce (both internal and external to the LA).
### Table 3.6: Professional group in receipt of any training by Workforce/Learning Development Departments

<table>
<thead>
<tr>
<th>Professional group receiving AOD training</th>
<th>Number by WLD department (n=94)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Work qualified practitioners and Social Work students</td>
<td>92 (98%)</td>
</tr>
<tr>
<td>Social care staff (non-social work qualified)</td>
<td>84 (89%)</td>
</tr>
<tr>
<td>Other allied professionals</td>
<td>74 (79%)</td>
</tr>
<tr>
<td>Private, voluntary and independent (PVI) workers</td>
<td>40 (43%)</td>
</tr>
</tbody>
</table>

3.4.6 Provider type

Respondents were asked to estimate the proportion of all training (not just AOD training) provided in different forms (in-house social care trainers, commissioned external trainers, or joint training with colleagues from health, education or other specialists). Table 3.7 below shows that, on average, 31% of all training is provided by in-house social care trainers; almost 20% is provided jointly; and almost half (47%) is provided by external trainers. A comparison of ‘all’ training and AOD training is included in a later analysis.

### Table 3.7: Workforce/Learning Development Departments training provider

<table>
<thead>
<tr>
<th>Provider type</th>
<th>Per cent by WLD department (n=94)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training provided by commissioned external trainers</td>
<td>47%</td>
</tr>
<tr>
<td>Training provided by in-house social care trainers</td>
<td>31%</td>
</tr>
<tr>
<td>Training provided jointly with colleagues from health, education or other specialists</td>
<td>19%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
</tr>
</tbody>
</table>

3.4.7 Organisational changes

A final characteristic of WLD departments considered in the survey was whether there had been recent structural or organisational changes. This enabled us to explore whether any such changes had implications for the provision of AOD training. Staff within 74 of 94 WLD departments (76%) reported that their departments had been the subject of recent organisational change.

3.4.8 Individual respondent characteristics (job title and length in post)

A final consideration in this section is the profile of the individual respondents themselves (n=98). The only respondent-related questions included in the survey asked for job titles and length in post. The majority of respondents had been in post for 1-4 years (41%) or 5+ years (47%) indicating that respondents were experienced and knowledgeable about their roles.

As the job titles below reveal, people in slightly different roles completed the surveys. This variable was used to ensure that variations in responses were not due to different roles rather than difference in provision, particularly between responses given by workforce development managers and other workforce development staff, such as officers and consultants.
Table 3.8: Job titles/roles of respondents, number and per cent (n=98)

<table>
<thead>
<tr>
<th>Job title categories</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce development managers</td>
<td>50 (51%)</td>
</tr>
<tr>
<td>Workforce development officers</td>
<td>29 (30%)</td>
</tr>
<tr>
<td>Workforce development consultants</td>
<td>9 (9%)</td>
</tr>
<tr>
<td>Substance use training officers</td>
<td>5 (5%)</td>
</tr>
<tr>
<td>LSCB training coordinators</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>Workforce development staff for mental health</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Social care manager</td>
<td>1 (1%)</td>
</tr>
</tbody>
</table>

The majority of respondents were workforce development managers, officers or consultants (90%) with an additional eight in other specialist training roles in service areas such as mental health, safeguarding and AOD use, and one social care manager. Five of these eight were in specialist AOD use training roles. Chi square tests were used to test whether those based in a WLD department responded differently to those based in other teams with regard to a) respondent knowledge of a strategy for training on AOD abuse, b) respondent knowledge of the existence of tools for working with AOD abuse, and c) respondent knowledge of policy/guidelines for working with AOD use. No statistically significant differences in responses between workforce and non-workforce staff were observed. Additionally, managerial versus non-managerial roles were assessed for differences in knowledge about training strategies and tools for working with AOD abuse. A significant difference was found between managers and non-managers in their awareness of policy and practice guidance, and unexpectedly, non-managers were more likely to report that they were aware of policy and practice guidance for social care practitioners. Thus, there may be some bias in responses between managers and non-managers on this particular issue.
3.5 Findings (Part 1): The extent of employment-based AOD training

3.5.1 Amount of AOD training

AOD training was provided across the majority (83%, n=77/94) of WLD departments in 2011-2012.

Of the 81/98 respondents who said that AOD training was provided by their WLD departments, only 68 reported the number of courses delivered in the past year. Of these, the average number of courses delivered was 4.56 (median 2) within a range of 1-23. Table 3.9 below illustrates that while there are a minority of WLD departments providing a large number of AOD courses, the majority of WLD departments only provided up to 2 courses to social care practitioners in 2011-2012.

Table 3.9: Number of AOD training courses provided, by respondent (n=85/98)

<table>
<thead>
<tr>
<th>Number of courses provided</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 AOD courses</td>
<td>17 (20%)</td>
</tr>
<tr>
<td>1-2 AOD courses</td>
<td>34 (40%)</td>
</tr>
<tr>
<td>3-5 AOD courses</td>
<td>17 (20%)</td>
</tr>
<tr>
<td>6-10 AOD courses</td>
<td>7 (8%)</td>
</tr>
<tr>
<td>11+ AOD courses</td>
<td>10 (18%)</td>
</tr>
</tbody>
</table>

There were some significant differences revealed between the average number of courses provided across LA types and region. An Analysis of Variance (ANOVA) (a test of difference between group means) was utilised to compare the average number of courses provided by type of authority and region. The ANOVA showed significant differences in average number of courses provided by LA type (F=3.20; p<.05). Unitary Authorities (n=27) provided the largest average number of courses (6) in the last year compared to other Local Authority types and London Boroughs. London Boroughs provided the lowest average number of courses (2). In terms of region, the West Midlands and North West regions provided the highest average number of courses in the past year (8.06) and Yorkshire & Humber and North East region (2.27) and London (2.32) having provided the fewest (F=3.0; p<0.05).

Data on alcohol consumption in the last week published by the Office for National Statistics (ONS) (2011) were consulted to explore whether the observed regional differences in average number of courses provided might relate to regional differences in drinking patterns. In other words, are more courses provided on average in regions with higher consumption levels to meet service needs? However, the data do not show a clear pattern, which might reflect the different categories used for analysis in this report. While London ranks the lowest on drinking in the last week (60%), the Yorkshire & Humber region (which provides, on average, fewer training courses) ranks the highest on consumption in the last week (72%). It is possible that fewer numbers of courses are provided in London and other regions due to pooled training provision across LAs (such a tri-borough training agreement between Westminster City Council, Hammersmith and Fulham London Borough and Kensington and Chelsea Royal Borough).

1 Two outliers of 40 and 44 courses were removed from this analysis.
3.5.2 **Mandatory nature of training**

AOD training in 2011-2012 was only reported as mandatory by 23% of respondents (n=15/64) who said that they provided this training in the last year. Therefore over three-quarters (77%) of those who responded to this question (n=49) said that this training was optional. For those who said that AOD training was mandatory, this included mandatory training for all social care practitioners (n=4), all social care practitioners in Children’s Services (n=3), for newly qualified social workers (n=1), for AOD treatment services (n=2), for Approved Mental Health Practitioners (n=1), foster carers (n=1) and safeguarding practitioners (n=1).

3.5.3 **Facilitating provision of AOD training outside the local authority**

Respondents were also asked whether they facilitated staff access to other forms of AOD training not directly commissioned and provided by the WLD department. Of those who said their departments directly provided AOD training and answered this question (n=62/98), 74% (n=46) said they also facilitated access to training by other providers outside of the LA. Of those said their departments did not provide AOD training (n=15), 73% (n=11) facilitated access to AOD training outside of the LA. Therefore only 4 respondents reported that their WLD departments neither provided nor facilitated any AOD training at all. Table 3.10 below lists the types of training and opportunities that WLD departments report signposting or facilitating staff access to, with Making Research Count and Research in Practice – collaborative research dissemination services in the UK - training most frequently reported.

**Table 3.10: Other training providers (n=57)**

<table>
<thead>
<tr>
<th>Other training type</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research in Practice</td>
<td>19 (33%)</td>
</tr>
<tr>
<td>Making Research Count</td>
<td>18 (31%)</td>
</tr>
<tr>
<td>Other external events and conferences</td>
<td>15 (26%)</td>
</tr>
<tr>
<td>Local DAAT</td>
<td>13 (23%)</td>
</tr>
<tr>
<td>Other health based training</td>
<td>8 (14%)</td>
</tr>
<tr>
<td>Other briefings, seminars, team meetings or forums</td>
<td>8 (14%)</td>
</tr>
<tr>
<td>LSCB</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>

**Summary of key findings (Part1): Extent of AOD training**

- In the past year (2011-2012), alcohol and other drugs (AOD) training was provided by 77 WLD departments (82%).
- However, almost one fifth (n=16, 18%) of WLD departments had not delivered any AOD training in the past year.
- Seventy-five per cent 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.
- WLD departments delivered, on average, 4.56 courses in 2011-2012.
- Regional data shows that London and Yorkshire & Humber and the Northeast provided the fewest average courses in 2011-2012; with West Midlands and North West provided the greatest average number of courses in 2011-2012.
• AOD training was mandatory in less than one-quarter of WLD departments.
3.6 Findings (Part 2): The development of AOD training

As well as clarifying the extent of employment-based AOD training provided, we were also interested in understanding more about how WLD departments develop training on AOD issues, who may be involved in its development, and whether respondents feel they have sufficient access to materials on working with AOD use issues to utilise in training. In particular, we were interested to know what priority is given to this kind of training in strategic or policy documents.

3.6.1 Dedicated AOD training strategy

Twenty-one of 63 respondents reported that there is a dedicated AOD training strategy. Six of these respondents (29%) said that this strategy was the same for both Children’s and Adults’ Services and 11 (52%) said it was not the same. Information provided by 18 respondents indicated that strategies are either developed in-house (n=12) or by specialist agencies such as the DAAT (n=3). The final three said that their strategies were currently under review or being developed. Unfortunately we were unable to access any copies of these strategies and so we are unable to comment on the level and nature of coverage.

3.6.2 Policy and practice guidelines

Almost half (n=60, 45%) of those who responded to the question on policy and practice guidelines were aware of specific AOD policy or practice guidelines provided by their LA to support social workers and social care practitioners in their work with AOD use. Just over a quarter (26%) of these said that these policies were the same for Children’s and Adults’ Services; 22% said they were not the same; and the majority (52%) did not know. Six respondents from Children’s Services departments named specific policies relating to children and/or young people, for example, ‘meeting the needs of children or unborn children whose parents have substance misuse problems’ and a policy on ‘working with at-risk youth’. One respondent mentioned that they work to the National Treatment Agency (NTA) and Department for Education and Skills guidance. Three respondents from joint CS and AS training departments named specific policies such as the joint strategic needs assessment; a health and well-being strategy; a protocol on Hidden Harm; and a policy for working with intoxicated young people. Finally, two respondents from an AS training department said that there were policy guidelines but did not specify their exact nature.

It should be noted that the earlier analysis of differences between workforce development and non-workforce development professionals indicated that there may be some bias within these findings.

3.6.3 Tools for working with AOD use

Respondents were asked if their WLD departments provided tools to social workers and social care practitioners for identifying and assessing AOD use issues with service users. Over half of those who responded to this question (59%) said that they did. Ten (28%) of these said the tools were the same for Children’s and Adults’ Services; 37% that they were not the same; and the remainder (34%) did not know. Twenty-three of these mentioned specific tools, including: an assessment and care management procedure; a non-specific alcohol assessment tool; a generic tool for young people; tools that are part of the Framework Assessment; the Substance Use Screening Tool (SUST); and a generic tool for
alcohol (the respondent provided no further clarification); Asset assessment tool; a Barnardo’s assessment tool; a bespoke in-house assessment tool; a Drug Use Screening Tool (DUST). One screening tool was named as SMART, but it is not clear what the acronym stands for and may well be a bespoke tool.

Table 3.11: Training strategy, policy and practice guidelines and tools

<table>
<thead>
<tr>
<th>Description</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedicated training strategy in place for alcohol and other drugs (n=63)</td>
<td>21 (33%)</td>
</tr>
<tr>
<td>Respondent awareness of policy or practice guidelines provided by LA to support social care practitioners in their work (n=60)</td>
<td>27 (45%)</td>
</tr>
<tr>
<td>Provision of tools for identifying and assessing AOD (n=61)</td>
<td>36 (59%)</td>
</tr>
</tbody>
</table>

3.6.4 Developing AOD training

A range of people in different roles contributed to the development of AOD training, as table 3.12 below indicates. Common contributors were members of the local DAAT, LSCB and social work and social care practitioners. Less common contributors were service users and a strategic lead for substance use. Others included a multi-agency youth services group; a refugee and migrant forum; a faith forum; voluntary sector services; local organisations commissioned in the area; learning and development team; specialist workers; and a carers support worker.

Table 3.12: Roles involved in the development of AOD training

<table>
<thead>
<tr>
<th>Roles</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members of the local DAAT</td>
<td>42 (52%)</td>
</tr>
<tr>
<td>Members of the LSCB</td>
<td>39 (48%)</td>
</tr>
<tr>
<td>Social work and social care practitioners</td>
<td>32 (40%)</td>
</tr>
<tr>
<td>Members of the PCT</td>
<td>30 (37%)</td>
</tr>
<tr>
<td>Service managers</td>
<td>26 (32%)</td>
</tr>
<tr>
<td>Team managers</td>
<td>23 (28%)</td>
</tr>
<tr>
<td>Strategic lead for substance use</td>
<td>19 (24%)</td>
</tr>
<tr>
<td>Service users</td>
<td>17 (21%)</td>
</tr>
<tr>
<td>Other</td>
<td>8 (10%)</td>
</tr>
<tr>
<td>None of the above</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1 (1%)</td>
</tr>
</tbody>
</table>

Finally, respondents were asked to indicate what types of resources and materials they accessed for use in AOD training courses delivered through their departments. The highest percentage of respondents reported that they accessed key social work/social care texts with just over a third having accessed key substance use texts. One fifth named ‘other’ materials, such as policy documents, research findings, joint protocols and an Essential Shared Capabilities (ESC) Dual Diagnosis module. Just under a fifth respectively, accessed Research in Practice materials and resources about motivational interviewing. A small number highlighted Making Research Count (MRC) and Research in Practice (RIP) resources, although it should be noted that groups do not offer specialist AOD materials or national resources. It does occasionally provide regional events reporting research relating to substance use. A small number said ‘none of the above’ but did not provide detail about the
materials that they *did* use. Finally just over 10% said they did not know what materials were utilised in AOD training.

**Table 3.13: Resources and materials accessed to support AOD training development**

<table>
<thead>
<tr>
<th>Resources/materials</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key social work/social care texts</td>
<td>29 (36%)</td>
</tr>
<tr>
<td>Key substance use texts</td>
<td>27 (33%)</td>
</tr>
<tr>
<td>Other (including policy documents, research findings, SCODA and joint protocols, ESC Dual Diagnosis module)</td>
<td>16 (20%)</td>
</tr>
<tr>
<td>Research in practice</td>
<td>15 (19%)</td>
</tr>
<tr>
<td>Resources on motivational interviewing</td>
<td>15 (19%)</td>
</tr>
<tr>
<td>Making Research Count</td>
<td>10 (12%)</td>
</tr>
<tr>
<td>None of the above</td>
<td>9 (11%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>10 (12%)</td>
</tr>
</tbody>
</table>

3.6.5 **Course follow up and evaluation**

Respondents (n=98) were also asked to describe whether any follow-up mechanisms were provided by the trainers or training team following AOD training courses, and whether AOD training courses were evaluated for impact on practice.

Provision of follow-up support by the training team was reported by 25 respondents (40%) and 31 (51%) respondents evaluate impact on practice. Open questions provided space for respondents to give detail about these follow-up mechanisms and evaluation strategies. Twenty-one provided further detail about the ways in which they provided follow-up support after training; however, seven respondents interpreted this question to mean follow-up evaluation and two respondents provided responses unrelated to the question, thus these nine are excluded from the analysis. The responses provide only brief detail so it is difficult to assess the extent to which the following follow-up mechanisms support staff learning:

1. Training knowledge is addressed through reflective supervision (n=3).
2. Provision of advice and guidance about how the learning can be implemented in the workplace (n=2).
3. Informal follow-up, for example, via email with the trainers if needed (n=2).
4. Follow-up is tailored to the needs of specialist workers (n=1).
5. Follow-up is provided through an e-learning programme (n=1).
6. Signposting staff to other training or resources (n=1).
7. Identification of additional learning needs via follow-up contact (n=1). Follow-up assessments are undertaken and workbook guidance provided (n=1)

Twenty-five respondents provided detail about evaluation strategies and three areas were mentioned:

1. Reflection and discussion in supervision and during appraisals (n=8);
2. Evaluation forms at the end of the course (n=6) and
3. Some form of delayed evaluation of impact on practice (n=11). Only one respondent specified that courses are evaluated three months after training.
Summary of key findings (Part 2): Development of AOD training

- Just over one quarter of WLD departments (28%) said there was a dedicated training strategy or a series of programmes on working with substance use for social care/ work and social care practitioners; slightly more reported awareness of policies and practice guidelines for working with AOD concerns (40%).
- Almost 60% of WLD departments said they provided tools or resources for assessing and identifying AOD use to support social care professionals in their work.
- DAATs and LSCBs representatives 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.
- A range of materials were utilised in the development of AOD training; key social work/social care texts were most commonly reported (36%).
- Some follow-up mechanisms by the trainers or training team were reported, although the methods were variable and many WLD departments do not follow-up after training at all.
- Only half of WLD departments evaluated their AOD courses and of those that did, only a modest number reported the use of evaluation forms and delayed follow-up.
- Respondents commonly (more than 80%) reported that they had access to materials on core issues such as alcohol and its effects, drugs and their effects, impacts on physical and mental health and types of treatments/interventions available.
- Fewer respondents reported having access to materials on AOD use and issues of ethnicity and culture, gender dimensions, substance use theory and, importantly, how to talk about alcohol and drug problems.
3.7 Findings (Part 3): Characteristics of AOD training

Respondents were asked to name each AOD course their department provided in the past year, and were given space to name up to six courses only. Each course was then followed by a range of questions about course characteristics such as level, frequency, length, provider, substances and topics covered. Some WLD departments offered more than 6 AOD courses in the past year and this is a limitation of the survey, as it became clear that some WLD departments offered more than 6. Therefore generalizations to all AOD training must be done with caution. This section presents descriptive characteristics of specific AOD training courses, and, where relevant, any significant relationships between course characteristics are illustrated.

As previously noted, 68 of 77 WLD departments that provided AOD training in the past year offered detail about the number of courses provided. In total these departments delivered 385 courses in the past year. Not all WLD respondents were able to provide full details of all of these courses, however, due to space limitations on the survey. We have detail on all courses provided by 53 WLD departments; and detail on a partial number of courses for an additional 15 WLDs. In total then, we have data on 190 courses across 68 WLD departments. Of those which provided follow-up detail on course characteristics, 11 were excluded as duplicates. Therefore, the findings presented below are based on 178 courses about which respondents provided further details.

3.7.1 Target audience

Respondents in WLD departments were asked to indicate to which professionals they targeted their AOD training. For example, they were asked whether they targeted courses at social workers in CS and/or AS, other social care staff in CS and/or AS or other allied professionals in CS and/or AS. They could select as many target audiences as were relevant for each course. Table 3.14 (below) shows that courses were targeted more commonly at professionals in Children’s Services than Adults’ Services. Social workers in both Children’s and Adults’ Services were targeted most often in comparison to other social care staff and other allied professionals. The pattern in provision seen in table 3.14 does not stem from unequal response proportions in the sample, as approximately one third of respondents were in CS training departments, one third were in AS training departments, and one third were from joint CS and AS training departments.

<table>
<thead>
<tr>
<th></th>
<th>Children’s Services</th>
<th>Adults’ Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social workers</td>
<td>112 (70%)</td>
<td>90 (51%)</td>
</tr>
<tr>
<td>Other social care staff only</td>
<td>105 (65%)</td>
<td>77 (43%)</td>
</tr>
<tr>
<td>Other allied professionals</td>
<td>102 (57%)</td>
<td>69 (39%)</td>
</tr>
</tbody>
</table>

Two new variables were created to explore specific target audiences more closely. One new variable reflects target audience by directorate – in other words, this reflects courses aimed at CS only, AS only, or JTDs. A second variable was created to reflect the professional group to which courses were targeted – courses which are targeted only at social workers for example, only at other social care staff, or whether courses were targeted at all
professionals (including social workers and other social care staff). Table 3.15 indicates that the majority of courses were aimed at all professionals (including social workers and other social care staff). Few courses were targeted solely at social workers as a professional group or other social care staff as a professional group. Although a slightly higher percentage of courses in AS only were aimed at social workers only than those in CS only or JTDs, the numbers within these groups are very small which means further tests for significant differences are likely to be unreliable.

**Table 3.15: Target audience of AOD training by directorate and professional (n=156)**

<table>
<thead>
<tr>
<th></th>
<th>CS only n(%)</th>
<th>AS only n (%)</th>
<th>AS and CS n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social workers only</td>
<td>5 (8%)</td>
<td>10 (27%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Other social care staff only</td>
<td>5 (8%)</td>
<td>2 (5%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>All professionals</td>
<td>52 (84%)</td>
<td>25 (67%)</td>
<td>50 (88%)</td>
</tr>
<tr>
<td>Total</td>
<td>62 (100%)</td>
<td>37 (100%)</td>
<td>57 (100%)</td>
</tr>
</tbody>
</table>

**3.7.2 Substances covered on courses**

Based on a multiple choice prescribed list, respondents were asked to indicate, for each course named, which substances were the focus of the course. Table 3.16 illustrates that of 165 courses with available data, half covered all substances, including prescribed medications and poly-substance use; 16% covered alcohol and drugs but excluded prescribed medications and/or poly-substance use; 10% focused on drugs only and alcohol only.

**Table 3.16: Focus on AOD training courses (n=165)**

<table>
<thead>
<tr>
<th>AOD training focus</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All substances, including alcohol, other drugs, problematic prescribed medications and poly-substance use</td>
<td>82 (50%)</td>
</tr>
<tr>
<td>Alcohol and other drugs (excluding prescribed drugs and poly-substance abuse)</td>
<td>27 (16%)</td>
</tr>
<tr>
<td>Drugs only</td>
<td>16 (10%)</td>
</tr>
<tr>
<td>Alcohol only</td>
<td>16 (10%)</td>
</tr>
<tr>
<td>Alcohol and other drugs (including prescribed drugs)</td>
<td>14 (8%)</td>
</tr>
<tr>
<td>Alcohol and other drugs (including poly-substance use)</td>
<td>10 (6%)</td>
</tr>
</tbody>
</table>

**3.7.3 Course length**

Respondents provided data about the length of courses for 162 out of the total 178 courses. The shortest course was one hour and the longest course was 16 hours, however the average length across all the courses was 6.3 hours (with a median of 6.0 hours). The length of courses was transformed into a categorical variable with three categories: 1-3.5 hours; 3.51-7 hours; and 7.1-17 hours. Figure 3.2 graphically illustrates the breakdown of these categories, and that the majority of AOD courses lasted between 3.5-7 hours.
3.7.4 Provider type

Table 3.17 presents data on the provider of AOD training courses. The most common provider of AOD training was externally commissioned trainers, followed by joint provision with other colleagues from other departments within the LA or specialist AOD use services. The least common provider for AOD training was in-house social care trainers.

Table 3.17: Who provides AOD training? (n=165)

<table>
<thead>
<tr>
<th>Provider type</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AOD training provided by externally commissioned trainers</td>
<td>65 (39%)</td>
</tr>
<tr>
<td>AOD training provided jointly with colleagues from health, education or other specialist services</td>
<td>59 (36%)</td>
</tr>
<tr>
<td>AOD training provided by in-house social care trainers</td>
<td>36 (22%)</td>
</tr>
<tr>
<td>Other</td>
<td>5 (3%)</td>
</tr>
</tbody>
</table>

Provider types for AOD training were compared with provider types for all training. Significance tests could not be utilised because the data on AOD training uses a different unit of analysis than the data on all training. However, the comparison reveals that a much larger proportion of AOD courses were jointly run with other specialist colleagues as compared to all training in general. Fewer AOD courses were run in-house and by externally commissioned trainers than all other training combined. Figure 3.3 illustrates this trend.
3.7.5 Course level
Of 155 courses providing data on level of provision, half (n=83) were reported to be basic, with a further 41% (n=68) reported to be intermediate. Intermediate was defined as a course assuming some prior knowledge, and advanced as a course requiring some specialist knowledge. Relationships with other course characteristics were explored and they reveal that there are some significant differences in level of course by length of course ($\chi^2 = 22.7$, df=2, $p<.000$). Basic courses are significantly more likely than intermediate or advanced courses to be delivered in a half day and intermediate courses are more likely than basic courses to be delivered in up to one day. The number of advanced courses available for analysis was insufficient so it is not possible to note any significant patterns for these courses.

Bivariate analysis also showed significant differences in level of training by target audience by directorate ($\chi^2 = 13.2$, df=4, $p<.010$). Basic courses were more likely to be targeted at professionals across CS and AS than at professionals in CS directorates or AS directorates only. Intermediate courses were more likely to be delivered to professionals in CS only.

3.7.6 Course frequency
Just over a third of all training courses were provided to staff twice a year, with a quarter being provided once a year and as requested/needed (see table 3.18). The category ‘As requested/needed’ must be interpreted cautiously because it does not clarify any frequency of provision. Eighteen per cent of courses are provided at some other frequency, however, this was not well defined in the survey making interpretation of this category also difficult. Analyses were run to explore the relationship of frequency with other course dimensions, including only those courses provided once or twice a year, and no significant associations were revealed by frequency of training.
Table 3.18: Frequency of training (n=166)

<table>
<thead>
<tr>
<th>Frequency of training</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twice a year</td>
<td>56 (34%)</td>
</tr>
<tr>
<td>As requested / needed</td>
<td>41 (25%)</td>
</tr>
<tr>
<td>Once a year</td>
<td>40 (24%)</td>
</tr>
<tr>
<td>Other</td>
<td>29 (18%)</td>
</tr>
</tbody>
</table>

3.7.7 Mode of delivery
Respondents were asked to describe the mode of delivery of their AOD training courses. They were given a range of choices including face-to-face, multi-disciplinary, web-based, service user led and other (to which they were asked to specify). There was a great deal of overlap amongst these categories so for ease of interpretation and analysis; three categories were created to remove the overlap. Of those courses where detail was provided (n=152), a majority (62%) were delivered face-to-face only. Over a third (32%) were considered face-to-face in a multidisciplinary context; and a small number (7%) were face-to-face and something else (including web-based or service user led).

3.7.8 Course content
Content of AOD training was explored in the survey using a list of 19 topic areas, with space provided for respondents to describe any other content not listed. Table 3.19 below lists these topic areas in order of coverage. Data was available for 169 courses, and of these, almost three quarters included teaching on attitudes and values relating to AOD use and problems. Reasons people use and misuse, alcohol and its effects and working with or referring to specialist alcohol and drug workers were also fairly common topic areas covered in AOD training courses. Areas with least coverage were substance use and issues of ethnicity and culture, gender issues and theory of substance misuse.

Table 3.19: Content delivered in AOD training courses (n=169)

<table>
<thead>
<tr>
<th>Topic area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes and values relating to substance use and problems</td>
<td>122</td>
<td>72</td>
</tr>
<tr>
<td>Reasons people use and misuse</td>
<td>113</td>
<td>67</td>
</tr>
<tr>
<td>Alcohol and its effects</td>
<td>114</td>
<td>67</td>
</tr>
<tr>
<td>Working with or referring to specialist alcohol and/or drug workers</td>
<td>109</td>
<td>64</td>
</tr>
<tr>
<td>Impact of physical health</td>
<td>104</td>
<td>62</td>
</tr>
<tr>
<td>Identifying problematic alcohol use</td>
<td>102</td>
<td>60</td>
</tr>
<tr>
<td>Illegal drugs and their effects</td>
<td>102</td>
<td>60</td>
</tr>
<tr>
<td>How to assess risk relating to drug or alcohol issues</td>
<td>97</td>
<td>57</td>
</tr>
<tr>
<td>Impact on mental health</td>
<td>97</td>
<td>57</td>
</tr>
<tr>
<td>Types of intervention/treatment available</td>
<td>95</td>
<td>56</td>
</tr>
<tr>
<td>Impact on children and families and parenting</td>
<td>92</td>
<td>54</td>
</tr>
<tr>
<td>Identifying problematic drug use</td>
<td>88</td>
<td>52</td>
</tr>
<tr>
<td>How to talk about drug or alcohol issues with service users</td>
<td>87</td>
<td>51</td>
</tr>
<tr>
<td>Prescribed drugs and their effects</td>
<td>75</td>
<td>44</td>
</tr>
<tr>
<td>Drug and alcohol government policy</td>
<td>75</td>
<td>44</td>
</tr>
<tr>
<td>Substance misuse theory</td>
<td>58</td>
<td>34</td>
</tr>
<tr>
<td>Substance use and issues of ethnicity and culture</td>
<td>47</td>
<td>28</td>
</tr>
</tbody>
</table>
### 3.7.9 Topics by hours of training

The average number of topics covered per course was 9 (with a median also of 9). We also examined the number of topics covered by length of course and discovered increases in number of topics reported as length of course increased. An Analysis of Variance (ANOVA) on course length by number of topics reported revealed that these differences in mean are significant (F=2.250, p=.05).

- Courses which ran up to half a day covered an average (and median) of 8 topics (range 0 - 17 topics);
- Courses which ran up to a whole day covered an average (and median) of 9 topics (range 0 - 19 topics);
- Course which ran up to two days covered an average (and median) of 13 topics (range 7 - 19 topics).

However, the number of topics reported is high, particularly for half day courses. It is questionable whether eight topics could be covered sufficiently in less than three and a half hours. This also raises questions about the accuracy of the data. The person responding to the survey may not be the person delivering the training, in which case their knowledge of what is covered may not be accurate.

### 3.7.10 Topics associated with key course characteristics

Bivariate analysis was undertaken on each topic area by all course characteristics to explore whether there are patterns in the ways in which topics are incorporated into courses. For example, do some topics require a greater length of time in training than others?; or are some topics covered more frequently in advanced courses rather than basic courses? Only three course characteristics - length, level and target audience by directorate - revealed significant differences. Only those topics which emerged as significant are presented here.

Seven topics were significantly more likely to be delivered during longer training sessions (7 to 16 hours) than half day courses or up to a day. This could be because they are seen to require greater attention. Alternately, the course focus may dictate the inclusion of particular topics:

- Identifying problematic drug use – significantly more likely to be covered in a whole day rather than half a day or up to two days (χ²=12.05, df=2, p=.002).
- Attitudes and values relating to substance use – significantly more likely to be covered in a whole day (χ²=7.57, df=2, p=.023).
- Reasons people use and misuse – significantly more likely to be covered in a whole day (χ²=7.29, df=2, p=.026).
- How to assess risk related to drug or alcohol issues– significantly more likely to be covered in up to two days (χ²=6.86, df=2, p=.032).

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2 Frequency of course was not examined by topic because two of its categories are not possible to interpret accurately (e.g. ‘as needed/requested’ and ‘other’); and target audience by professional was not examined by topic because too few courses were delivered to social workers only and other social care practitioners as a group, that any test of difference would not be reliable.
- **Impact on mental health** – significantly more likely to be covered in up to two days ($\chi^2=7.66, df=2, p=.022$).
- **Drug and alcohol government policy** – significantly more likely to be covered in up to a whole day ($\chi^2=9.21, df=2, p=.010$).
- **Substance misuse theory** – significantly more likely to be covered in up to two days ($\chi^2=21.43, df=2, p=.000$).

Similarly, significant differences emerged for three specific topics and the level at which they were delivered:

- ‘**alcohol and it’s effects**’ was more likely to be delivered in a basic course than an intermediate or advanced course ($\chi^2=6.85, df=2, p<.032$);
- ‘**how to assess risk**’ was significantly more likely to be delivered in an intermediate or advanced course than a basic course ($\chi^2=7.42, df=2, p=.024$);
- and **substance use theory** was also more likely to be delivered in an intermediate or advanced course ($\chi^2=6.51, df=2, p=.039$).

Finally, practitioners in CS were more likely to be the target audience for the following topics than practitioners in AS or to both CS and AS:

- **Attitudes and values relating to substance use** ($\chi^2=9.55, df=2, p=.008$)
- **Reasons people use and misuse** ($\chi^2=6.20, df=2, p=.045$)
- **How to talk about drug or alcohol use with service users** ($\chi^2=16.95, df=2, p=.000$)
- **How to assess risk related to drug or alcohol issues** ($\chi^2=11.23, df=2, p=.004$)
- **Impact on physical health** ($\chi^2=9.12, df=2, p=.010$)
- **Impact on mental health** ($\chi^2=6.67, df=2, p=.036$)
- **Impact on children, families and parenting** ($\chi^2=6.60, df=2, p=.037$)
- **Gender differences in alcohol and drug use** ($\chi^2=6.61, df=2, p=.037$)

### 3.7.11 Focus of course titles

A limitation to the topic list in table 3.19 above is that it does not include content related to specific service user groups and therefore data about AOD training provided on alcohol and older people, or substance use among those with learning and physical disabilities, for example, is limited. However, an analysis of course titles provided some further insight. The titles of all named (170/178) training sessions were analysed qualitatively to determine the broad focus or nature of the training. Table 3.20 below provides a list of categories into which the course titles could be categorised. The most common group of course titles was general substance use awareness or knowledge, followed by courses focusing on substance use in the family. Courses with specific focus on young people and older people were far less common, and from the titles given there were no courses which appear to target service user groups such as those with sensory loss or learning disabilities. Specific focus on substance use and mental health was also surprisingly low considering the high prevalence of people with co-existing mental health and substance use issues (Department of Health, 2002).
### Table 3.20: Focus of course titles (n=170)

<table>
<thead>
<tr>
<th>Title category</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broad-based training courses on drugs and alcohol</td>
<td>68 (40%)</td>
</tr>
<tr>
<td>Parenting, families and impact on children and young people</td>
<td>58 (34%)</td>
</tr>
<tr>
<td>Young people</td>
<td>11 (6%)</td>
</tr>
<tr>
<td>Interventions</td>
<td>11 (6%)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>7 (4%)</td>
</tr>
<tr>
<td>Older people</td>
<td>6 (4%)</td>
</tr>
<tr>
<td>Courses with specific focus which do not fall into other categories</td>
<td>6 (4%)</td>
</tr>
<tr>
<td>Assessment skills</td>
<td>3 (1%)</td>
</tr>
</tbody>
</table>

### 3.7.12 Access to materials to support course content

The research team felt that it might be possible that some content may not be covered in the same depth or breadth as other content because of a lack of access to materials that provide the relevant learning and skills. In order to explore this, we asked respondents to report whether they had access to materials or resources which address the topic areas listed in table 3.20 above. This question, however, is not reported by individual course data (n=178) as above because it was not asked as a follow-up question to individual courses. The data here is instead based on the 98 respondents who completed the survey. Of these, 67 respondents answered this question. Respondents most commonly report having access to materials and resources on, for example, alcohol and its effects, illegal drugs and their effects, impacts of substance use on health, mental health and children and families. Fewer respondents report having access to materials and resources on ‘how to talk about drug or alcohol issues with service users’, ‘substance use theory’, ‘gender differences in drug and alcohol use’ and ‘substance use and issues of ethnicity and culture’.

### Table 3.21: Access to material on specific content for AOD training courses

<table>
<thead>
<tr>
<th>Sufficient access to material (n=67)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and its effects</td>
<td>88%</td>
<td>12%</td>
</tr>
<tr>
<td>Illegal drugs and their effects</td>
<td>88%</td>
<td>12%</td>
</tr>
<tr>
<td>Identifying problematic alcohol use</td>
<td>87%</td>
<td>13%</td>
</tr>
<tr>
<td>Types of intervention/treatment available</td>
<td>84%</td>
<td>16%</td>
</tr>
<tr>
<td>Impact of physical health</td>
<td>83%</td>
<td>17%</td>
</tr>
<tr>
<td>Impact on mental health</td>
<td>83%</td>
<td>17%</td>
</tr>
<tr>
<td>Identifying problematic drug use</td>
<td>82%</td>
<td>18%</td>
</tr>
<tr>
<td>Reasons people use and misuse</td>
<td>82%</td>
<td>18%</td>
</tr>
<tr>
<td>Drug and alcohol government policy</td>
<td>81%</td>
<td>19%</td>
</tr>
<tr>
<td>Attitudes and values relating to substance use and problems</td>
<td>81%</td>
<td>19%</td>
</tr>
<tr>
<td>Impact on children and families and parenting</td>
<td>79%</td>
<td>21%</td>
</tr>
<tr>
<td>Prescribed drugs and their effects</td>
<td>76%</td>
<td>24%</td>
</tr>
<tr>
<td>How to assess risk relating to drug or alcohol issues</td>
<td>74%</td>
<td>26%</td>
</tr>
<tr>
<td>How to talk about drug or alcohol issues with service users</td>
<td>69%</td>
<td>31%</td>
</tr>
<tr>
<td>Substance misuse theory</td>
<td>68%</td>
<td>32%</td>
</tr>
<tr>
<td>Gender differences in alcohol and drug use</td>
<td>63%</td>
<td>37%</td>
</tr>
<tr>
<td>Substance use and issues of ethnicity and culture</td>
<td>58%</td>
<td>42%</td>
</tr>
</tbody>
</table>
Summary of key findings (Part 3): 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.
- Half of all courses (n=82/165, 50%) focussed on all substances, including alcohol, other drugs, problematic use of prescribed medications and poly-substance use; only a small number focussed solely on drugs or alcohol;
- The average length of course was 6.3 hours; the majority of courses fell between 3.5 hours and 7 hours.
- 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%).
- 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.
- Just over a third (34%) of courses were provided to social care staff twice a year; and a further quarter were delivered once a year. The remaining courses were delivered ‘as needed/requested’ or in some other way, however, these categories are difficult to interpret.
- 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 substance use theory.
- On average, 9 topics were covered in AOD courses; as length of course increased, so did the number of topics covered.
- Some topic areas are associated with length of course, level of course and target audience by directorate.
3.8 Findings (Part 4): Impacts and challenges to AOD training

3.8.1 Changes to provision of AOD training

In order to gauge recent and anticipated changes to the amount and nature of AOD training in Local Authorities, respondents (n=98) were asked to report whether the levels of training provided this year had changed from last year, and if it was anticipated that the amount of training will change next year; 78 respondents answered this question. Figure 3.4 shows the percentage of respondents who told us that levels of AOD training would increase, decrease and stay the same. More than half of respondents said training levels had remained the same from the year before. Of these (n=47) 28 (60%) said they expected the training would remain the same the following year also; while 13 (30%) anticipated increases, and 6 (13%) anticipated decreases. Of those who had not provided AOD training in the past year (n=16), 10 of these anticipated that there would be no change in levels of training in this area next year; 5 said that there would be increased levels of training; and one did not respond to this question.

One quarter (25%) said that AOD training had decreased from the past year, and 15% that they expect it to decrease next year. We examined the extent to which AOD training appears to be on a continual decrease. Of the 12 respondents who said training had decreased, 33% (n=4) said they expected further reductions in this training next year also with the remaining eight respondents expecting it to stay the same or increase. Of those who saw an increase in AOD training this year compared with last year (n=19), a majority (n=11, 60%) expect it to remain at the same level next year; 6 (32%) expected a further increase in this training; and only 2 (10%) felt the levels would decrease next year. The data show that generally, levels of training are remaining the same, for a small number, training has been decreasing and similarly, for a small number, training has been on the increase.

Figure 3.4: Percentage change in levels of training provided, last year and next year

Open-ended follow-up questions were analysed for further context on reported changes by departmental structure (i.e. Children’s services only, Adult’s services only and joint Adult/Children’s services departments), although no clear patterns in responses emerged. Twenty-four respondents provided further follow up detail about the nature of the changes.
Decreased training (referring to comparisons with both the previous and next year) was attributed commonly to budget reductions/pressures, for example: “Budget pressures have reduced all training provision”. Restructuring was also a key factor in the reduction of training, for example: “Due to enormous restructuring processes, we have access to far fewer social care practitioners than ever before”.

One respondent in a joint CS and AS training department noted challenges to accessing experienced trainers: “I believe we ran this course twice last year but have had issues accessing trainers”. Finally, several respondents mentioned lack of demand being the driving force of decreasing AOD training provision: “We have had to cancel training due to poor response to applying even though it has been advertised”. Lack of demand must be set in the context of other challenges identified within the survey. Some workforce development staff brought attention to problems with ‘release time’, stating that there is often a lack of capacity within social work department that prevent managers from releasing their staff to attend training.

3.8.2 Barriers to provision of AOD training
Existing barriers to the provision of AOD training were explored with two questions: one asking respondents if barriers existed and a second open-ended question to elicit further detail on what these barriers are. Seventy-seven of 98 respondents answered this question, and of these, just over half (55%) said there were no barriers (n=42), while just under half (45%) reported that there are (n=35).

Eight specific barriers to AOD training were identified by 32 respondents in the follow-up question (see table 3.22). The most common barrier identified (n=12) was a lack of resources, which included both financial and non-monetary aspects such as time: “Costs and time”. Budgets and finances were referred to most often however: “Financial cuts in budgets have led to courses being cancelled”.

A commonly reported barrier (n=11) was the inability of social workers to be able to attend training within an environment of austerity, lack of resources and staff, and the attending high workloads: “Services are so low on staffing that capacity to be released to deliver training is greatly reduced” and “Capacity on the release of front line social care practitioners to attend training”. Several respondents noted that AOD use often competes with other areas that also require the provision of training, suggesting a perception that there is not enough time to deliver or receive training in all areas. Several other respondents perceived that AOD use is given a low priority strategically within the Local Authority.
Table 3.22: Barriers to increased AOD training reported by respondents

<table>
<thead>
<tr>
<th>Barrier type</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of resources (financial and non-monetary)</td>
<td>12 (37%)</td>
</tr>
<tr>
<td>Lack of capacity among social work staff to attend training</td>
<td>11 (34%)</td>
</tr>
<tr>
<td>Competing priorities on training areas</td>
<td>4 (12%)</td>
</tr>
<tr>
<td>Low strategic position of alcohol and other drugs within Local Authority</td>
<td>4 (12%)</td>
</tr>
<tr>
<td>Restructuring process as a barrier</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Low desire of non-specialist social workers to train in substance use</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Accessing materials and training is difficult</td>
<td>1 (.5%)</td>
</tr>
<tr>
<td>Non-compulsory nature of training</td>
<td>1 (.5%)</td>
</tr>
</tbody>
</table>

Finally, an open-ended question was used to elicit comments from respondents about what would help them to provide more AOD training (n=33). Nine themes, as identified in table 3.23, were mentioned by respondents, some of which overlap and reflect those barriers/challenges which were identified earlier. Funding and resources were the most commonly noted themes. Non-monetary resources were clearly identified as a need:

*Perhaps nationally available training resources, similar to those produced by the Skills for Care project - Carer's Everybody's business, some information potential for e-learning. Although I feel it would still need skilled trainers so some funding would be inevitable. LA resources are stretched to the limit trying to meet all 'good practice' and 'essential training' commitments”*

*More resources i.e. more suitably knowledgeable workers who have training skills.*

Table 3.23: Support required to provide AOD training

<table>
<thead>
<tr>
<th>Support required</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>7 (15%)</td>
</tr>
<tr>
<td>External resources</td>
<td>7 (15%)</td>
</tr>
<tr>
<td>Non-monetary resources</td>
<td>6 (12%)</td>
</tr>
<tr>
<td>Strategy for identifying training needs</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>Strategic support and direction</td>
<td>4 (8%)</td>
</tr>
<tr>
<td>Capacity</td>
<td>4 (8%)</td>
</tr>
<tr>
<td>Better joined up processes</td>
<td>4 (8%)</td>
</tr>
<tr>
<td>Release time for social workers to attend / increased demand</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>Reduction in bureaucracy/ reduction in charges for training</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>

Summary of key findings (Part 4): 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.

- Decreases in training were reported to be a result of budgeting constraints or organisational change processes.
- 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’ of social care practitioners to attend training was also a common barrier.
- 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.
3.9 Feedback from Knowledge Exchange event

As described earlier in this report, a Knowledge Exchange event was held towards the end of the project which included a group of workforce development professionals in addition to social work educators and social work practitioners and managers. In part one of the KE events, the groups assigned to discuss LA training were provided with four questions designed to start them thinking about the potential findings of the study. They were given time to discuss the questions as a group and then provided feedback in a panel discussion. The four questions posed to the attendees were:

1. What percentage of responders knew whether there was a strategy in place for alcohol and other drugs training? What are some of the reasons why they may or may not know about it?
2. Do you think alcohol and other drugs training provision is more or less likely than other training to be externally commissioned or run jointly with other colleagues or specialist services? What’s your reasoning for your answer? Do you think in-house trainers have enough expertise in this area?
3. How much of alcohol and other drugs training provision do you think is basic, intermediate or advanced? Why?
4. Do you think that Local Authority region made a difference to alcohol and other drugs training provision in any way? How so, and why do you think this might be?

In respect of Question 1, KE attendees guessed that a small proportion (around 10%) of respondents would say a strategy was in place for AOD training. The general consensus was that they thought it would be unlikely for WLD departments to have such a strategy. The findings supported this perspective, although a slightly higher percentage (28%) of WLD departments reported having designated training strategies for alcohol and other drugs.

KE attendees felt that most training on AOD would be externally commissioned, noting that there is often a lack of expertise in house to train on these issues. It was also emphasised that because AOD is a multi-agency issue, that it would make sense to draw on the expertise of others outside the Local Authority. Attendees also suggested that e-learning was becoming increasingly common. Some attendees with practice backgrounds felt negative about this trend, because they suggested that some practitioners prefer to learn, or learn more effectively, in a personalised face-to-face environment. WLD attendees acknowledged this point but suggested that e-learning provides another way of learning, and that e-learning should not become a substitute for face-to-face learning but be provided in tandem. For instance, one described how e-learning was used as a gateway into higher level courses.

KE attendees judged correctly that most AOD related training would be delivered at a basic level (although our findings also showed a significant proportion delivered at an intermediate level as well). They also correctly guessed that most training would be non-mandatory. Experienced workforce staff at the event noted that other core training such as safeguarding has to be made mandatory to meet LA regulations and that this is likely to be at the expense of courses such as AOD. Attendees also believed that most AOD related training would be delivered in an ad-hoc manner, although our findings showed that a significant proportion is delivered once a year. Workforce development attendees
explained that training departments carry out comprehensive training needs assessments and have to demonstrate the value of the courses they are delivering; it is possible that AOD training is not prioritised because, as some respondents in the research indicated and which was underscored by the experiences of the KE attendees, demand can be low for a number of reasons including ‘release time’ being restricted. Attendees finally noted that training needs are not just met by courses but through other methods such as shadowing more experienced staff, through supervision and department seminars.

Finally, regarding Question 4, attendees guessed that some regions might have extra specialist programmes and provision that might be explained by stronger links between university qualifying and post-qualifying social work departments and Local Authority training. Indeed, the findings showed that some regions have a far higher average number of yearly AOD-courses than would be expected, although the survey data does not provide information allowing us to unpick this issue further.

Attendee feedback in Part 2 of the day included a range of ‘solutions’ to the challenges in providing AOD training in CS and AS. First, it was agreed by WLD staff that a strategy should be in place for AOD training. There was a suggestion that AOD training could be absorbed within safeguarding training. A WLD development staff member suggested that one way of introducing AOD issues into mandatory training would be to absorb it within other core areas, for example safeguarding.

Some attendees felt that a helpful output would be an evidence-based costing of AOD problems which could then be used by training departments to justify the need for mandatory AOD training.

As mentioned earlier, e-learning was suggested as a positive development but one that should be in WLD departments’ toolboxes and that it should not be a replacement to face-to-face learning. Some topic areas may well be suitable for an e-learning environment but other topics, such as those related to attitudes and values or how to talk to people about their AOD use may not be appropriate for e-learning.

A final point made was that AOD training materials and resources need to be better communicated to social care practitioners. This could be done through the College of Social Work, or the British Association of Social Workers although not all social care practitioners are members of either organisation. Another route would be directly through training departments in LAs.
3.10 Discussion

The findings of this research provide an important contribution to the evidence base of employer-based training on AOD, filling a gap in knowledge about the extent and nature of this training in Local Authority Children’s and Adults’ Services in England. There are some limitations to the study, however.

Although the response rate was higher than average for online surveys in general, it was still less than optimal which reduced our ability to conduct more sophisticated statistical analysis. As highlighted in the methodology, the survey design constrained the number of courses for which we could collect detailed information therefore we have not been able to verify some course information. While the study has painted a solid descriptive picture of AOD training in Local Authorities, we did not collect data on course uptake which would have been very useful given the amount of courses which were optional. Further, while we know some mechanisms are in place to capture learning through evaluation, we were unable to assess the quality of the courses themselves, or the evaluation methods being utilised. Finally, it has not been possible to fully establish the depth of training around key topic areas, such as how to talk about AOD use with service users. It should be noted that, while many of the respondents may have good knowledge of the range of AOD courses provided, they may not be the people delivering the training, therefore their direct knowledge of the specific topics covered may not be precise. The remainder of this discussion revisits key findings and discusses implications and recommendations.

The findings showed that access to AOD training for social work and social care practitioners employed by LAs in England is widespread, with the majority of responding WLD departments providing such training. This is a positive finding and suggests that WLD departments recognise AOD use issues as comprising part of the work of social care professionals. However, nearly one-fifth of responding departments had not directly provided AOD training in the past year for their social care staff, which also indicates that such employment-based training cannot be assumed for all CS and AS practitioners. Many of these departments had recently been the subject of organisational change, which may have impacted on their delivery of training more generally and some reported that their training strategies were currently under review. Over half of those who did not provide AOD training reported, however, that they facilitated access to this training outside of the LA. It is not known whether or not social care professionals are able, or willing, to take up this external training.

This research shows that AOD training is provided through a variety of mechanisms. Most commonly, WLD departments do not rely on their own in-house staff to provide this training but they were instead ‘buying in’ expertise or jointly providing courses with other colleagues or specialist services. Indeed, as compared with all training, AOD courses were more likely to be delivered jointly with other colleagues or specialist agencies and, in contrast, AOD courses were less likely to be delivered by in-house trainers. Other studies which have shown low levels of AOD training and preparedness among frontline social work staff may provide some explanation for the lack of expertise among in-house social care trainers (Galvani et al., 2011). Further, as some delegates at the Knowledge Exchange event noted, in an era of austerity and shrinking budgets, it is impossible to have all expertise in all areas.
of practice on staff. Thus, teaming up with specialist AOD use services is likely to be a key strategy in the provision of AOD training. Joint provision of AOD training with health and/or safeguarding colleagues may provide a positive multi-disciplinary experience and help increase networks and joint working between professionals. However, the risk is that the focus of the training might target health or safeguarding issues at the expense of wider social concerns relating to AOD use or may not be relevant for the social care role. As the findings showed, there is minimal attention to issues such as gender and ethnicity which may at least be in part a function of the discipline and perspective of the providers. This might also help to explain why the social care workforce reported low levels of preparedness for working with AOD use in the original study completed by Galvani and colleagues while this study clearly shows that for the majority, some form of employment-based training on AOD use is available – even if it is just at a basic level.

While training provision on alcohol and other drugs is relatively common across WLD departments, the strategic priority placed on responding to AOD use within LAs is less clear through the data collected in this study. Only a third of respondents, for example, identified that dedicated training strategies on AOD use had been developed. Considered alongside the finding that most AOD training is not mandatory for staff, it does not appear that training on alcohol and other drugs is a strategic priority within WLD departments. Anecdotal reports from workforce development staff at the Knowledge Exchange event and several respondents in the survey noted that WLD departments are under significant pressure to provide training in core statutory issues such as safeguarding, mental capacity or lone working, and these competing priorities may at least partly explain why AOD training provision is not mandatory or prioritised. Additional feedback from the knowledge exchange included reports that AOD training is often provided each year because it was provided the year before, with little strategic direction guiding the programme offered. The data on changes to the amount of AOD training compared to last year and next also support these comments. Indeed, a conclusion within the Social Work Task Force (SWTF) report (2009) was that social work lacks a shared understanding of overall direction, shape and content of its programme of professional development across all topic areas.

The findings highlighted that training is more commonly targeted at professionals within Children’s Services than those in Adult’s Services; further, that social workers are more often the target of training than other social care professionals. Additionally, practitioners in CS are more likely to be the target of intermediate training than practitioners in AS. These trends suggest that in some settings, social workers in Children’s Services fare better in terms of availability of AOD training than any other social care professional group, a finding supported by Galvani et al.’s (2011) previous study of social workers. The greater focus of training on alcohol and other drugs on professionals in Children’s Services is likely to derive from the central role that safeguarding plays within Children’s Services and the prevalence of AOD concerns on children at risk of harm (DCSF/Home Office/Department of Health 2008, Forrester and Harwin 2006, Galvani and Forrester 2011, Foster and Richmond 2003, Hayden 2004, Manning et al. 2002, OCC, 2012, Weaver et al. 2003). Although safeguarding in Adults’ Services is prioritised and there is increasing recognition that AOD use problems are relevant to professionals working with adults (HM Government, 2010), the research did not find a high level of evidence to suggest this is supporting an increased engagement with AOD concerns. The evidence base in recent years has emphasised AOD
use issues relating to work with children and young people more than it has emphasised issues in relation to adults or older people which could provide an explanation for the focus of AOD training. These findings suggest, then, that social workers working with adults - particularly those with learning and physical disabilities and older people - may be the least confident and prepared in communicating with their service users about AOD (Hutchinson et al., 2013). Thus employer-based training is in a good position to provide support and learning to improve the confidence and communication skills of practitioners working with adults.

An analysis of course titles and content revealed that there were very few courses specifically designed for practice areas in Adults’ Services such as Learning Disabilities, Physical Disabilities and Older Persons. While the majority of practitioners in Adults’ Services had reasonable access to basic training on AOD concerns, there appears to be very little training targeted at specific service user groups or practice areas. Findings from Strand 1, which examined the experiences and views of social workers working with people who have learning disabilities or physical disabilities and older persons, support this finding. Social workers in these areas tended to have lower proportions of AOD use on their caseloads than social workers working with children or other adults. Therefore the lack of courses focussed specifically on these service user groups may reflect the fact that these social care practitioners less frequently encounter AOD use problems. However, a key question remains – do social workers in these areas really encounter fewer AOD use problems or do they not know about AOD use problems because they do not ask about them?

There were encouraging findings that AOD training is developed via contribution from a range of people/roles across different disciplines. However, data on course titles and course content indicates that there is strong health or safeguarding emphasis on AOD training which could reflect an uneven input from those in other disciplines. Low involvement of social care managers in the development of AOD training was, for example, concerning. While we know that at least some WLD departments undertake needs assessments to meet stringent targets through, for example, the LSCB, Safeguarding Adults’ Executive Boards, Performance, Learning and Development reviews and training forums (as one attendee at the knowledge exchange explained and a brief examination of some LA workforce development plans revealed), this study did not collect information across all WLD departments about how needs are identified and therefore it remains unclear what mechanisms are in place to do this. However, manager involvement may be one effective way of communicating these needs and thus their involvement in AOD training could be very important. The lack of management contribution may also be a reason for the absence of strategic direction on such training.

While we do not know what levels of training social care practitioners are expected to have from their qualifying or professional training by LA employers, it would appear that most WLD departments feel that basic and intermediate levels are most appropriate. It is possible that the high levels of basic training delivered stem from the fact that many social care practitioners receive little AOD training in their qualifying training (Galvani and Forrester, 2009). Most AOD training is provided in a face-to-face environment, but there are a small number of departments which have introduced web-based training. The findings
indicate that the web-based training was always accompanied by face-to-face training, which may be a good approach to supporting the different learning needs and preferences of staff. Increasing web-based approaches may be a positive way of reaching more staff within an environment of shrinking resources. However certain areas that require more intensive input (e.g. such as attitudes and values; interpersonal skills) may not be appropriate for a web-based environment. A combination of web-based input with face-to-face training however may be beneficial. One member of the knowledge exchange noted that in their training department staff were required to complete introductory web-based courses before they could attend higher level face-to-face training courses.

Topic areas covered within training were varied, but most common were attitudes and values relating to AOD use; reasons for using and misusing; and alcohol and its effects. Least common were the areas of gender, ethnicity and culture which, significantly, were the same topic areas that social care practitioners in the previous study identified as areas of practice in which they felt most unprepared by their qualifying social work or professional training (Galvani et al. 2009). Further, Galvani et al.’s (2009) study found that social workers feel unprepared to talk about AOD use with their service users. Another study found this is a particularly acute issue for professionals working with older people (Shaw & Palattiyil, 2008). In the current study, just 51% of AOD training courses covered this area of practice. The combined evidence from both studies presents a worrying picture about how social workers are prepared to communicate with service users about AOD use, and this is in turn concerning in light of national guidance, government vision and workforce strategies which place high priority on a confident and competent workforce. Communication is identified as a key skill, yet social workers are not being consistently supported to effectively communicate about AOD use (Skills for Care, 2011; SWTF, 2009).

Attitudes take time to change and the previous study by Galvani and Forrester (2009) found poor attitudinal engagement with AOD issues by social workers (see also Hutchinson et al., 2013), thus questions remain about how well WLD training departments can engage with topics such as these. The data did show however that professionals in CS were more likely than professionals in AS to receive training on attitudes to AOD use, how to assess risk, the impact of AOD use on health, mental health and children, families and young people and on gender, suggesting that there are important gaps in provision for AS professionals. Professionals in Children’s Services directorates are more likely to receive training on health impacts, and importantly, training on how to talk about drug or alcohol use with service users. In the context of safeguarding, this makes good sense; but it is also worrying that professionals in Adults’ Services are not as likely to be given the opportunity to learn and practice how to start a dialogue with their adult service users about their AOD use.

Respondents noted a range of barriers to the provision of AOD training, most commonly referring to the lack of financial resources. A combination of an environment of austerity coupled with restructuring and change in LA departments have reduced overall training provision in some LAs and shrunk capacity through redundancies. Respondents also mentioned that a key barrier to provision is the high caseload held by practitioners in social care and the ensuing problem of adequate ‘release time’. This is not a new problem, and has been noted elsewhere (SWTF, 2009; Laming, 2009; Munro, 2011). Poor workload management systems do not include time for professional development and supervision
tailored to the position of each practitioner. This reinforces the perception that CPD courses are ‘add on’ to real work rather than an essential part of the social work task (SWTF, 2009). The problem of high workloads and release time, within the context of training which is not mandatory, means that AOD training may not be in high demand and there was some evidence of this in the survey data. Poor demand may then lead to reduced provision in a competitive environment when every training provision needs to be justified in terms of outcomes and benefits to practice.

While some mechanisms were in place in some WLD departments to follow-up staff after training, these varied in terms quality and intensity of follow-up and who took responsibility for them. Training departments could work more closely with researchers to develop more robust ways of evaluating the impact of their training in order to develop the evidence needed for further development.

Unfortunately, the survey did not collect data on uptake of training so it is not possible to compare the proportions of professionals who had access to the training and those who actually attended the training. To motivate people to attend, one participant at the knowledge exchange event said that their WLD department ‘charge’ the person’s team budget for those who register but do not turn up for training. Other participants spoke about the importance of supporting continuing professional development in this area through means other than traditional training courses. Peer-led reflective work groups supervised by a skilled facilitator were suggested as potential way forward or regular access to an AOD use specialist with a good knowledge of social care for peer mentorship.
3.11 Implications and recommendations for WLD departments:

1. In light of the findings which show a high level of external and joint training with other colleagues in, for example, health, WLD training departments should work closely with providers on the content of AOD training. It is important to ensure an appropriate balance of consideration is given not only to the implications on health and for safeguarding, but also to other dimensions such as complexities associated with AOD use in ethnic minority groups or on practical skills such as how to talk about AOD use, how to assess levels of risk and how to support changes in behaviours.

2. AOD training should be given higher priority for professionals in Adults’ services who are currently receiving the lowest amount of input on AOD use; the combined findings from previous research, from Strand 1 and Strand 2 as well as input from the KE attendees suggest that professionals in Adults’ Services need more training, particularly on legal issues around AOD use, mental capacity and how to talk to adults about their AOD use.

3. Given the low numbers of WLD departments without a specific, dedicated strategy of AOD training, greater strategic direction on AOD training is needed through the development of specific training strategies, with clear input from social care professionals and managers. It may be appropriate to incorporate such a strategy within other strategies such as safeguarding, mental well-being or lifestyle choices, however if this is the case attention to AOD use needs to be explicit and coherent.

4. Greater support of CPD by social care managers could be achieved through ensuring there is adequate release time for social care practitioners to attend courses which would strengthen their practice. Alternatively CPD on AOD use could be fulfilled through more creative and practice-based means such as access to a dedicated AOD use specialist advisor, action learning sets with a skilled facilitator or short term secondments.

5. Dissemination of AOD training needs could be improved through a greater commitment and contribution by managers skilled in AOD in the development of AOD training.

6. While some WLD training departments provide consistent follow up, the data show that follow-up quality is variable. WLD departments need to work closely with researchers and evaluators to develop systematic evaluation and follow-up of courses which would aid in needs assessments and address value for money.

7. Simple and accurate methods of quantifying the ‘impact’ of AOD training is needed to ensure it remains a priority for WLD departments.

8. Given the findings in Strand 1 show social workers’ low levels of confidence in asking their service users about their AOD use; and the findings in Strand 2 highlighting the gaps in social work education around this area - WLD departments should increase training focus on this key area of practice to improve the confidence of social work staff.

9. Additionally, there appears to be patchy access to resources and materials in this area of practice; yet the fact that some respondents reported accessing such materials suggests that there are resources available. WLD departments should ensure that they identify relevant materials, texts and resources for use in training courses but also to share these with social care practitioners more generally to encourage self-directed learning.
3.12 Implications for research

- As noted elsewhere in this report, this study could only focus on Local Authority employment-based training. Additional research on the scope, nature and extent of training in voluntary sector or private sector agencies would provide a more rounded and comprehensive picture of the status and priority of AOD training across the country, particularly within the changing nature of the workforce in adults’ social care.
- Any additional research in this area should examine uptake of training in order to clarify demand and need.
- Additional research into the experiences of social care professionals accessing employment-based AOD training would help clarify barriers and match needs with actual provision.
- Research into the links between qualifying/post-qualifying social work programmes and Local Authority training departments would be important to understand the interface between them, identify ways of reducing overlap between training and identify good practice.

3.13 Conclusion

This study was the first of its kind to examine the extent and type of AOD training provision across Children’s and Adults’ Services. The findings revealed that most WLD departments provide access to this training, however most courses are not mandatory and few departments have strategies in place to adequately embed training on AOD issues. Training is a key component in improving the communication skills and confidence of the workforce, which is a central tenet in national policy and direction. While social workers may be confident in many areas of their work, research has indicated that they are less confident about their work in relation to AOD use. Further, the findings from Strand 2 of this research revealed that qualifying social work programmes are not adequately equipping students to work with AOD, therefore WLD departments need to fill these gaps in knowledge. Ensuring that all social workers in statutory services receive training in AOD use is a crucial step towards supporting social workers to really engage with their service users’ AOD use issues and deliver a high quality service.
References


community mental health services and 50 clients attending community substance misuse services.’ *Journal of Substance Use*, 7(4), 221-228


APPENDICES
Appendix 1 – Local Authority Workforce and Learning Development Survey

Q1. Please select your type of Local Authority
   • Borough Council
   • City Council
   • County Council
   • District Council
   • London Borough
   • Metropolitan Borough Council
   • Metropolitan District Council
   • Other ____________________

Q2. Which of the following best describes the region your LA is located in?
   • Central
   • East
   • London
   • Midlands
   • North West
   • North East
   • South East
   • South West
   • West
   • Other ____________________

Q3. Which of the following best describes your LA area?
   • Rural
   • Suburban
   • Urban
   • Mixture of above

Q4. Which Directorate do you facilitate training for? (please tick all that apply)
   • Children's Service
   • Adults' Services
   • Other LA departments/agency's or external agencies (please state) ____________________

Q5. What is your job title? Please state

Q6. How long have you been in your current post?
   • Less than a year
   • 1-4 years
   • 5 or more years

Q7. Which groups of social care staff do your team/department provide training to? (please tick all that apply)
   • Social workers and social work students
   • Other allied professions
   • Social care practitioners (not social work qualified)
   • Others ____________________

Q8. Approximately what proportion (%) of all the training your team provides is (please enter a valid number in each box):
   • Run in-house by social care trainers
   • Run in-house by commissioned external trainers
   • Jointly run with colleagues from health, education or other specialists services such as the safeguarding board (LGSB)
   • Other
Q9. Have there been any recent structural or organisational changes to the training/workforce development department/role?
   - Yes (please give brief details) ____________________
   - No

We are now going to ask you a few questions about the training your team/department provide to social work and social care practitioners on working with substance use. This can include stand alone sessions, briefing sessions, short presentations at meetings etc. This is in relation to training you either a) run in-house, b) is run by an externally commissioned trainer, or c) is jointly run with colleagues from health, education or other specialist services such as the local safeguarding board (LGSB). The term substance use includes alcohol, other drugs, problematic prescribed drug use and problematic poly drug use. The term social care practitioners includes all front line practitioners working in Children’s and Adults’ Services (including qualified social workers, other allied professionals, care managers, social services assistants, children and families workers, support workers and residential, day care or domiciliary workers in various settings). We will also ask a bit later in the survey about any training you facilitate access to on alcohol and other drugs, but not directly provide (such as through MRC or the PCT).

Q10. In the past training year, has the training/workforce development team provided training for front line social work and social care practitioners working in Children’s or Adults’ Services on working with substance use (either run in-house/run by an externally commissioned trainer/jointly run with colleagues from health, education or other specialist services)?
   - Yes
   - No

Q11. How many different training sessions on working with substance use have been provided to front line social work and social care practitioners in the past training year? (please enter figure in the box below)

Q12. Please can you list the title of each training session (up to six) - the names you provide will feed through to a set of the questions regarding each session
   - Training session 1
   - Training session 2
   - Training session 3
   - Training session 4
   - Training session 5
   - Training session 6

Q12a. How long is each of the training sessions (please state in hours)?

Q12b. Who runs each training session?
   - Run in-house by social care trainers
   - Run by externally commissioned trainers
   - Jointly run with colleagues from health, education or other specialist services
   - Other

Q12c. Which substances are covered on each of the training sessions? (please tick all that apply)
   - Alcohol
   - Other drugs
   - Problematic prescribed medications
   - Problematic poly substance use

Q12d. Who is the target audience for each of the training sessions (please tick all that apply)?
   - Social workers in Children’s Services
   - Social care practitioners in Children’s Services
   - Other allied professionals in Children’s Services
   - Social workers in Adult’s Services
   - Social care practitioners in Adult’s services
   - Other allied professionals in Adult’s services
Q12e. At what level would you consider each training session to be?
- Basic (no previous knowledge)
- Intermediate (some previous knowledge)
- Advanced (requiring specialist knowledge)

Q12f. How frequently are each of the training sessions provided?
- Once a year
- Twice a year
- As requested/needed
- Other

Q12g. How are each of the training sessions delivered? (please tick all that apply)
- Face to face
- Web-based training
- Multi-disciplinary
- Service-user led
- Other

Q12h. Using the list below, please indicate the content of each training session
- Alcohol and it’s effects
- Identifying problematic alcohol use
- Illegal drugs and their effects
- Prescription drugs and their effects
- Identifying problematic drug use
- Reasons people use and misuse substances
- How to talk about alcohol and drug use
- How to assess risk relating to alcohol and drug use
- Impact on physical health
- Impact on mental health
- Impact to children and families and parenting
- Types of treatment/intervention available
- Substance use and issues of ethnicity and culture
- Gender differences in alcohol and drug use
- Working with or referring to specialist alcohol and/or drug workers
- Drug and alcohol government policy
- Substance misuse theory
- Other (Please specify)

Q13. Are any of the above training sessions supported by any follow-up mechanisms by the trainers or training team?
- Yes (please give further details) _________________
- No

Q14. Is any of the training above mandatory, and if so, for whom?
- Yes (please give further details) _________________
- No

Q15. Do you evaluate the impact of your substance use training on the practice of social work and social care staff?
- Yes (please give further details) _________________
- No
Q16. Do you facilitate access to any other forms of training on working with substance use for social work and social care practitioners which are not formally provided or commissioned by the LA training/workforce development team (for example, informing people about external events and training such as Making Research Count, Research in Practice, PCT or Drug and Alcohol Action Team provision)?
- Yes (please give further details) ____________________
- No

Q17. How does the amount of training provided to social care practitioners on working with substance use in the this training year compare with the training year before. Is it ...
- More than last year (please provide details) ____________________
- The same as last year
- Less than last year (please provide details) ____________________

Q18. In terms of training on substance use in the next training year, do you anticipate providing ...
- More training than this year (please provide details) ____________________
- The same amount of training as this year
- Less training than this year (please provide details) ____________________

If you have a training directory or other documentation on the training provided (such as a workforce development strategy), and you are happy to upload and share this, please do so here. Please be reassured that no identifying details will be included as part of any reports or publications. This final section asks you about how training on working with substance use is developed for social work and social care practitioners

Q19. Do you currently have a dedicated training strategy or a series of programmes on working with substance use for social care work and social care practitioners?
- Yes (please give further details) ____________________
- No

Q19a. If yes, is this strategy or series of programmes the same for practitioners in Children's and Adults' Services?
- Yes
- No (please give further details) ____________________
- Unknown

Q20. Do you provide social work and social care staff with tools or resources for identifying and assessing substance use?
- Yes (please state) ____________________
- No

Q20a. If yes, so you provide the same tools or resources for identifying and assessing substance use to practitioners in Children's and Adults' Services?
- Yes
- No (please give further details) ____________________
- Unknown

Q21. Are you aware of any policy or practice guidelines in your LA to support social work and social care staff working with substance use?
- Yes (please give further details) ____________________
- No

Q21a If yes, are these policy or practice guidelines the same in Children's and Adults' Services?
- Yes
- No (please give further details) ____________________
- Unknown

Q22. Please indicate if any of the following have been involved in the development of training on substance use (please tick all that apply)
- Strategic lead for substance use
- Members of local Drug and Alcohol Action Team (DAT/DAAT)
- Members of local PCT
- Members of local Safeguarding Board
- Service managers
- Team managers
- Social work and social care practitioners
- Service users
- Others (please state) ________________
- None of the above

Q23. Please indicate if any of the following materials were accessed to support the development of training on substance use for social care practitioners (please tick all that apply)
- Resources provided by Making Research Count
- Resources provided by Research in Practice
- Resources on motivational interviewing
- Key social work/social care texts on working with substance use
- Key substance use texts
- Others (please state) ________________
- None of the above

Q24. Are there any barriers to providing training to social care practitioners on working with alcohol and other drugs, and if so, what are they?
- Yes (please state) ________________
- No

Q25. Do you have access to sufficient material to inform training provision in relation to the following areas?
- Alcohol and it’s effects
- Identifying problematic alcohol use
- Illegal drugs and their effects
- Prescription drugs and their effects
- Identifying problematic drug use
- Reasons people use and misuse substances
- How to talk about alcohol and drug use
- How to assess risk relating to alcohol and drug use
- Impact on physical health
- Impact on mental health
- Impact to children and families and parenting
- Types of treatment/intervention available
- Substance use and issues of ethnicity and culture
- Gender differences in alcohol and drug use
- Working with or referring to specialist alcohol and/or drug workers
- Drug and alcohol government policy
- Substance misuse theory
- Other (Please specify)

Q26. What would help you to provide more training on this subject?
Thank you so much for completing this survey. Your response is valued and important. If you have any further comments in relation to training social practitioners to work effectively with alcohol and other drug related problems, please do let us know in the box below.