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Social Work Services and Recovery from Substance Misuse: A Review of the Evidence

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Social Work Services and Recovery from Substance Misuse: A Review of the Evidence

Dr Sarah Galvani
Professor Donald Forrester

with

Ms Georgia Glynn; Ms Michelle McCann;
Professor Andy Guppy; Mrs Christine Hemsley;
Mrs Mary Hillson; and Dr Angela Thurnham.

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Executive Summary

Introduction

This project was jointly commissioned by the Scottish Government, the Association of Directors of Social Work (ADSW) and the Institute for Research and Innovation in Social Services (IRISS). Its purpose was to review the evidence base to determine the contribution made by social work and social care to supporting people with alcohol and/or other drug problems. The findings were to be set within the context of the recovery based approach to working with substance use[1] that is at the core of Scotland's national drugs strategy.

Aims and methodology

The review involved three separate searches:

1. Evidence of the effectiveness of social work/social care interventions with people with alcohol or drug problems
2. Information about social services' workforce development in the area of substance use
3. Evidence of specific social work roles and functions with people who have alcohol or drug problems.

To do this a combination of Rapid Evidence Assessment (search 1) and Rapid Evidence Mapping (searches 2 and 3) were undertaken.

Findings

Interventions

A total of 57 relevant studies were included in the final review. The majority of studies related to forms of 'case management'. Case management is a term covering a wide-ranging set of approaches to providing and coordinating appropriate service provision. In Scotland and the UK one form of case management is better known as care management. Key features of effective case management approaches identified in the search included:

- The form of case management offered needs to match the needs of the service users being worked with: the more complex the needs of the service user group, the more intensive and long-term the form of case management will need to be.
- The more serious the problems of service users, the more likely that case management will be beneficial.
- Approaches that focussed on developing and sustaining a relationship appeared more likely to be linked to positive outcomes than forms of case management which focussed on effective service coordination.
- Other common features of successful case management approaches included:
    - A tendency to have a limited number of service users per worker

[1] The term 'substance' refers to alcohol as well as other illicit drugs throughout unless otherwise stated.

- An emphasis on creatively engaging individuals, for instance through out-of-hours work and interventions based in service users' homes or other places that they might attend
- Access to additional services rather than simply coordinating existing services
- Availability when needed, for instance through 24-hour on call services or long-term consistent availability
- All emphasised skilful communication and engagement, and a large number based this on motivational interviewing or variations thereof.

In addition, there were some promising social work interventions not based on case management, particularly in relation to families where parental substance use problems were raising serious concerns about whether children could remain at home. They may be worth considering in a Scottish context. However such interventions will require rigorous evaluation to begin to address the concerning lack of studies relating to interventions with children affected by parental problem drug and/or alcohol use.

There were also some examples of interesting interventions for people whose substance use was linked to their mental health. However the outcomes for homeless people with mental health and substance use problems were less positive and deserve consideration in terms of developing interventions that address the range of needs they have.

Some key areas of social care produced few or no intervention studies, including older people (1 study), people with disabilities (0), children in care (0) and domestic violence (0). This suggests a systematic lack of evidence and/or attention to substance use interventions with these groups.

Workforce development

A sample of 48 relevant articles was identified. Three key points emerged: first, training social workers can improve their attitudes, knowledge and work in this area, even though some studies suggest such changes are not always maintained. Further, where social workers feel it is a legitimate part of their job to address substance use, training has a greater impact. Second, there are a range of educational barriers that need to be overcome to ensure social workers are equipped for working with alcohol and drug use. In particular, "situational constraints" created by organisations that do not consider working with substance use to be their focus and the challenge of providing training and skilled supervision when there is limited expertise within the current workforce appeared to be important. Third, in social services with specialist substance use workers, both staff and service users report more positively about their knowledge, skills and the support available to them.

Roles and functions

The final total of relevant literature was 25 articles. The literature suggests that social workers are well placed to play an active role in supporting people with alcohol and other drug problems because of the profession's holistic and ecological approach. It also suggests that an ongoing and intensive involvement with service users may often be an appropriate role for them to fulfil rather than a shorter, time-limited involvement. However attention needs to be paid to challenges for social workers fulfilling these roles including lack of training, role support and legitimacy and

tensions between conflicting roles, such as care and control, personal versus professional views, to name a few.

Discussion

The literature provides clear evidence that social work could, and should be, a key profession in helping people and communities affected by drug or alcohol problems. The strongest evidence related the key skills and values of social work to substance use to indicate the unique contribution that social work can make to helping people in their recovery journey. There was also strong evidence that social workers and other professionals across the whole of social care deal with high numbers of service users with drug and/or alcohol problems and they need the skills necessary to work effectively with such issues. However, it was also clear that workers received little training or support in developing their skills, knowledge and values in relation to substance use. This highlights the importance of structural changes aimed at equipping social workers and other social care professionals with the skills they need to engage constructively with drug and alcohol issues.

The empirical evidence evaluating ways in which social workers might intervene in relation to drug or alcohol issues was relatively limited and the literature that did emerge was predominantly from the USA, with little from the UK. Nonetheless, it is clear that various forms of intensive case management can help individuals with complex psycho-social problems associated with their drug or alcohol use. In Scotland and other parts of the UK, *care* management is already in place and is one form of case management. It is therefore important to ensure the common successful features of case management are applied to care management in the Scottish context. Interventions that protect workers case loads and that emphasise skilled communication and engagement – usually using some form of motivational interviewing – seemed particularly likely to be helpful. In addition there were several examples of social work interventions for service user groups with serious and complex drug or alcohol problems that indicated the potential positive contribution that social work can make. Some of these may be worth considering in Scotland.

Policy implications and recommendations

<u>Policy and practice</u>

1. Review and expand care management in Scotland

The evidence offers some support for the extension of care management approaches with substance users across Scotland. However it also suggests caseloads need to be limited and there needs to be a focus on the development of skilful communication using interventions based on motivational interviewing.

2. *Develop and evaluate effective social work and social care interventions*

There is an urgent need to develop and evaluate new approaches among older people, people with disabilities, people suffering domestic violence and children in care.

3. *Improve education and training on substance use for social workers and social care workers*
Consideration could be given to mandating substance use education within the qualifying and post-qualifying social work curricula. Attention also needs to be paid to the training and education of social care staff that fall outwith the social work curricula.

4. *Ensure organisational support and responsibility*
All organisations providing social care provision have a clear responsibility to ensure its workforce have the skills and support to help individuals with drug or alcohol problems.

5. Develop and monitor relationship skills
Good communication skills cannot be assumed, nor can skilled and empathic assessments or positive attitudes towards working with this service user group. These are vital to effective engagement and need to be at the core of professional development.

6. Ensure effective and informed supervision
Supervisors need to receive appropriate training to support workers to work confidently and sensitively with drug and alcohol issues, and to monitor and support the further development of social workers' interpersonal and relationship building skills.

<u>Research</u>

1. Evaluating the effectiveness of existing services in Scotland
The lack of Scottish studies highlights a lack of research on social work and social care interventions with people who use substances problematically. In particular, care management as an approach in Scotland would benefit from evaluation.

2. *Determining key effective elements*
Research exploring the effective elements of interventions is also needed. While this review identified some key elements that appeared to be consistent across the more successful interventions, more work is needed to clarify if it is the intervention, particular aspects of it, or the therapist skills that are key to its success.

3. Establish the effectiveness of training
Rigorous research is needed on the effectiveness of substance use training on social workers' knowledge and practice. Studies should be experimental in design following up at intervals to measure actual behaviour change.

1 Introduction

1.1. In the UK, social work and social care responses to alcohol and other drug use have arguably been led by initiatives in Scotland. Almost a decade ago key policy documents and consultations sought to improve social care practice with children and families in Scotland affected by parental substance use problems (Scottish Executive 2001). Far earlier, the Scottish Education Department Social Work Services Group (1988) was among the first to issue guidance for social workers on working with alcohol 'drinkers'. This lead has continued with the establishment of a Standing Committee on Substance Misuse from within the Association of Directors of Social Work. In April 2010, its position statement made clear its commitment to improving the profile of social work within the drug and alcohol field and working with Alcohol and Drugs Partnerships (ADPs) to develop strategy and improve partnership working (ADSW 2010).

1.2. In parallel to this has been the growth of the 'recovery' approach within the substance use field. This approach challenges current practice and service delivery and seeks to reject medicalised and short-term interventions that focus only on the person's substance use. It seeks, instead, to change the power base, putting service users in charge of their own recovery journey, with professionals supporting individual resilience, using empowering processes with flexible and individual responses rather than a one size fits all service, and adopting evidence-based practice that is located both in the scientific literature *and* in the experiences of people experiencing recovery (White undated). This fits well with social work principles and underpinning theoretical frameworks. Further, it proposes a different way of service delivery that addresses the Scottish Advisory Committee on Drug Misuse's (2008: 41) concerns about the "re-medicalisation of services" that have emerged from joint social work and health partnerships.

1.3. Available evidence suggests that Scotland has higher rates of alcohol and/or other drug problems than other parts of the UK and many other countries in Europe (Audit Scotland 2009). The implications of this are felt throughout health and also social care services. The recognition of the risks to children and the importance of a timely response have long been on the agenda in Scotland, receiving added focus since the publication of *Getting Our Priorities Right* in 2001 (Scottish Executive 2001). Similarly the drugs strategy, *The Road to Recovery – A New Approach to Tackling Scotland's Drug Problem* (Scottish Government 2008) also identified families and communities as a priority. This commitment continues with the Scottish Government's current alcohol strategy (2009) *Changing Scotland's Relationship with Alcohol: A Framework for Action*, identifying families and communities among its four key areas of focus.

1.4. Yet the social harms go beyond child welfare, affecting many social service user groups, including older people, people experiencing mental distress, people with disabilities and people experiencing domestic abuse. The social care sector in Scotland has responded to some degree. In Scotland, approximately half of its 32 authorities now have specialist substance use teams located within their social work service (personal communication, Robertson 2010). While this is a start, the ongoing

development of social work service responses in terms of interventions and workforce development needs to be underpinned by the evidence available.

1.5. Throughout the UK there is an increased focus on 'what works' when intervening with people using alcohol or other drugs. The development of the substance use specialist workforce is also being given an increasingly high profile. The Scottish Government (2009) has committed to developing the evidence base on 'what works' in drugs recovery with which to underpin substance use service delivery and to develop a suitably skilled workforce that is fit for purpose. To this end it has commissioned and published a review of the drugs evidence base (Best et al. 2010), while the Scottish Ministerial Advisory Committee on Alcohol Problems (SMACAP) is conducting an Essential Services Review, taking into account evidence on effective interventions. At the same time, social work as a profession is responding to the publication of *Changing Lives – Report of the 21st Century Social Work Review* (Scottish Executive 2006). Within the report the Scottish Government commits to avoid doing "more of the same" when it is clear that new ways of working will be needed to ensure demand can be met and that services can cope with the increasingly complex needs of service users. Exploring the evidence base for social work interventions in substance use melds these two overlapping commitments.

1.6. This report contributes to meeting these commitments by reporting on the evidence in relation to three specific areas:

Search 1: Evidence of the effectiveness of social work/social care interventions with people with substance use problems

Search 2: Information about social services' workforce development in the area of substance use

Search 3: Evidence of specific social work roles and functions with people who have problem drug and/or alcohol use.

2 Methodology

2.1. The methods used to carry out the reviews were a Rapid Evidence Assessment (search 1 – interventions) and Rapid Evidence Mapping (searches 2 and 3 – workforce development and roles/functions). The following is a summary of the methodology.

Rapid Evidence Assessment (REA)

2.2. REAs share many of the features of systematic literature reviews, however they are carried out to inform policy to a tighter deadline. The key features of a systematic review are that it is:

- *thorough* (in that an attempt is made to identify all of the literature relevant to the question under study) and
- *transparent* (the methods used are made explicit, so that they could be replicated and it can be understood how and why the studies included have been identified).

2.3. REA attempts to achieve these aims by following the procedures of a systematic review but imposing clear limiters as part of the search and retrieval strategy including dates of searches and deadlines for document retrieval beyond which outstanding material is excluded (Government Social Research and EPPI Centre 2009).

2.4. The broader focus of searches 2 (workforce development) and 3 (roles and functions) raised concerns about the appropriateness of conducting an REA. Following discussion with the steering group, an initial Rapid Evidence Mapping was agreed after which further discussions were held about how the evidence was to be assessed.

Rapid Evidence Mapping (REM)

2.5. REM combines principles of systematic mapping with features of a Rapid Evidence Assessment to provide a systematic but quick overview of the literature available and gaps in the evidence. Systematic mapping is particularly appropriate for exploring the literature when little is known about what is available or the nature of the evidence. It retains a broader focus than systematic review processes – in that it is exploring an area rather than answering a question - and the initial map provides a visual overview of what literature is available. This provides a basis for decisions about what aspects or type of literature to explore further. It is also an effective way of identifying gaps in the research (Clapton et al. 2009). As with the REA, the REM should be both thorough and transparent. (Appendix 3 contains rapid evidence maps for the three search strands.)

Search terms

2.6. A comprehensive list of search terms for each search was compiled and piloted at the beginning of the project. Many of them resulted in no hits or only duplicates of the more commonly used search terms. The final list of search terms was reduced substantially and can be found in appendix 1.

Inclusion/exclusion criteria

2.7. For all three searches the following criteria were applied:

2.8. *Substance misuse:* The studies had to be focused on problems related to illegal drug or alcohol use. We excluded tobacco related studies.

2.9. *Social work and/or social care:* The literature needed to be specifically related to social work and/or social care. It is difficult to define social work. It is evident from the literature reviewed below that in some instances non-social workers were delivering services in ways consistent with social work (for instance many types of "case management"). On the other hand, some of those delivering various interventions within the substance misuse field were social workers despite the intervention being a psychological one delivered in a health setting. Furthermore, the nature of social work varies between countries. There is also no broadly agreed definition of social care. It may be that "we know what it is when we see it", but concrete definitions seem elusive. As a result, influential policy documents often deliberately do not define social care (e.g. Sharland 2009). Similarly, interventions were rarely identified as "social work" interventions, and it was therefore necessary to develop a working definition of what to include and what not to exclude. At the heart of this was an awareness that we did not wish to duplicate other work being undertaken for the Scottish Government, which was reviewing the evidence on recovery and drug use (Best et al. 2010); our remit was the social work/social care contribution.

2.10. The broader focus of searches 2 and 3 meant the definition of social work and social care was less of a challenge as the search terms resulted in limited hits. For search 1 – interventions – the focus on what was included as social care had to be teased out further. In practice, two broad types of studies were included. First, studies that looked at some form of substance misuse intervention and involved a social work/social care element were included. In practice this meant that the intervention being studied needed to be more than a "treatment" for drug or alcohol issues; there needed to be some attention to broader social or community issues (e.g. coordinating services or addressing wider social factors such as housing). A second group of studies related to social work responses to substance misuse in non-specialist settings. These studies were far more likely to outline a particular specialist social work intervention to address specific combinations of substance misuse and other social work/social care problems. This included social work responses to substance misuse and mental illness, homelessness, child welfare concerns and other areas of social care.

2.11. In order to ensure reliability in this categorisation procedure all studies were double checked and, if there was any disagreement, triple checked to ensure consistency. In fact, while defining social work/social care may be theoretically challenging, in practice there was a very high level of agreement in deciding whether interventions were social work/social care interventions.

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2.12. *Type of study:* Empirical research only was among the initial criteria for all three searches, however it became apparent that adhering to empirical research only for search 3 was not tenable and would result in almost no literature. This criteria

was dropped for search 3. Literature that was primarily theoretical in nature was excluded for all searches. For search 1 - interventions - primary prevention studies and a variety of descriptive studies were also excluded. It included any research focussed on whether a specific service, element of a service or type of intervention made a difference.

2.13. In addition, to secure the rapid nature of this evidence assessment only studies published since 1995 were included as was literature that was retrieved by 6th August 2010. (Further details of inclusion/exclusion criteria can be found in appendix 2.)

Approach to analysis

2.14. The analysis of literature identified through a REA depends on whether the evidence is qualitative or quantitative in nature. A key dimension in judging the quality of evaluative research is the internal validity of the study. Internal validity is the degree to which causal inferences can be drawn from the findings. In broad terms, the more rigorously a study excludes other potential explanations for a finding the stronger the internal validity. To evaluate this element of the study we used the Maryland Scale (see page 18) (Sherman et al. 1998). This has been extensively used in systematic reviews and REAs. For qualitative data guidance is available but it is more difficult to appraise (Government Social Research and EPPI Centre 2009). What qualitative data was found was appraised according to the rigour of its research design in terms of its appropriateness to the aims of the study and analysis (Public Health Resource Unit 2006).

Reliability

2.15. The intervention studies were rated by a team of five researchers. Reliability in ratings and inclusion/exclusion criteria were established through a three stage process:

* A sub-sample of 10 articles was independently rated. Differences between raters and issues emerging were discussed and resolved.
* Raters reviewed the articles allocated to them. Where they found a decision difficult to make they asked for a second rater to review an article. If this did not resolve the issue a third rater read the article.
* For every rater a sub-sample of between 10 and 15 articles was independently and blindly rated. High levels of overall reliability were established.

2.16. For search 2 and 3, the same rating system was not appropriate. Instead, after a double screening of included abstracts, a rapid data extraction form was drawn up using open text boxes to record key summative information about the literature depending on the nature of the article (see appendix 4 for categories).

Limitations of methodology

2.17. The decision to set the cut-off date at 1995 meant that studies previous to this have not been reviewed and it is not possible to know how many would have met our inclusion criteria. However agreeing and adhering to a date limiter is an accepted feature of REAs as is the need to set limits on the retrieval of full texts (Government Social Research and EPPI Centre 2009). A small number did not arrive in time for data extraction and analysis and therefore were not included.

2.18. The main limitation is not in the reliability of the inclusion decision but the possibility that we did not identify studies appropriate for inclusion through the search strategies used. For instance, it might be that a promising approach within the substance misuse field has many features consistent with social work, but did not include explicit reference to social work, care management or case management or other keywords in the abstract. Such a study would not be identified and therefore could not be included in the current review. While this is an inherent limitation in the type of review undertaken, the report remains an excellent resource for surveying the range of social work and social care contributions to substance misuse treatment. It is able to provide a broad picture of the field, identify the most well supported interventions and highlight promising approaches. Further, it offers a comprehensive exploration of the literature on workforce development and roles and functions.

2.19. The second group of studies that may have been missed are those where the focus is on another topic and substance misuse is mentioned in the study as a relevant or key issue. If substance misuse is not identified as a keyword or in the abstract it would not be possible to identify the study. For instance, the literature on Intensive Family Preservation Services has tended to identify such services as working less well when parents misuse drugs or alcohol – but this was not identified in our searches because it was buried in the detailed text of specific studies. This is not a limitation in the searches undertaken as much as a limitation in systematic review methodologies. Systematic reviews have been imported from health settings to introduce transparency and thoroughness to considering the evidence base, but they may prove less useful in areas where the literature is not well developed or complex factors interact in ways that may mean that relevant issues (such as drug or alcohol use) are not explicitly identified in a piece of research.

2.20. A third limitation is that the literature evaluating substance use interventions in social work and social care is very limited. As a result it is difficult to draw clear conclusions about ‘what works’. Instead this review attempts to identify what is promising or well supported in the literature.

2.21. A final significant limitation is that the intervention studies were predominantly from the USA. Only eight were from the UK and none were from Scotland. The remainder were from a wide variety of other countries, though most were from other English speaking countries with few from Europe. This is an important finding in its own right, however it creates difficulties in interpreting the applicability of results, as patterns of drug and/or alcohol use, services for individuals, and broader social systems for delivering help, are very different in the USA. This is considered where appropriate in discussing findings.

3 Findings: Effective Interventions (Search 1)

3.1. The results in this chapter are presented in six sections, each with a summary of key findings. The first section provides an overview "map" of the empirical literature identified in the search. Subsequent sections review findings in relation to the social work or social care contribution to substance misuse treatment, and then on service users with a variety of co-existing issues, namely mental illness, homelessness, child welfare or protection issues and a final section that brings together the few relevant studies that did not fit into one of these areas.

3.2. It is important, however, to emphasise that the primary purpose of this review is to identify the nature and extent of the existing research literature in relation to social work and social care interventions. Where we identified no research or where the findings are very limited we have not been able to comment. In the discussion of the findings however we attempt to outline possible ways forward in relation to substance misuse and social work in Scotland that build on the existing evidence base while making suggestions for new or innovative ways forward.

Overall pattern of research findings

3.3. Initial searching resulted in 8300 hits. However after screening processes a total of 57 studies were identified as meeting the required criteria outlined in chapter 2. Figure 1 shows the process of inclusion and exclusion.

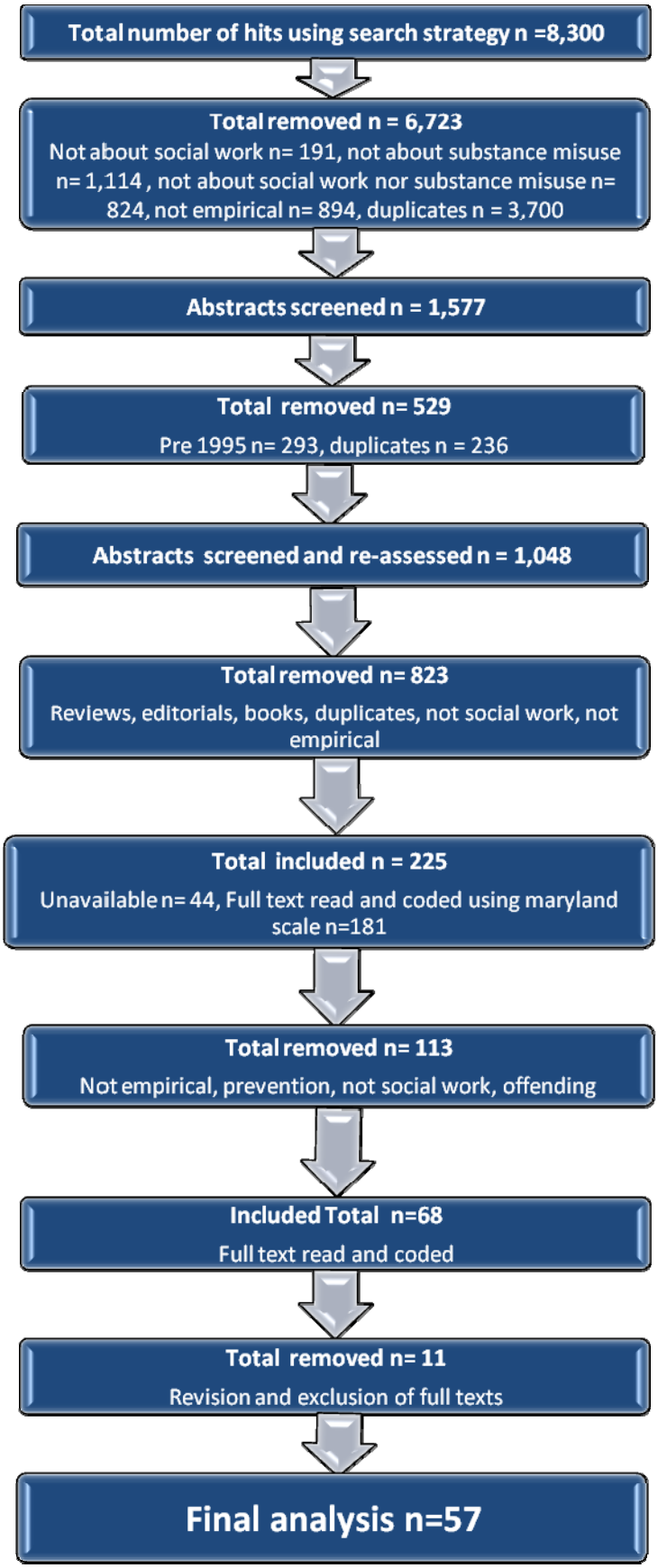
3.4. The breakdown of studies by service user group is set out in table 1.

Table 1: Service user group for intervention studies

Service User Group	Number of studies
Substance misuse	11
Mental illness	14
Homeless	13
Families (abuse, neglect etc)	18
Older people (>65)	1
Children in care	0
Disability (physical or learning)	0
Domestic violence	0
Total	**57**

3.5. The surprising finding from this table is the absence of intervention studies relating to substance misuse and older people, people with disabilities, children in care with substance misuse issues or domestic violence. Research has identified substantial levels of, and vulnerability to, substance misuse among these groups, yet in general we found almost no studies evaluating effective interventions in relation to social work/social care. This is a concerning finding as it points to a lack of social work/social care research on what works in relation to these groups.

Figure 1: Review process – search 1 (interventions)



3.6. Studies were rated according to the level of "internal validity" on the Maryland Scale (see table 2 below). In general REAs or Systematic Reviews would focus on Level 4 and 5 studies. However, given the complexity of evaluation in relation to social work and the paucity of robust studies it was decided to include studies at Levels 2 and 3. Those rated 1 or less were excluded from subsequent analysis. Such studies were in general descriptions of services with little or no evidence in relation to outcomes for service users. The service user group that studies focussed on are set out in table 3 (below). This suggests a fairly even division between before and after studies (level 2) and randomised controlled trials (level 5). There were few other comparative designs.

Table 2 – Maryland Scale (originally Sherman et al. (1998), cited by Government Social Research and EPPI Centre, 2009)

	Increasing methodological quality
Level 1	Observed correlation between an intervention and outcomes at a single point in time. A study that only measured the impact of the service using a questionnaire at the end of the intervention would fall into this level.
Level 2	Temporal sequence between the intervention and the outcome clearly observed; or the presence of a comparison group that cannot be demonstrated to be comparable. A study that measured the outcomes of people who used a service before it was set up and after it finished would fit into this level.
Level 3	A comparison between two or more comparable units of analysis, one with and one without the intervention. A matched-area design using two locations in the UK would fit into this category if the individuals in the research and the areas themselves were comparable.
Level 4	Comparison between multiple units with and without the intervention, controlling for other factors or using comparison units that evidence only minor differences. A method such as propensity score matching, that used statistical techniques to ensure that the programme and comparison groups were similar would fall into this category.
Level 5	Random assignment and analysis of comparable units to intervention and control groups. A well conducted Randomised Controlled Trial fits into this category.

Table 3 – Maryland Scale rating of studies included in search 1 (n= 57)

Group	**Maryland Level 2**	**Maryland Level 3**	**Maryland Level 4**	**Maryland Level 5**	**Total**
Substance misuse solely	5	1	2	3	11
Mental illness	4	2		8	14
Homeless	9	1		3	13
Families(abuse, neglect etc)	6	3	2	7	18
Older people (65+)				1	1
Children in care					0
Disabilities (physical and learning)					0
Domestic violence					0
Total	**24**	**7**	**4**	**22**	**57**

Case Management

3.7. Many of these studies evaluated different models of case management. However, from these, there is no consensus on what case management is. In the current studies it varies from a 30-minute intervention to access to a worker who has availability 24 hours a day, 7 days a week, and who has access to a wide range of specialist services and considerable intervention expertise in their own right.

3.8. Given this variation it is worthwhile unpicking what is meant by case management. Different authors identify different types of case management, with some describing two, four or six types. Thornicroft (1991) goes further in suggesting 12 dimensions that need to be taken into account in evaluating case management approaches. These included dimensions as diverse as team versus individual delivery, intensity of service delivery, whether the intervention is delivered within a health or social services setting and case load numbers. Support for Thornicroft's approach comes from one meta-analysis that found that low staff caseloads were the only element of case management that was reliably linked to outcomes (Gorey et al. 1998). More recently Vanderplasschen et al. (2006) have reviewed the literature on case management in relation to drug and alcohol problems. They defined case management as:

> "a client-centred strategy to improve coordination of care, especially for people with multiple needs" (p15)

At its heart are core processes of assessment, planning, linking, monitoring and advocacy.

3.9. Given these variations in case management approaches it appears unhelpful to ask the question whether case management works. The answer will inevitably depend on what is meant by case management, the context in which it is delivered and for whom it is intended. In the following sections we therefore instead attempt to describe the types of case management in the different studies and in chapter 6 we draw some conclusions about the key elements of effective case management.

3.10. There are obvious links between case management and care management as practiced in Scotland and other parts of the UK though, as with the case management studies explored here, care management will be developed and delivered in a specific context that will influence its impact. Given this, and with no Scottish studies evaluating the effectiveness of care management, it is not possible to make any comments on the effectiveness of it. Instead in the discussion section the general findings about research on case management are related to care management.

Social work and social care contributions to substance misuse interventions and treatment

Summary of key findings

- Eleven studies were identified – 10 were North American and one Australian; no UK studies of social work contributions to substance misuse treatment were identified.
- Most studies linked prolonged case management intervention to better service user recovery.
- A small number of studies indicated that even low levels of targeted case management intervention could impact positively on outcomes.
- Common elements identified as supporting improved outcomes were the use of motivational interviewing and the quality of the individual case manager and their relationship with the service user.
- Some studies suggested that integrating agencies at an organisational level may be necessary.

Overview

3.11. This group of studies focussed on substance misuse interventions where there was an additional social work or social care element. All the studies looked at versions of case management, though what this involved varied enormously as detailed below.

3.12. Eleven studies were identified which investigated substance misuse interventions with an additional social work or social care element. Moreover, in two instances two reports assessed the same initial study; thus out of these 11, there were nine different studies evaluated. This low number of studies is in itself an important finding, given the prevalence of substance use problems and the potential contribution that social work might be expected to make.

3.13. All 11 studies looked at case management (CM), though what constituted CM varied widely between the studies (as discussed below). Three studies looked at CM delivered solely pre or post treatment, two before (Mejta et al. 1997, Okpaku et al. 2010) and one after (Carroll et al. 1998). The remainder provided varying amounts of input during treatment. One considered a single element of CM (Rogers et al. 2008) - the therapeutic alliance between the case manager and service user.

3.14. The vast majority (nine) involved case management for both drug and alcohol use, while two studies focussed solely on drug use (Carroll et al. 1998 and Okpaku et al. 2010).

Key findings from the research literature

3.15. Detailed accounts of the findings from each study are provided in appendix 5. This section identifies key common findings from across studies.

3.16. Four common themes or issues emerged from the literature. First, as noted above, the breadth of CM interventions varied from intensive packages providing access to a broad range of services supporting substance treatment, social, physical and psychological needs (Mckay et al. 2003, McLellan et al. 2003, McLellan et al.

1998 and 1999, Carroll et al. 1998, Hall et al. 2009) to far narrower remits offering only support to access specific services (Samet et al. 2003). The majority of CM interventions involved ongoing intensive support throughout treatment and sometimes beyond. The aftercare CM intervention described in Carroll et al. (1998) adjusted the frequency and intensity of CM interventions to assessed service user need. Other programmes typically offered regular CM meetings, and one gave attendance incentives (Morgenstern at al 2008).

3.17. There are always challenges in interpreting the implications of findings from research in one context (such as the USA) for another (such as Scotland), however there are reasons to believe that this is particularly likely to be true for CM. CM involves coordinating access to services. However, patterns of service eligibility and availability are very different between the US and the UK. For instance, Samet et al. (2003) reported on a CM service that was effective at linking people leaving residential treatment with primary health care. Such linkages are likely to be important – but the need for CM to provide them is considerably amplified in a privatised system such as the USA compared to the National Health Service General Practitioner system in the UK, where those with alcohol and/or drug problems (like all other citizens) are entitled to free health care. In this respect, CM is likely to be less comparable across different social systems than individualised "treatment" interventions; effective ways of helping individuals are likely to have more similarities than effective ways of coordinating services in different systems.

3.18. This is a major issue in interpreting the CM literature. However, this does not mean that valuable lessons cannot be learnt. There were some striking commonalities in the literature identified and the factors associated with successful case management are likely to have implications for the Scottish context.

3.19. The second key theme identified the importance of the *quality* of the case manager/service user relationship. As discussed above, Rogers et al. (2008) focused on the nature of the therapeutic alliance, though they did not measure for individual case manager effects. Although McLellan et al. (1999) did not have adequate samples to establish statistical significance, they believed that differences between case managers were a significant factor in service user outcomes. Likewise, Morgenstern et al. (2008) suggested that the impact of case managers on service users' long-term abstinence was linked directly to the service user/case manager relationship rather than the case manager's ability to engage the service user in initial treatment. Hall et al. (2009) identified that the personal styles and motivations of case managers could affect outcome(s). Across these studies, case managers who saw their service users more often, were more active in coordinating services, and developed an empathic and respectful relationship with service users, seemed likely to be achieving more positive outcomes.

3.20. A third key theme identified across the literature was related to this. A number of studies, including Samet et al. (2003), Morgenstern et al. (2008) and Okpaku et al. (2010) highlighted the use of motivational interviewing (MI) by case managers as an effective means of developing or increasing service user desire to enter treatment, or engage with primary healthcare on leaving detoxification programmes. MI is a style of communication based on a foundation of skilled empathic listening aimed at helping individuals to resolve ambivalence about behaviour change. It has a very

strong evidence base in relation to alcohol and drug treatment. Its use in successful CM interventions is therefore interesting, and points to the importance of attention to the development of skilful communication and helpful relationships between service users and social workers or others providing CM.

3.21. The final theme was that CM often requires more than good relationships between workers and service users. Often structural change may be necessary for effective service delivery (McLellan et al. 2003, Mckay et al. 2003 and Samet et al. 2003). Integrating specific social work CM into existing substance treatment programmes took time but proved effective (McLellan et al. 1998), especially if an appropriate range of services were pre-contracted (McLellan et al. 1999). This is a finding repeated in other areas, where effective case management interventions require more than simple coordination of existing services, but active structural change to ensure that case managers have access to an appropriate range of resources.

Substance misuse, mental illness and social work/social care

Summary of key findings

* The well-established links between substance misuse and mental health issues have led to a number of attempts to provide services appropriate for the co-existence of such issues.
* The search identified 14 studies focussed on this group with a social work or social care element; 10 of these were US studies and four were from the UK.
* The studies were extremely heterogeneous, with none replicating specific approaches. This suggests an under-developed area for research from which it is difficult to draw clear conclusions.
* There were four studies that suggested that additional training on evidence based approaches might improve the effectiveness of case management for those with a dual diagnosis.
* There were some examples of promising or interesting approaches that might be worth further consideration:
* Case management by trained peers who had a history of diagnosed and disclosed mental illness appeared to be as, or more, effective than case management by professionals
* One study indicated that community care, rather than acute hospital care, could be effective and save money for service users with dual diagnosis.

Overview

3.22. The well-established links between drug and/or alcohol problems and mental illness have led to interest in developing services better able to deal with the co-existence of both issues. Our searches identified 14 studies evaluating social work or social care interventions for this particular group. However, the studies were of extremely heterogeneous interventions and none replicated particular approaches. It is therefore difficult to draw general lessons. Instead, some examples of interesting or promising approaches are provided as well as highlighting where studies showing positive outcomes differed.

3.23. Of the 14 studies identified, ten were undertaken in the US and four in the UK. Eight were assessed at the highest Maryland Scale rating of 5. The other six interventions were assessed at a rating of 3 or below.

Key findings from the research literature

3.24. Three of the UK studies appeared particularly interesting. The first study evaluated a training and supervision programme for case managers in three London boroughs, designed to help them manage substance use problems among people with severe mental illness. Results found significant improvements in service users' psychotic and general psychopathology symptoms and they also reported fewer care needs, though there was no significant effect on levels of substance use at 18 month follow up (Craig et al. 2008).

3.25. A second study, carried out by Johnson et al. (2007), also looked at improving services for service users with dual diagnosis by providing training and supervision for staff, this time with staff working in community mental health teams in London. The intervention consisted of a treatment manual, a five day training course in assessment and management of dual diagnosis (drawing on both motivational interviewing and cognitive-behavioural relapse prevention techniques), and subsequent monthly supervision. The primary hypothesis, that a) the experimental group would spend fewer days in hospital over 18 month follow up and b) show reduced alcohol and drug consumption, was not confirmed. Limitations to the study included high attrition, reliance on clinician substance misuse diagnosis and the fact that fidelity to the intervention by the case managers was not measured. In addition, the intervention was of low intensity and the limited amount of training provided might not have been sufficient to influence clinical practice.

3.26. A study in three NHS Trusts compared routine care of people with dual diagnosis and their carers with a motivational intervention, individual cognitive behavioural therapy (CBT), and a family intervention programme (plus routine care). There were no significant differences between the percentage of days they were abstinent from drugs and/or alcohol relative to baseline measures between the additional interventions compared to routine care alone (although at all points but one during the trial the treatment group had a greater percentage of days abstinent than the control group) (Haddock et al. 2003). There *were* however significant improvements in patient functioning over 18 months compared to routine care. Caution should be taken in interpreting these results as only 36 patient and carer pairs took part. If the same trends had been maintained with a larger sample they would have achieved significance and this therefore seems to be a promising intervention.

3.27. Two of the North American studies are of particular interest for the Scottish context. Sells et al (2006) investigated the impact of peer case managers on experiences and outcomes for service users with dual diagnosis. In a prospective longitudinal randomised control trial, Sells et al. (2006) found that peer case managers may be more effective during the early stages of treatment at forging therapeutic connections with service users experiencing problems with both substance use and mental ill health. Peer staff who had publicly disclosed histories of severe mental illness (some had co-occurring drug use disorders) received training on key areas of case management practice from professional and peer

healthcare staff. Training focused on identifying their individual areas of strength and used past experiences with recovery as a tool for understanding role modelling and hope building for others. Each peer case manager had an average caseload of 10-12 service users (about half of the non-peer case manager caseload), worked in treatment teams alongside non-peer case managers and received supervision from clinical supervisors (although no further details are provided on levels of supervision). Participants perceived higher positive regard, understanding, and acceptance from peer case managers rather than from non-peer case managers at six months (but not at 12 months), with initially unengaged service users showing more contacts with peer case managers and decreasing contacts with non-peer case managers. Increased levels of positive regard and understanding at six months positively predicted 12-month treatment motivation for psychiatric, alcohol, and drug use problems and attendance at Alcoholics and Narcotics Anonymous meetings. This is an interesting study and a positive finding, given the focus within recovery approaches on service user involvement throughout services. However, the fact that peer case managers had half the caseload of other case managers makes the results difficult to interpret. As noted above, limited case load is the single factor most consistently associated with positive impact from case management approaches.

3.28. Another study of particular interest was carried out by Timko et al. (2006). Timko et al. evaluated the effectiveness of community-based treatment compared to hospital-based acute residential treatment (both with the same level of service intensity) for dual diagnosis patients over a 12 month period. Community-based treatment included receiving a variety of social care services, from a variety of professionals, designed to integrate individuals into the community. They found that patients had better substance use outcomes when they were initially assigned to community rather than acute hospital care. The most interesting feature of this research is that it indicates that where significant services are provided it is possible for service users, even with comparatively acute problems, to be effectively (and economically) helped in the community. However, without a full understanding of the service context within which this intervention was provided it is difficult to draw strong conclusions.

Substance misuse and social work or social care interventions for homeless service users

Summary of key findings

* Thirteen studies were focussed on homeless individuals with alcohol or drug problems; 12 were US studies and one from the UK.
* In a reflection of the complex needs of this service user group, the interventions all had multiple elements, with most being provided in various forms of “outreach” aimed at engaging homeless individuals in the community.
* Take-up of services was highly variable which makes identifying the key elements of effective interventions difficult. As a result, it is hard to be sure which of these contribute most to an effective intervention.
* Studies could be grouped into those looking at enhanced forms of Case Management, those using an Assertive Community Treatment model and those attached to soup kitchens – though in practice there was considerable overlap in the methods used.

* Overall studies produced positive findings that indicated an ability to engage this traditionally "hard to reach" group and produce meaningful changes.
* One key to effectiveness is a focus on engaging and retaining homeless people in treatment.
* The group for whom there were the least positive outcomes was homeless people with a combination of serious mental illness and substance use problems.

Overview

3.29. Homeless individuals were not a focus of our literature searches, however nonetheless a number of studies identified social work or social care interventions relating to alcohol or drug use for this service user group. This is perhaps a reflection of the fact that for homeless people interventions broader than individual or group therapy are likely to be appropriate.

3.30. Thirteen relevant studies were identified as being within this cluster. All but one of these were from the USA, but all focused on samples of people who were substance users as well as defined as homeless in some way. Upon close review, some of the reports overlapped in terms of the studies on which they were based and in such cases only findings from the main reports are reflected in the conclusions.

3.31. It was also noted that some large scale evaluation programmes were not fully captured at this stage of the review. For example, the study by Braucht et al. (1995) is known to be associated with several other evaluations of interventions for homeless substance users that were conducted in the USA following the implementation of the Stewart B. McKinney Homeless Act of 1987 (U.S. P.L. 100-77). These absences indicate an inherent limitation in the broad search being undertaken: while these other studies may be relevant, if they did not explicitly identify either substance use or broader social care/social work elements to the intervention in the title, keywords or abstract they would not be identified in the searches.

Key findings from the research literature

3.32. A difficulty in interpreting the data in this area was that (a) all the interventions evaluated were complex interventions involving multiple elements, (b) the relative contribution or take-up of different elements was rarely reported, and (c) where information was provided it suggested that take-up of elements varied considerably. This makes it difficult to draw conclusions about which elements of interventions produced results.

3.33. Three broad types of intervention can be identified. The first is "case management" (which involved some aspect of coordination of specialist services usually combined with one or more evidence based therapeutic approaches). The second was "assertive community treatment". The third was not so much a type of intervention as a focus on service provision attached to soup kitchens in the US.

3.34. Case management in relation to homeless individuals covered a very wide range of interventions. Some examples of the types of services studied included:

* Braucht et al. (1995) described a range of inputs available to all service users including detoxification: an average of 26 days in residence, an average of 105 contacts with an addictions counsellor over the 4 month treatment period, 41 hours of substance use treatment and 64 days of housing from external agencies. Their intensive case management approach also provided case managers working in pairs with a maximum of 15 service users per pair.
* The intervention described by Bradford et al. (2005) provided service users with a weekly psychiatric clinic held at a homeless shelter with 'supportive psychotherapy' and 'pharmacotherapy as clinically indicated'. The treatment approach emphasised 'continuity of care while in the shelter, short-term goal setting and availability of case-management services' through contact with a psychiatric social worker.
* Harrison et al. (2008) described the intervention approach as following case management, but also including elements of motivational enhancement, cognitive behavioural therapy (CBT), twelve step work and relapse prevention in individual counselling and group therapy sessions.

3.35. While there can be seen to be great variation in the intervention elements within a case management approach across the above studies, outcome results were generally positive. For instance, studies reported significant reductions in alcohol use and criminal behaviour (Braucht et al. 1995), large improvements in housing, employment, mental health and substance use measures (Moore et al. 2009), decreased use of emergency services (Witbeck et al. 2000) and increased employment (Bradford et al. 2005). Thus, while it is difficult to draw specific conclusions about the best type of case management approach for homeless people, it is clear that enhanced access to services facilitated by a case manager tends to have significant positive impacts.

3.36. The second intervention approach that featured in several studies was that of assertive community treatment (ACT). ACT interventions are typically team-based with shared caseloads, a low staff to service user ratio of around 1:10. The teams usually include psychiatrists, have daily case discussions and provide a 24/7 service coverage with no time limit on services provided (Calsyn et al. 2005). However, it is important to note that there are very considerable overlaps between ACT and case management:

* Meisler et al. (1997) described an ACT intervention programme with a number of distinct elements. The programme incorporated medication administration and monitoring, acquisition of basic resources (including housing and general health care), general skills training and development of a social network. The ACT programme also included components of specific substance use treatment in individual and group formats within a non-abstinent model. In terms of outcomes, Meisler et al. (1997) indicated a significant reduction in terms of severity of substance use for 41% of the dually diagnosed service users at final follow-up (between 12 and 48 months). There were also significant improvements in housing and competitive employment suggested from statistics presented.
* Morse et al. (2006) also used interventions based on an ACT model (see Calsyn et al. 2005 for description). One group of service users received an integrated

ACT model where support for substance misuse was provided by the team delivering mental health care support, whereas the ACT-only service users were directed to other providers for substance misuse services. These two ACT intervention conditions were also compared with a standard care control group who were provided with listings of community treatment agencies and were advised about openings at the various agencies and provided with linkage. The results reported by Morse et al. (2006) indicated significant improvements in terms of substance misuse and stable housing over time, but did not indicate strong significant differences across the treatment groups.

* Padgett et al. (2006) also included an ACT approach but emphasised the role of providing housing support within their evaluation. For the 'housing first' group, housing was not contingent on sobriety or treatment compliance. Individuals randomly assigned to the control group were referred to standard care programmes that offered abstinence-contingent housing and services based on a 'treatment first' model. The results presented by Padgett et al. indicated no significant improvement in terms of heavy alcohol and drug use rates over follow-up periods of up to four years. However, an earlier report from this project (Tsemberis et al. 2004) indicated that there were significant improvements in housing status for participants over time.

3.37. The third group of studies looked at interventions focussed around soup kitchens. The studies reported by Nwakeze et al. (2000), Kayman et al. (2005) and Rosenblum et al. (2005) involved a range of interventions including case management, peer consumer advocacy, as well as more focused elements including motivational enhancement for recovery and recovery education and skills. However, by the nature of their location and the service user characteristics, many of the more focused elements were not fully engaged with by service users. For example, 38% of the service users in the study by Rosenblum et al. (2005) did not engage at all with the motivational enhancement or recovery skills intervention components, receiving just basic case management support (information and referral services as well as peer advocacy).

3.38. Finally, Dunn et al. (2006) – in the only UK study - described a pilot scheme designed to engage opiate-dependent hostel residents in a methadone maintenance prescribing service. The satellite clinic was held at the hostel two mornings per week. Retention rates of 93% at two months and 87% at four months seemed impressive and these were associated with significant reductions in daily drug use (heroin and crack cocaine).

3.39. Several of the studies reviewed in this section attempted to compare across treatment modes (often comparing treatment and 'service as usual'). Thus most were comparing an enhanced social work or social care intervention with the services usually received. It is important to be aware that positive outcomes therefore rely on services being significantly better than those usually received. On the one hand, this is a more challenging (though wholly appropriate) focus for evaluative research – and therefore to achieve significance services would need to be particularly good. On the other hand, effectiveness is in part defined by the quality and impact of "service as usual". If normal services in the USA are less good than those in Scotland then an intervention that "worked" relative to usual service in the US might not "work" in Scotland. This is one of the important considerations in

looking at US research on effectiveness of interventions. Where detail was available, there were few strong examples of particular treatment approaches being significantly more successful. Mostly this was due to the fact that the control samples also received considerable support thus reducing the likelihood of significant effects for the enhanced treatment condition. However, factors such as engagement and retention seem particularly important with homeless service user groups and practical factors enhancing access and motivating retention should be considered in the design of interventions for these difficult to reach and retain service users. The soup-kitchen studies reported by Kayman et al. (2005) and by Rosenblum et al. (2005) would seem good examples of interventions designed to reach homeless service users.

3.40. Where the studies were more clearly focused on service users with dual diagnoses, the results suggested less emphatic success in reducing substance use. A repeated theme in those studies focusing on homeless service users with serious mental health disorders was the rather varied nature of substance use among the samples. As many service users did not appear to be frequent heavy substance users, there may be some limitations in the relevance of high cost substance misuse focused interventions across the larger service user group.

Substance misuse and child and family social work

Summary of key findings

There are some promising interventions aimed at families with serious levels of concern where a child has entered or might enter care. Successful approaches have in common:

* a very high level of intensity of direct work
* direct work tends to be based on motivational interviewing (MI) or adaptations of MI and pays considerable attention to skilful and non-judgemental communication and engagement of individuals with alcohol or drug problems

A weakness in the existing literature is that the follow-up periods are relatively limited and we know little about longer-term patterns of lapse or relapse and the potential problems for children or parents associated with this.

Overview

3.41. In reviewing the literature relating to substance misuse and child and family social work, three important observations need highlighting before considering more specific evidence on interventions. First, there are remarkably few studies identified. Parental problem drug and/or alcohol use has been a major focus of concern for child welfare systems in the UK, the USA and several other countries in recent years, and it has also been of increasing concern within the substance use treatment field. Yet only 17 studies (published in 18 papers) were identified and many of these related to small samples or had serious methodological limitations. This is, therefore, a very limited evidence base from which to draw conclusions.

3.42. Second, the evidence is almost entirely North American, with only one study from the UK. This means that care needs to be taken in extrapolating findings to the Scottish context. Furthermore, many are framed within the USA's legal system, and in particular several relate either to "Family Drug Treatment Courts" (FDTC) or to children entering public care in the USA, and this may make translating to a Scottish

context particularly challenging. There are numerous differences between these interventions and the Scottish legal, policy and practice context. For instance, at the heart of the FDTC approach is an attempt to make the legal system less adversarial – but the Scottish system is far less adversarial and procedural and more "problem solving" already. Furthermore, the drugs of choice have significant differences to the Scottish situation, with high proportions of crack cocaine and methamphetamine in several of the samples.

3.43. Third, the studies identified are nearly all based on special interventions, such as specialist courts or projects. The only exception is Jansson et al. (2005), which is a small-scale study of intensive case management for mothers for the four months following the birth of a child. This contrasts with the literature around substance use and homelessness and also mental illness, as in both fields there is interest in case management in its own right. In the child and family welfare field, while case management is a feature of a number of interventions, almost every study identified is of a specialist intervention. The literature therefore has little to say about effective approaches in local authority child and family social work. These are significant limitations in the literature; however, there are some interesting themes and findings emerging.

Key findings from the research literature

3.44. Most of the studies can be grouped together as a heterogeneous amalgam of promising interventions explored through an initial pilot study or evaluation. Most of these studies have limited sample sizes and they are generally characterized by either no comparison group or one that may not be entirely valid as a comparison group. Most importantly, none appear to have been replicated in further studies. Nonetheless, while these studies indicate a rather immature area of research, they do provide some promising indications of approaches that might be of interest. Some highlights worth noting include:

- Grant et al. (2004) provide a very small scale study of an intervention for mothers who themselves were affected by Foetal Alcohol Spectrum Disorder. This is a very under-researched group and while the study had serious limitations there are nonetheless indications that a fairly intensive parent assistance programme may reduce alcohol and drug use as well as having other positive outcomes.
- Brook and McDonald (2007) provide an important study that is noteworthy for quite a different reason: it reports on an intervention that did not appear to work. The intervention was a comprehensive service-delivery programme aimed at improving coordination of services for families affected by drug or alcohol problems where children entered foster care. In an unexpected finding the service appeared to make reunification *less* likely and, perhaps of greater concern, children who did return home were *more* likely to re-enter care than a comparison group not receiving the services. The reasons for these findings are complicated, and may include the fact that there was greater scrutiny of intervention families and that, in some of the family courts, any positive urine test automatically meant a child being removed. It is also possible that the focus of the intervention on service coordination and delivery failed to deliver a meaningfully improved service as experienced by service users.

* Slesnick and Prestopnick (2005) describe an interesting intervention based on family therapy principles aimed at young people who ran away from home and their families (the young people all had a substance use problems). The intervention, carried out in a rigorous experimental design, produced significant reductions in substance use and other key issues and suggests a promising approach to working with this often hard to reach/engage group.
* Forrester (2008a) is noteworthy for being the only UK study. It reports promising findings in relation to the capacity for an intensive crisis intervention service (named "Option 2") that worked with families affected by drug or alcohol problems to reduce the need for public care. Option 2 provides a brief six-week intervention within a crisis intervention framework. Workers work intensively with families, including 24-hour availability, using communication styles influenced by motivational interviewing and solution focussed approaches. An interesting feature of the findings was that while the proportion of children entering care was the same for those receiving Option 2 and a comparison group, the overall use of public care was less in the Option 2 group because the children took longer to enter care and left more often and more quickly. As a result, Option 2 produced significant cost savings, however the authors underline the fact that the impact on child welfare was not studied and that a reduction in the use of care is not necessarily a good thing.
* Comfort et al. (2000) report on an attempt to increase the engagement of women with children into a drug treatment service. The study uses an experimental design to compare normal services with enhanced services aimed at increasing engagement of mothers with the service (such as by the provision of transport, child care and an "engagement worker" who would escort individuals and provide phone reminders) . Increased services aimed at engaging women had no impact, however in the discussion of this finding it appeared likely that the women were anxious about using child care in case it resulted in child protection referrals. This points to some of the complexity in the issue of effective engagement. The authors conclude that a greater emphasis on relationship-based elements of engagement rather than practice services may be appropriate.

3.45. There are two areas in which there are more substantial bodies of evidence: Recovery Coaches and Family Drug Treatment Courts (FDTC). A single large evaluation of Recovery Coaches is reported in three separate papers (Marsh et al. 2006, Ryan et al. 2006, 2008). The Recovery Coach model involves an independent "coach" who provides extremely intensive assessment, advocacy, case management and direct work with parents when a mother is identified as using drugs during pregnancy. The coach is available at all times of the day and night (24 hours a day, 7 days a week) – also a feature of the Option 2 service. Recovery coaches are assisted by outreach staff who specialise in identifying and engaging parents who are not engaging with services through patient, persistent and assertive outreach. The goal of the recovery coach is to engage parents with serious substance misuse and child welfare issues in a variety of appropriate services. The evaluation was a large-scale and rigorous piece of research using a randomized controlled design. It found statistically significantly increases in the rates of reunification of children removed, though the overall proportion remained small (12% compared to 7% of babies not receiving the service). The intervention also significantly reduced the likelihood of a further new born child experiencing withdrawal and it increased

engagement in substance misuse and other services. Overall it appears to be a very encouraging approach.

3.46. The remaining studies all focus on FDTCs. FDTCs take a variety of forms, with differences in levels of intensity and extent of services provided and a variety of other elements of the ways in which courts work. They also vary according to whether they include all families entering public care with substance misuse issues or only some. Common themes include: regular meetings with a designated judge who actively manages the case; a focus on recognising and rewarding achievements; better coordination of services for families; and a specialised team who work with families to improve such coordination. Overall, the FDTCs have promising findings, suggesting swifter access to drug treatment, higher rates of reunification with parents and no indications of this being associated with subsequent breakdown. One concerning finding was that Worcel et al. (2008) found that for children permanently placed elsewhere final placement took longer in an FDTC. A common problem across the studies is that they rely on a quasi-experimental design, and the comparison group – usually those referred to the court before the FDTC was put in place – tend to differ from the intervention group. In particular, the intervention group tends to involve younger children and one might therefore expect more positive outcomes. Still more importantly we do not have long-term follow-up studies and none of the published data looks directly at child or parent welfare. We therefore know that parents are more likely to receive treatment and children are more likely to return home, but we do not know what the long-term impact is on the children's welfare. It is possible that not entering care may lead to a poor outcome for children in the long term, as care tends to improve children's welfare (Forrester et al. 2008a). FDTCs are therefore a promising approach but further evaluation work is needed. An English version of the FDTCs has been established in London (the Family Drug and Alcohol Court). Evaluation is ongoing.

Substance misuse and other areas of social work or social care: older people, people with disabilities, domestic violence and children in care

Summary of key findings

* The lack of intervention studies regarding children in care, older people, people with disabilities (physical or learning) and domestic violence is a major gap in the evidence base. Only one study was found relating to older people, one for children who had run away from home and none in relation to domestic violence or individuals with disabilities
* The study focussing on older people with co-existing mental health and substance problems found promising results from an intensive support programme that was primarily home based, supported links to other services and used motivational approaches
* The study focussing on young people who had run away from home found that family therapy could significantly improve the likelihood of them successfully returning home

3.47. The consistent finding in previous sections of this report regarding the various social care groups is that there are few studies in substance misuse and social work/social care. This finding persists in searches for substance misuse and older people, people with disabilities, people experiencing domestic violence or children in

care. Research has identified substantial levels of, and vulnerability to, substance use among these groups, yet we found almost no studies evaluating effective interventions.

3.48. Only one study regarding older people and social work or social care interventions was identified in our literature search. This study concerned older people with co-occurring substance misuse and mental health needs. The study proved to be a promising intervention and was rigorously evaluated in an RCT. This was a North American study of a community intervention for older adults known as the Geriatric Addictions Programme (GAP) (D'Agostino 2006). GAP is based on a harm reduction model that focuses on reducing the negative consequences associated with substance misuse in this population. The intervention combined geriatric care management assessment, motivational counselling and linking individuals to older peoples' services and substance misuse services. It provided a high level of intensive direct work. A particular strength of this intervention was that – in common with most social work approaches – it was home based in order to address issues of shame, stigma, social isolation and decreased functional abilities that could act as barriers to this population accessing a traditional treatment setting. Although the principal evaluation measure is completion of the treatment programme, rather than substance misuse outcomes, the study suggests a promising approach to engaging and retaining this marginalised, socially isolated and hard to reach group of older people.

Children in care and substance misuse

3.49. None of the studies we found concerned children or young people in care with substance use problems – despite strong evidence that they are particularly common amongst this group (see Meltzer et al. 2002). The Slesnick and Prestopnick study (2005) mentioned above (p.30) may be relevant for this group. The intervention was aimed at young people with substance problems who *ran away from home* and their families. The intervention involved intensive family therapy to support the return of the child home. The research used a rigorous experimental design and produced significant reductions in substance misuse and increased likelihood of successful return home. The success of this intervention with unstable and drug misusing young people who run away from home, may have some applicability to young people in care. Young people with substance use problems who either runaway and/or are in care both experience instability and family breakdown.

Conclusion

3.50. This chapter has covered a wide variety of social work and social care interventions relating to alcohol and drug problems. These have included studies relating to substance misuse as a main focus of work or where it interacts with other issues that have involved social workers. Overall, three conclusions can be drawn from this literature. First, this is a relatively undeveloped field of study without a strong evidence base and with some areas with almost no research. Second, where there is evidence it highlights the potential contribution that social work can make to helping those with drug and/or alcohol problems – particularly those with the most serious problems. Third, a consistent feature of effective interventions was the emphasis they placed on supporting the delivery of skilful social work. This makes it particularly important to consider the extent to which this is a general focus in social work and social care. This is the question turned to in the next section.

4 Findings: Workforce Development (Search 2)

Summary of key findings

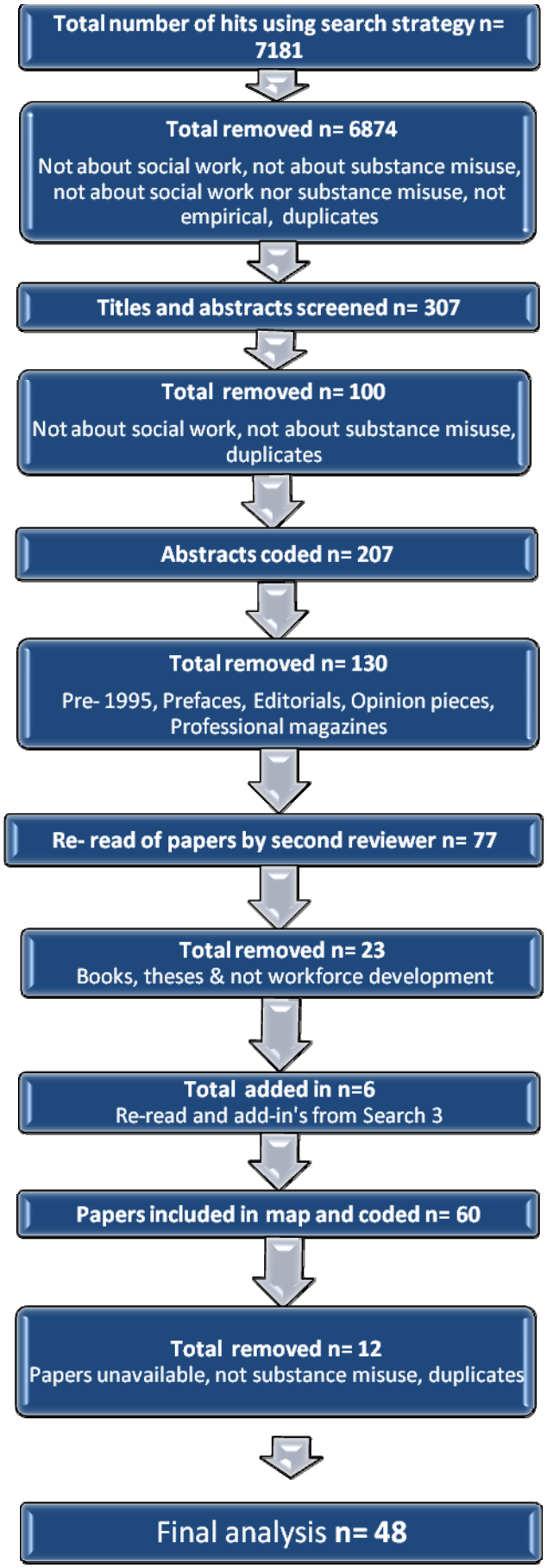
- The evidence reviewed found that formal academic-based social work education has failed social workers in terms of preparing them for working with substance use. This is highlighted through literature focussing on attitudes, preparation for practice, current practice and training needs
- The evidence suggests training improves attitudes but is equivocal about its ability to improve knowledge or competence
- Where improvements in knowledge are noted, there is often an elective component to the training suggesting that the more motivated and interested people are prior to training, the higher the chances of positive outcomes
- Appropriate communication skills appear to be key to overcoming barriers to working with people with problem drug and/or alcohol use.

4.1. A preliminary search identified over 7000 articles using the agreed search terms (see appendix 1). After several applications of the inclusion/exclusion criteria at different screening and secondary reviewing stages, the final Rapid Evidence Map consisted of 60 pieces of literature including some identified in search 3 which were most appropriate for search 2. The review process is shown in figure 2. These final 60 papers went forward for full text retrieval, reading and data extraction set against the codes and categories developed for this purpose (see appendix 5). Six of the 60 did not arrive before the cut off date, on full text reading six more were excluded - one was not substance use specific, one was a non-systematic literature review, one was pre-1995 but not highly relevant (as noted in chapter 2 it was agreed that only highly relevant earlier research studies would be included) and three related to studies already included without significantly different foci. Thus the final sample was 48.

Overview

4.2. Empirical studies were the primary focus of this search. From the 48 studies only three used a control group, and a further 14 used some type of comparison group although this often involved comparing results across professional groups. Again, the majority of studies were from North America (n=26), followed by the UK (n=18), Canada (n=2), and South America (n=2). It was disappointing that the searches were unable to uncover any European literature in spite of broad search terms within databases that include European literature sources. This suggests that either the databases only access a small amount of the European literature available or that there is not much European literature on this topic.

Figure 2:
Review process: search 2, workforce development



4.3. The literature fell into nine broad themes as outlined in table 4 below:

Table 4: Themed groupings from search 2 – workforce development

Theme	N =
Attitudes/knowledge of social work staff and managers, and preparation for practice	17
Impact of training on practice/behaviour	9
Extent of substance use on the social work curriculum	4
Approaches to social work education about substance use	4
Tool development: practice and research	4
Practice/skill development	3
Current practice	3
Training needs	4
Total	**48**

Thus the majority of the literature focussed on assessing current attitudes towards working with people who used substances or their preparation and practice for it.

Key findings from the research literature

Attitudes and preparation for practice

4.4. While the focus of the 17 studies was on a broadly similar topic, the sample profiles were often very different making it difficult to draw reliable conclusions in this theme. For example, one British sample included 24 practising social workers (Lightfoot and Orford 1986), while a North American study included 197 Master's in Social Work (MSW) teachers, graduates and alumni from a particular social work programme (Loughran et al. 2010). Further, some of the literature focussed on alcohol only or drugs only while others focussed on both.

4.5. In spite of this, two key points emerged from the literature. First, from both UK and North American literature, social workers in practice often felt unprepared by their formal academic training for working with substance use problems. Level of study, that is Bachelors or Master's degree level, made no difference. The level of training received by respondents varied widely from none at all to those reviewed in the North American literature who had taken an additional license to practice with service users with alcohol and drug problems. Second, the more experience, knowledge and training the respondents reported, the more positive their attitudes were about working with those with substance use. They also had a greater sense of legitimacy for engaging with substance use issues, that is, they felt it was a legitimate part of their jobs to be asking about substance use. Across the studies, respondents that had limited-to-no training demonstrated poorer attitudes, greater pessimism and higher levels of concerns about working with people with alcohol and drug problems.

4.6. A crucial insight from Lightfoot and Orford's (1986) study of the effectiveness of an alcohol education package was the effect of situational constraints on therapeutic attitudes. Staff with greater constraints in their workplace had less positive therapeutic attitudes and a lack of supportive supervision contributed to this. They found that social workers were more situationally constrained than nursing

colleagues. While it was a small study, (n=48, 24 social workers and 24 CPNs), its findings are still relevant 24 years later in the context of increasing demands on social workers to take on complex caseloads as well as increasing bureaucratic and administrative demands.

Impact on training on knowledge and practice

4.7. Closely related to the above theme were a group of studies that focussed on measuring the impact of training or education on people's knowledge and practice. Some showed modest improvements in knowledge or practice (Forrester et al. 2008b, Gorman et al. 1990, Johnson et al. 2002). While this appears to contradict the findings in the previous section, the study by Gorman et al. (1990) offers one explanation. Gorman et al. found greater improvement in attitudinal scores after the delivery of their alcohol education package but knowledge scores were not as improved. Thus it is possible that attitudes can improve but this does not necessarily translate into improved knowledge or practice. However in Gorman et al.'s study this improvement in attitude had also deteriorated at the six month follow up point.

4.8. Three studies reported some improvement following training but a lack of reported methodological detail or methodological weaknesses in the study does not allow reliable conclusions to be drawn. A study by Straussner and Vairo (2007) found that a post-masters training course on 'substance abuse' run over one academic year (including two summer sessions and six courses) resulted in self-rated improvements on three scales; values, skills and knowledge, and behaviour change. However, respondents who felt that specialist 'substance abuse' work was part of their job had higher ratings on all scores. This suggests that pre-existing role legitimacy could be important in ensuring participants maximise the use of training rather than an outcome of the training itself. Forrester et al. (2008b) also reported little take up of the offer of additional support and training following initial training of social workers – again suggesting a lack of engagement that may be individually or situationally determined.

4.9. While Amodeo et al. (2002) found post graduate training produced improved practice and engagement with the issue of substance use, no pre-test data was collected with which to compare it. However a comparison group who did not receive the training did not rate as highly on a number of measures. Similarly Amodeo and Fassler (2000), based on the same study, found improvement on some measures with a comparison group, but not on all of them, for example, self-rated competence in assessment showed no significant difference. Further, the low response rates for Amodeo's two studies suggest caution in interpreting the findings.

4.10. Interdisciplinary training and networking opportunities were both associated with better reported outcomes. A study by Jones et al. (2002) found their interdisciplinary training initiative improved collaboration across specialist services which was retained at 6 month follow up. This finding however should be treated with caution given the lack of control or comparison group with which to compare its results. Participants in the Lowden and Hall (2006) study in Scotland reported that the networking opportunities the training afforded were also helpful. They also reported high post-test scores following substance use training but they had no comparison group and no measure of whether it actually affected their practice.

Mason (1996) also found that an additional benefit of the training was the networking it offered.

4.11. What this group of studies demonstrates is the clear need for improved research studies that contain both pre- and post-test methodology, a comparison or control group, and to follow up at intervals using methodologies that allow for exploration of actual rather than self-reported behaviour change.

Extent of substance use in the social work curriculum

4.12. Four studies emerged in this area. The one UK study by Harrison (1992) is included as it is the only known survey of social work programmes and the extent of their teaching on substance use conducted in the UK. All four studies however reported similar low levels of input on substance use in the social work curriculum, with some programmes providing no input or elective input only to social work students.

Approaches to social work education about substance use

4.13. This group of studies all adopted different and innovative approaches to teaching substance use. These included experiential learning (Caldwell 2007), in which students were asked to give something up for a week, for example, going to the gym or another habit or routine. Other approaches involved training social work faculty in substance use (Amodeo and Litchfield 1999) and reviewing whether they included more input in their teaching than non-trained faculty. The latter study did find an increase in substance use teaching by trained faculty members. Carpenter and Hewstone (1996) mixed medical and social work students (n= 85) for training on substance use and found improved attitudes in the majority but worsened attitudes in a minority (19%). Finally, Billingham (1999a) evaluated an elective module on substance use with a small number of students (n=16) and found an increase in self-rated knowledge in a number of areas particularly around service provision and interventions.

4.14. Thus all the approaches demonstrated some degree of improvement although it is important to note that all but Carpenter and Hewstone's (1996) participants elected to study in the area, which may have affected the positive findings.

Tool development: practice and research

4.15. Four studies focussed on the development of tools for practice or research purposes. Bernstein et al. (2007) developed an alcohol screening tool (SBIRT) and evaluated its use by 402 staff in emergency departments of hospitals in the USA. They found improvements in confidence and use over the follow-up period but suggested booster sessions and systemic/infrastructure changes were needed to maintain improvements. Two studies by Hohman et al. (2006, 2008) report on the development, piloting and re-testing of a tool designed to measure the resistance of social workers to discussing alcohol and other drug issues with service users. While the primary focus was on the tool development they found, in both the pilot study and subsequent main study, that many of the students lacked training in various aspects of substance use and that some were concerned about upsetting the service users so avoided discussing alcohol use with them. Finally, Kranz (2003) developed a tool to identify gaps in social workers' knowledge and skills for working with substance related issues.

Practice/skill development

4.16. Three studies looked at the development of practice or skills development. Two of these focussed on motivational interviewing (MI). Forrester et al. (2008b) trained 40 social workers in MI skills and observed role plays of the social workers in action with a fictitious service user before and three months post training. While there was a statistically significant move towards less confrontational approaches, improved listening skills and greater confidence in working with alcohol issues, overall the level of listening skills was relatively low even after training. Very few workers demonstrated skilful use of MI. Barsky and Coleman (2001) aimed to identify a set of competencies using MI skills for teaching and evaluating substance use with students. They developed a model of coding positive and dysfunctional skills with experienced MI practitioners and tested the model with a student cohort. While there was low inter-rater agreement which limits the usefulness of the approach, the students found the codes helpful in practice. The third study by Burke and Early (2003) explored how social workers involved in substance use programmes for young people made decisions about what interventions to use and outcome measures and found a lack of evidence-based practice. Decisions tended to be made on individual preferences.

Training needs

4.17. Four very different articles comprise this theme relating to training needs; two empirical studies and two policy/practice analysis commentaries. Billingham (1999b) reviewed the Local Government Association's guidelines on working with drug using parents while Collins et al. (1988) reviewed the literature on alcohol education in social work training in Scotland and the barriers to improving education on this topic. They suggested that such barriers may include: a lack of knowledge of the subject among social work educators and an associated lack of confidence in helping students to cope with related practice challenges; outdated knowledge of alcohol approaches among practice tutors; limited content on social work courses and limited placement opportunities in alcohol and drug services. Collins et al. (1998) suggested that organisational priorities often focussed on children or people at risk because of the 'drinker' rather than on the 'drinker' per se. Finally, their study highlighted the importance of social workers having a sense of role security when working with 'drinkers', that is, the need for them to receive support and supervision not just knowledge and training. Both reviews concluded that there was a need for training in order to meet need or, in Billingham's case, to meet the recommended guidelines.

4.18. Two North American studies explored the training needs of social workers working within substance use agencies (Hall et al. 2000, Vander Bilt et al. 1997). Hall et al. assessed the needs of 303 social workers and found that they reported higher levels of skills and knowledge in 10 or 12 areas explored compared to other treatment providers but that a significant number lacked any support from clinical supervision. Assessment, dual diagnosis and 'advanced clinical skills' were their training priorities. Vander Bilt et al. (1997) explored the use of screening instruments of a range of professionals including social workers. Social workers were less skilled in conducting urine screening than their counterparts from medicine, nursing or substance use counselling. However, this is not surprising as urine screening is not a social work task. Further social workers fared worse on their use of the AA 20

Questions Screening than their counterparts. However, the authors found that many professionals did not use screening tools and suggest a greater emphasis is needed in training and education on screening processes.

Current practice

4.19. Three UK studies commented on current practice issues. Two focussed on parents with substance use problems. Hayden (2004) surveyed 47 social workers in one children's services department, and held group interviews with separate samples of 13 parents "in recovery" as well as an unstated number of social workers. She also interviewed parents supported by a link worker, who worked to bridge the gap between social services and alcohol/drug services. Social workers said they did not know enough about substance use to work with the issues it raised and that it negatively affected their work with parents in that they didn't know how to help the parents. They also felt afraid at times and felt that specialist advice on alcohol and drugs would help. These findings are concerning and will be discussed further in chapter 6. The parents interviewed reported poor communication skills, a lack of knowledge of substances, and a lack of support from social workers, particularly referrals to specialist substance use agencies that would help their recovery. However the parents receiving support from the link worker found greater encouragement to achieve their goals and also recognition of their importance as individuals. In sum, social workers wanted specialist substance use input and a link role to support their practice and parents wanted social workers to support their child's needs in the context of their own recovery and not ignore the parent's needs.

4.20. Taylor and Kroll (2004) explored the tension of child versus parent focussed practice in a qualitative study of 40 health and social care practitioners from London and south west England including children and families social care staff, alcohol and drug specialists, CPNs, CAMHS staff and those specialising in working with young people. All practitioners reported difficulties engaging with parents using substances and many felt that their role was not to assess parenting ability as this was a specialist role while others avoided asking about children. Further, there were concerns about extent of knowledge of alcohol and other drugs as well as about other areas of specialist social work practice, for example, non-child care practitioners felt they did not know enough about child protection. Communication with parents and children, confidentiality and differing timescales for interventions were among the areas of contention.

4.21. Shaw and Palattiyil (2008) explored the experiences of 18 social workers working with older people, and their awareness of alcohol problems and attitudes towards a specialist alcohol service provider. As well as reporting increasing levels of alcohol use among older people and difficulties in identifying and responding, social workers felt the local alcohol services were not set up to work with older people's alcohol use and focussed more on younger people.

Conclusion

4.22. There are no unequivocal findings that provide an evidence-based response to the question of how to develop the social work workforce in relation to their practice with people who use alcohol and other drugs. However, research studies and commentaries provide insights and ideas and allow some preliminary conclusions to be drawn. First, training social workers can improve their attitudes,

knowledge and direct work in this area, even though some studies suggest such changes are not always maintained. Further, where social workers feel it is a legitimate part of their job to address substance use, training has a greater impact. Second, the literature highlighted a range of educational barriers that needed to be overcome to ensure social workers were equipped for working with alcohol and drug use. Third, where specialist substance use knowledge has been part of social work service delivery through specialist substance use social workers or through a specialist 'link' worker, both staff and service users have reported more positively about their knowledge and skills and support. Thus, where social workers specialise in substance use or are committed to engaging with the subject the evidence suggests they use their knowledge and skills to good effect.

5 Findings: Roles and Functions (Search 3)

Summary of key findings

- Social workers are well placed to play an active role in supporting people with alcohol and other drug problems because of social work's holistic and ecological approach.
- The literature, either explicitly or implicitly, suggests the need for an ongoing and intensive involvement with service users.
- Attention needs to be paid to challenges for social workers fulfilling these roles including lack of training, role support and legitimacy, tensions between conflicting roles, e.g. care and control, personal versus professional beliefs, to name a few.

Overview

5.1. The preliminary search identified 2175 articles using the search terms identified in appendix 1. After the application of inclusion and exclusion criteria during initial and full screening processes (see figure 3) the final total of relevant literature was 25. Given the limited amount of relevant literature available pre-1995 studies were also included. Nineteen of the 25 studies were North American, with two from Israel, two from the UK and one each from Ireland and Germany.

5.2. This was the broadest of the searches and the quality and quantity of literature found was disappointing. What did not emerge in this search were any clear models for social work practice with people using alcohol and/or other drugs, nor any empirical studies exploring the effectiveness of various roles or functions.

Key findings from the research literature

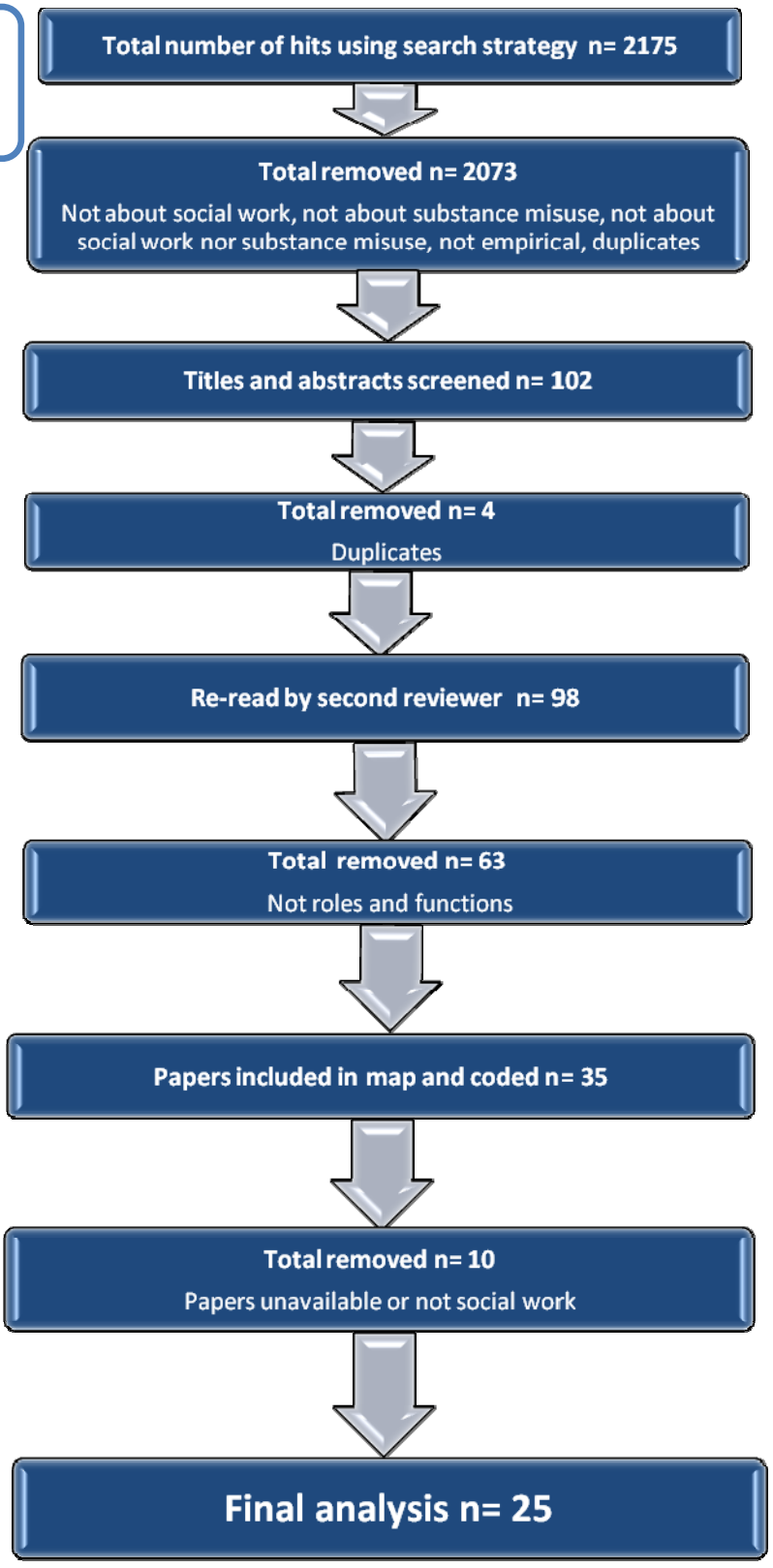
5.3. The 25 studies fall into three main groups; 14 relating to social workers' roles with specific service user groups, nine articles reflecting on social workers' roles with people using substances, and two that focus on the challenges social workers face working in this area.

Social workers' roles with specific service user groups

5.4. The majority of literature in this group was reviews and discussions (n=9). The remainder comprised empirical studies (n=3), meta-analysis (n=1), and guidance for practice (1). Four studies focussed on social work practice with older people using alcohol (Barnea and Teichman 1994, Goldmeier 1994, Millard and McAuley 2008, Raffoul 1986). Of these four, only the Scottish study by Millard and McAuley was empirical, the others were reviews of and reflections on practice with this service user group.

5.5. Millard and McAuley (2008) held focus groups with 90 staff and managers providing home, day and residential care to older people in order to explore how alcohol problems were identified, their perspectives on their role in doing so and the extent to which they referred on to specialists and any barriers for doing so. They found staff were concerned about discussing alcohol problems for fear of damaging their relationship and invading the person's privacy.

Figure 3:
Review process: search 3, roles and functions



Staff felt the relationship needed to be established to allow “hints” to be dropped about alcohol as appropriate. Some home carers purchased alcohol for service users or took them to the pub but others were concerned about litigation. The authors concluded that there was a need for appropriate home or day care services focussing on harm reduction.

5.6. Barnea and Teichman (1994) reviewed the literature on older people’s drinking and suggested that social workers are best placed to support older people in the community but that training is needed to address both knowledge of alcohol and older people and also negative attitudes towards older drinkers. They felt that social workers could contribute in this area by uncovering the issue, assessing and referring on, educating service users and their families on alcohol’s effects, educating other professionals and evaluating intervention outcomes. They also called for specific programmes geared to older people.

5.7. Goldmeier’s (1994) literature review focussed on the social worker’s role in intervening with older drinkers in the workplace, identifying five roles for the social worker:

* Broker – linking people to specialist community services
* Enabler – helping people develop alternative activities
* Teacher – providing education about alcohol
* Mediator and advocate
* Case manager – responsible for coordinating and following up services.

While this review focussed on social work roles and functions in workplace settings the roles Goldmeier describes are transferable to social workers in a range of settings.

5.8. Finally Raffoul’s (1986) review reflects that the social worker is the most appropriate person for intervening with an older person’s substance use due to their familiarity with the service user and their social context, knowledge of their medication and pharmacy services, and their ability to liaise between professionals.

5.9. Three studies focussed on social workers’ roles with substance using mothers (Cook 1997, Sun 2000, 2004). Cook’s review was limited but concluded that a social worker working with pregnant substance using women was in the ideal position to assess the woman in her environment and make recommendations to other professionals regarding her care. The reviews by Sun both offered guidance for practice, one for social workers working with pregnant substance users and the other for substance using mothers in the child welfare system. In relation to the latter, Sun suggests the social worker should treat the mother and children as one unit in terms of supporting their recovery, providing support that is sensitive to their culture and gender, offering life skills training, developing support systems, developing safety plans for children, and leading the coordinated work of an interdisciplinary team. In relation to pregnant, substance using mothers she draws on the same model as Goldmeier (1994) suggesting social workers should be teachers, brokers, mediators, advocates and also a “clinician”, tasked to increase the woman’s self-efficacy, build

social networks and helping women to overcome the shame and guilt associated with substance use.

5.10. Dumaine (2003) and O'Hare (2003) both focussed their reviews on people with co-existing substance use and mental health problems and the implications for social work practice. Dumaine conducted a systematic review and meta-analysis of effective interventions for people with "dual diagnosis" finding that intensive case management showed greatest effect sizes. As with other commentators in this section he identified a number of tasks, rather than roles, that he states are key to social work interventions: "outreach; engagement; assessment; goal setting; leverage, structure, and limit setting; linkage, coordination, and integration of treatment services; long-term continuity of care; and advocacy and resource development" (Dumaine 2003: 158). However, he points out many of these are intrinsic to a case management approach. O'Hare's (2003) review explored evidence-based practice in relation to social work and applied it to interventions for co-existing mental health and substance use problems. He too concluded that assertive case management, combined with "advanced clinical expertise", was part of social workers' role in delivering evidence-based interventions. O'Hare also listed a number of tasks and responsibilities for social workers, most of which have been mentioned above, with the addition of specific roles in relation to this service user group, e.g. helping people to make links between their substance use and their "psychosocial" conditions.

5.11. Two studies focused on the role of social workers in specialist substance use services (Fewell 1975 and Roberts et al. 2002). These were an alcohol treatment team and a therapeutic community respectively. Fewell's review described what treatment does and what a social worker's role could be within it, emphasising the importance of involving family members. Roberts et al. (2002) explored how resiliency theory, which is familiar to social workers, can be used to structure and enhance the experience of people staying within a therapeutic community. They concluded that social workers' knowledge of resiliency, as well as their skills in assessment, brokering service links, relapse prevention and treatment can benefit therapeutic communities. However, in the UK, these latter specialist substance use components are not routinely learned by social workers working outside specialist substance use practice.

5.12. Jenson et al.'s (1995) review focused on 'adolescent' with substance use problems and the implications for social work practice. As well as calling for more collaboration between 'adolescent' services, delivery of family therapy and more diverse services to meet the range of needs of 'adolescents' with substance use problems, the review called for the better education of social workers to equip them to intervene effectively. In a study exploring social workers' recording and practice in relation to people using alcohol and/or other drugs, Kagle (1987) reviewed 100 case records and interviewed 59 social workers from child welfare, family, mental health, and health services. He found that while a small number identified and raised the issue of substance use, many did not because they felt it was not the main issue. He stated that while child welfare and family service social workers were particularly sensitive to substance use problems among their service users they often did not initiate referrals and the barriers were both professional, for example, social workers failing to view the substance use as the core problem in their child welfare work, and

organisational, for example a reported lack of support from their agency for the referral or a perceived lack of effective specialist substance use services in the geographical area.

5.13. Finally, Toseland and Hacker (1982) conducted telephone surveys with 44 leaders of self-help groups to explore the role of social workers within them. Social workers were most likely to be involved setting-up the groups as well as providing material support for their establishment and linking service users and other services to the group. Their role in developing and supporting the ongoing work of the group was seen as crucial. While this is an old North American study it suggests a role for social workers in terms of self-help group facilitation which is not common in the UK but may increase if recovery approaches are adopted and service user involvement in services is expanded.

Challenges for social workers

5.14. Two articles by Burman (2004) and Garbin (1974) explored the tensions that exist for social workers working with substance use problems. Garbin's article was primarily an opinion piece outlining some of the tensions between professional values and expectations and personal beliefs in relation to substance use. While the paper is dated, the currency of the tensions and dilemmas between personal use of substances and ethical codes for professional practice remain. Burman (2004) explored the client centred versus social control aspects of social work practice, particularly within criminal justice processes that mandate people to attend treatment. Burman reflects on the importance of being clear about roles and limitations when functions conflict. However, also believes social workers have a clear role to play in supporting people in other areas of their lives which, in turn, will support their longer term abstinence from substances. Burman states that social workers are suited to this work due to the holistic nature of social work practice, but calls for transparency with service users and professionals when social workers take on dual roles that may conflict. Again the point of good communication and the education of other professionals as to roles and limitations was a key task for the social workers emerging from this review.

Reflections on the social worker's role

5.15. The remaining nine articles fall into the broad category of reflections on the social worker's role in working with substance use. Five are reviews of literature or policy and practice, three are opinion pieces, and one is a historical account of social workers' roles in "addiction" in the USA. It is worth emphasising that these are not studies of interventions or effectiveness of social work roles or interventions. While the focus of each study differed to varying degrees the messages from all were similar and overlapping. These have been summarised as follows:

5.16. *Social workers are increasingly seeing people with alcohol and/or other drug problems in their practice and this is set to continue*. This literature along with others detailed in previous sections of this report supports the fact that social workers are increasingly working with people with alcohol and other drug problems and therefore this needs to be considered in relation to their training and support needs.

5.17. *Social workers are best placed to work with people with a range of addictions due to the profession's holistic theoretical frameworks and flexible approaches to*

practice; in particular their ability to coordinate care across a range of services is important to people with complex needs. The importance and potential contribution of the profession's principles and theoretical underpinnings, in terms of its ecological and holistic approach to working with individuals and families, is a point that is repeatedly made in the literature and distinguishes it from other professions. Coupled with the location of many social workers within the community and their experience at coordinating services to support service users, social workers are perceived to be in a valuable position to engage and work with people with alcohol or drug problems in their home environments.

5.18. Social work relationships with service users are key to effective practice.
A number of studies highlight the importance of a positive and supportive relationship between social workers and service users being key to working with people with alcohol and drug problems. Of particular note is a study from 1953 by Sapir. While nearly 60 years old, the article stresses the importance of the social worker's interest in, and warmth towards, the service user. It also states a positive relationship is a basic and fundamental requirement of practice, and this requires understanding and support for the individual and their family members while the person is trying to change their substance using behaviour.

5.19. *There are synergies between recovery approaches to substance use and the social justice emphasis and advocacy principles underpinning social work practice*.
A number of the studies made reference to the place of social workers in promoting service users' views and perspectives through advocacy and empowering approaches to practice. The greater emphasis on service user involvement in their care and the services they receive are at the core of the recovery approach emerging in the substance use field.

5.20. Social work education has failed to respond to needs for social workers to be educated for, and skilled to, work with substance users.
It has already been noted above that social work education is not meeting social workers' needs in relation to knowledge and understanding of alcohol and drugs nor in relation to training in effective interventions.

5.21. Social workers also need to take "political action" (Morell 1996) to support changes in policy and practice both in social work education and practice and in policies that affect service users with substance problems.
Social work as a profession has long been concerned with social justice and fighting social injustice. Morell suggests that social workers in specialist addiction settings need to educate service users in the socio-political context of their substance use and seek to support them to advocate for social change that is supportive of people's recovery. The latter point is supported by Peleg-Oren et al. (2002) who consider it part of a social workers' role to campaign for better substance misuse services.

5.22. *Social work interventions need to be up-to-date with the evidence base*.
Several commentators spoke of the expanding knowledge base in relation to substance use and the changes to practice in the field and as well as the social work profession's ability to reflect on and integrate different ways of working in their practice. Vogt (2002) stated that social work had to keep in touch with the changing evidence base in prevention and intervention work.

Conclusion

5.23. The literature in this search primarily emphasised social workers' suitability for supporting people with alcohol and/or other drug problems both in terms of the range of tasks and roles that comprise social work practice but also the types of knowledge and principles that underpin their practice, e.g. advocacy, resilience, and balancing care and control. However, it had also identified a number of individual and organisational barriers to them doing so. What is clear is that the social worker-service user relationship at the core of the range of roles and tasks. Whichever role is adopted, establishing positive and supportive relationships both with individuals and in a wider role, such as educating and supporting family members, is key.

6 Discussion

6.1. This chapter discusses the evidence found in relation to the four key objectives of this research. These were to:

* Review the available evidence on the efficacy of social work and social care interventions in substance use treatment, care, rehabilitation and recovery
* Review the evidence on the distinct functions, roles, support and interventions provided by social work and social care professionals and their appropriate relationship with other interventions
* Collate information from the literature that would help the development of the workforce providing substance use services both in specialist services and in other social services such as mental health, criminal justice, children and families and community care
* Collate information in relation to 'what works' (including an assessment of the outcomes achieved) in non-Scottish contexts in order to inform innovative practice and debate about the transferability of such approaches to Scotland.

6.2. Given the links between the first and fourth objectives, these are discussed together followed by a discussion of objectives two and three. The discussion then offers some suggestions for future practice development, particularly in the context of the substance use recovery approach in Scotland.

Efficacy of social work and social care interventions

6.3. This was a challenging area to review primarily because the social work/social care contribution to substance use treatment was not always identified. There was also a dearth of evidence from the UK with the majority of the evidence and other literature stemming from North America. This, in turn, raises questions about its transferability to UK service contexts, and Scotland in particular.

6.4. In some respects the absences were as noteworthy as the evidence. There were few studies from the United Kingdom and none from Scotland. This suggests a systematic lack of research on the social work contribution to substance use services in these settings. A major practical issue that arises from this is the difficulty in interpreting findings carried out in other countries for understanding what "works" – or might work - in a Scottish context.

6.5. The second major absence was studies relating to older people, people with disabilities (physical or intellectual), children in care or those experiencing domestic violence. Given the importance of, and vulnerability to, substance use in all of these areas the lack of research is quite extraordinary. Even in the area of child and family social work only one UK study was identified that evaluated an intervention. This speaks to a systematic under-funding of social work and social care research (Marsh and Fisher 2005).

6.6. Nonetheless, despite this there was clear and consistent evidence that social work and social care can make an important and positive contribution to increasing the effectiveness of substance use treatment services. It was particularly striking that social work services were often successfully used with people with substance use

problems and what are often considered to be challenging additional circumstances, such as those with a mental illness, those who are homeless or those using alcohol and/or other drugs during pregnancy.

6.7. The literature in this respect relates predominantly to versions of "case management". There were, in addition, many promising or interesting interventions that had been evaluated, often on a one-off basis. The effectiveness of case management has been the subject of extensive debate in the academic and practice community. In large part this is because of wide variations in what is meant by "case management" and related variations in findings about the effectiveness of the approach. A more appropriate approach than attempting to identify whether case management "works" at a general level is to begin to explore what types of case management work, for whom and in what contexts.

6.8. Summarising the literature reviewed in chapter 3 there were some overall themes emerging regarding effective case management approaches. In general:

* *The form of case management offered needs to match the needs of the service users being worked with.* In broad terms, the more complex and longstanding the needs of the service user group the more intensive and long-term the form of case management will need to be.

* *The more serious the problems in the service user group, the more likely that case management will be beneficial.* Thus, for homeless individuals, service users with co-existing substance use and psychiatric problems and pregnant drug users, versions of case management appeared particularly beneficial. For those with less complex problems, such as individuals leaving substance use treatment without additional issues, case management did not always affect outcomes. This highlights the complexity of providing services in relation to substance use and misuse because patterns of use, service users' needs and the best services for them vary.

* *Approaches that focussed on developing and sustaining a relationship appeared more likely to be linked to positive outcomes than forms of case management which focussed on effective service coordination.* This is important in understanding the ambiguous evidence on the effectiveness of case management, because the intervention being evaluated is often primarily an administrative coordination of services. On its own this appears to have little benefit. The studies that reported the best outcomes for service users had a form of case management that was strongly focussed on the development of an effective helping relationship. Services were then coordinated based on this relationship, which allowed the building of a trusting relationship, helped in the engagement of the service user with services, meant that workers had a better understanding of the needs of the service user and that allowed a more equal exploration of options.

6.9. In addition to a focus on relationship-based case management, common features of successful case management approaches included:

* A tendency to have a limited number of service users per worker

- An emphasis on creatively engaging people, for instance through out-of-hours work, interventions based in service users' homes or other places (such as soup kitchens) that they might attend
- Access to additional services rather than simply coordinating existing services
- Availability when needed, for instance through 24-hour on-call services or long-term consistent availability
- All emphasised skilful communication and engagement, and a large number based this on motivational interviewing or variations thereof.

Information in relation to 'what works' (including best practice examples)

6.10. In addition to some form of case management approach, a variety of specific social work interventions or services had promising results. Once again social work services dealt with people with the most pronounced and complex problems, and there were some examples of noteworthy successes being achieved with these groups. This section provides more information in relation to four studies from the results section. Studies were chosen where the interventions or services seemed to be:

- Of potential relevance to the Scottish practice context
- Consistent with a recovery approach
- Demonstrating potential effectiveness.

6.11. Bouis et al. (2007) and Whetten et al. (2006) report on a comprehensive drug and alcohol treatment package for individuals with a "triple diagnosis" of HIV, mental health issues and substance use problems (primarily related to illegal drugs). It is a noteworthy study because it focussed on a group for which few interventions have been proven to have a positive impact. It also took an approach that was consistent with the principles of social work, in working with the individual and their broader social situation. The service combined attention to building a relationship based on motivational interviewing principles and then working with the individual and their broader social context (including other services they received, housing and other issues). The study provides a good example of a successful application of a complex psycho-social intervention with a group often found not to use mainstream services.

6.12. A second study of interest looked at peer case management for service users with substance use problems and mental ill-health issues. Sells et al. (2006) reported on an innovative form of case management in which peers with histories of severe mental illness worked with service users. This approach appears particularly consistent with a recovery emphasis, with its focus on the importance of service user control around services. It appeared particularly helpful in engaging and creating a good working relationship. Key elements in making the intervention work included a limited case load and good supervision for peer case managers.

6.13. To date, the evidence on effective interventions for children affected by parental problem drug use and their families is limited. Two case studies from the literature appeared particularly interesting in this respect. First, Ryan et al. (2006, 2008) found that an extremely intensive approach which included intensive outreach and engagement and access to a range of services helped pregnant women during and after pregnancy. The intervention produced not only positive outcomes for the

women but reduced the number of subsequent children born withdrawing from drugs. Given the significant social risks for such children, and the risk of them entering care, this is an approach that might be worth considering within a Scottish context.

6.14. Another service working with families affected by parental problem use of drugs or alcohol was evaluated by Forrester et al. (2008a). The study reported promising findings for an intensive service based in Wales aimed at families known to social services where there were serious concerns relating to parental alcohol or drug use. Of particular interest was the fact that the intervention appeared to reduce the time children spent in care and thus produced cost savings. Unlike other interventions – such as Family Drug and Alcohol Courts – this approach appears transferable to a Scottish context. The Option 2 service is providing the basis for broader system change across social care services in Wales which is currently underway.

6.15. While the studies identified cover a wide variety of presenting issues and describe a diverse range of interventions, there are some common themes. First, while the conventional literature on substance use problems has often dealt with the issue in isolation, in fact drug and/or alcohol problems are very likely to co-exist with a range of other circumstances, including domestic violence, mental health issues, poverty, child maltreatment and homelessness. Social work services are far more likely to be aimed at this complexity. Thus, while substance use treatment studies often exclude substantial numbers of individuals with additional or complex problems, social work interventions tend to be focussed on this very complexity. This highlights the importance of social work and social care for a recovery approach.

6.16. Second, people with complex problems require practitioners who have high levels of skill in engaging and working with them. Exceptional communication skills and positive attitudes to working with people who use alcohol and/or other drugs are crucial common features which allow practitioners to engage individuals who have often experienced stigma and multiple disadvantage over many years. These foundational relationship-based skills need to be complemented by an ability to keep working with people through patterns of behaviour change that may involve lapse and relapse and a focus on creating broader social changes for the individuals concerned. In particular, a number of studies focus on the importance of access to health care and housing.

6.17. Third, successful interventions are characterised by a relatively high level of intensity of input and protected or restricted caseloads. For instance, the Ryan et al. study involves workers working with no more than two families and Option 2 workers work with just one family at a time. Similarly in relation to case management, successful interventions with those with complex needs require a limited caseload and a supportive working environment.

Information that would help the development of the workforce

6.18. Given these key elements of effective social work provision for people with drug and/or alcohol problems, what are the lessons from the literature on the development of the social care workforce?

6.19. Most of the studies in this chapter explored training, from its impact on attitudes and knowledge to training needs, preparation for practice and curriculum design. The literature focuses exclusively on the social work population rather than the broader social care workforce suggesting a dearth of research looking at the latter group.

6.20. The current literature provides a clear message that social workers need to be trained in substance use and that social work education to date has failed to do this adequately and consistently. Of particular concern is the reported lack of knowledge of how to intervene to the extent that social workers know they are failing their service users (Hayden 2004, Galvani and Forrester 2008). Given the prevalence of substance use in social work caseloads, this situation should not be allowed to continue and social work education needs to improve quickly. The applicability of this finding to Scotland is difficult to establish. The focus of the Scottish Social Care Council's reviews of social work training is on meeting the standards set out in the *Framework for Social Work Education in Scotland* (Scottish Executive 2003) (personal communication, Smith 2010). As substance use is not mentioned in the Framework there is no review or monitoring of it. For social work educators looking to improve their education on this subject, attempts to develop materials targeting social work educators have recently been published by the Higher Education Academy for Social Policy and Social Work (SWAP).

6.21. The reported success of training contexts that allow for networking and interdisciplinary understanding is worthy of note. While the evidence here suggests equivocal results for training in relation to knowledge and competence, particularly in the longer term, generally there was overall improvement in attitudes. The importance of attitudinal change should not be underestimated as it is likely to be the first step towards people engaging fully with the subject and on which further training and practice can then build.

6.22. The historical lack of attention to substance use in social work education apparent in the evidence appears to have resulted in educators who are not able to adequately offer training and supervision in substance use issues with one study suggesting training educators may be a helpful way of increasing input on social work programmes. For educators, individual social work staff and the policy frameworks that support both groups, engagement with the issue of substance use appears to be the crucial component. Engagement also appears to be a vital factor in the evidence-based interventions (as a key part of the outreach and case management tasks), as well as for social workers looking to develop their skills for practice, and for social work academics incorporating relevant training onto the curricula. Finally, the need for engagement with substance use as a legitimate role for social work practice or as a legitimate topic for social work education came through in a number of studies. The literature suggests that those who *elected* to undertake training or felt it was part of their role, benefitted most from it. This in turn suggests that there may be work to be done *prior to delivering or receiving training* which seeks to ensure both practitioners and social work academics understand, accept and are committed to training and working in this area, otherwise there may only be modest improvements in practice. At least as important is a practice context that is supportive of their work in this area, not one which is so "situationally

constrained" (Lightfoot and Orford 1986) as to prohibit or restrict improved practice in this area.

6.23. A further key point is that, in delivering evidence-based interventions, training tends to be a means to engage and interest practitioners, but that lasting improvements in the skills of practitioners require direct supervision of practice. A training course can provide insight and motivation, but skill is improved through processes of doing and then receiving feedback – usually from those who have high levels of skill. This highlights the importance of systems that support excellent practice, rather than one-off training sessions. In the same way that the recovery approach points to a more long-term and ambitious focus on sustaining change for people with substance use problems, improving social work practice with substance use requires sustained focus on improved practice including monitoring and review.

6.24. The studies that were more focussed on the development of practice skills or exploring current practice highlighted the need for improved communication as a means of overcoming some of the barriers in effective engagement with people with substance use problems. Good communication by social workers cannot be assumed and while there may need to be more general improvement and emphasis in skill development, it may be that in the interim senior, or more experienced social workers, are identified to work with service users with problem alcohol and/or drug use, particularly where there are more complex and overlapping needs.

The distinct functions, roles, support and interventions provided by social work and social care professionals

6.25. There were no groups of studies evaluating distinct social work roles that clearly pointed to social workers having a particular role or function with people with substance use problems. This could be for a number of reasons:

* no distinct roles or functions have been identified for social workers working with substance use perhaps due to the primarily health and criminal justice led nature of responses to people with problem drug and/or alcohol use
* such roles or functions do exist but this is not reflected in the current literature
* the historical lack of engagement with substance use by the social work profession suggests that it is early days in terms of locating a specific role in the broader health dominated context of substance use service delivery.

6.26. However, the literature in this section emphasised the suitability of the social work profession's approach for supporting people with alcohol and drug problems due to its underpinning theories and principles. Social work is arguably a unique profession in its attention to the individual within both their immediate home environment and the wider socio-political context in which they live. This holistic approach to working with people underpins good practice in assessment and intervention processes. Further, its commitment to social justice and empowering processes make it a profession most suited to a care management approach. However the literature also identified some of the barriers to social work and social workers engaging with substance use issues at both organisational and individual levels.

6.27. Once again the need to educate and train social workers in order for them to see it as a legitimate part of their role and support them in helping service users effectively was a key theme emerging from the literature. This is not a new finding but its repetition in the literature is perhaps indicative of the many failed attempts in the previous 30 years to convince the social work profession and educators to embed substance use into the social work curriculum at qualifying and post qualifying levels (see Galvani 2007 for review). This, in turn, suggests that guidance and calls for change, unsupported by policies, effect little change. It also points to the fact that it is not just individual staff that need training but that there needs to be organisational commitment to supporting staff to work with substance use, particularly in light of the literature highlighting the challenges and potential personal and professional tensions that may emerge when working with people with substance use problems.

6.28. Among the roles identified in the literature but less commonly practised were those of educator and teacher in relation to substance use. This ranged from teaching people new skills to educating family members about substance use. These roles are the types of roles social workers are arguably already filling in other specialist areas of practice. However crucially in their application to working with people with substance problems this relies on social workers having a good knowledge of substance use, the types of intervention available and an understanding of what additional support will be required.

6.29. Importantly the literature reinforced the findings of the interventions search in terms of highlighting the need for a greater involvement for social work in supporting people with substance use problems, primarily in a case management or care coordination role, working with people throughout the various stages of behaviour change. This means adopting a role that begins with engagement and assessment and proceeds through to aftercare and coordination of other support services.

6.30. Community-based care management for people with alcohol and drug problems is already in operation in many authorities in Scotland (personal communication, Robertson 2010). While there is no known evidence on its effectiveness, the similarity of a number of its tasks and roles to key elements of case management is positive. Reviewing the extent to which the care management role in Scotland encompasses the roles and tasks identified here as being important is a possible way forward. So too is identifying the extent to which those in front line or supervisory positions have the training and skills to carry them out effectively.

Social work, the recovery approach and future directions for Scotland

6.31. Social work practice has a comfortable fit with the recovery agenda for substance use services in Scotland. The recovery approach presents a challenge for many substance use services to re-think their service delivery which has been dominated by individually focussed and professionally-led interventions for so long (Best et al. 2010). The emphasis in Scotland on recovery approaches offers a timely opportunity for the involvement of social work. Social work's prioritising of service user involvement, partnership work and a shift of power from professional as expert to service user as expert, make it well placed to support the principles and practice of the recovery approach. In its underlying principles of empowerment and advocacy,

as well as its quest to be service user-centred and strengths focussed, social work has an easy fit with these new approaches within the substance use arena.

6.32. What is also needed to support change in, or development of, social care work with people who use alcohol and/or other drugs is a strong policy context. In many ways Scotland is ahead of the game. A number of key Scottish policy documents have recognised the importance of addressing the social implications of problem alcohol and/or drug use, alongside health concerns, and to ensure support goes beyond individualistic specialist treatment and reaches into families and communities (Audit Scotland 2009, Scottish Government 2008a, 2009). At the same time there is also political recognition within Scotland that "generic services"[2] play an equally important role in supporting people with alcohol and/or other drug problems (Scottish Government 2008a) which needs to be capitalised upon. The Social Work Inspection Agency's (SWIA) (2010) recent report, *Improving Social Work in Scotland,* takes this further highlighting both the importance of addressing substance use in all social work services and also the likelihood of an increased need for an effective social work response in adult services in the future.

6.33. Social workers from a range of practice areas are frequently, if not daily, in contact with people with alcohol and/or other drug problems. They are supporting people who have highly complex needs and overlapping problems and circumstances. Further they are likely to be the main professionals working with such complexity as such overlapping problems are not usually addressed in specialist substance use services, particularly those that sit within health structures (SWIA 2010). In *Changing Lives: Report of the 21st Century Social Work Review* (Scottish Executive 2006) the then Scottish Executive set out the potential for developing new roles or growing existing ones. The findings of this review suggest both are needed in relation to social work interventions with people with substance use problems. It has once again highlighted the need to support all social workers, regardless of specialism, through education and training to ensure they engage with, then work with, the substance use problems of their service users. The framework and planning are already in place and, combined with leadership by the Association of Directors of Social Work (ADSW) and its Standing Committee on Substance Misuse, Scotland has a head start. In the next chapter recommendations on how this progress might be maintained are set out.

[2] The document does not offer a definition of generic services but it is often used to mean services that do not usually offer specialist substance use services, including most social work services, health visitors, housing departments and other front line services.

7 Implications and Recommendations for Policy, Practice and Research

7.1. Policy and practice

7.1.1. Implications for care management in Scotland

Given parallels between case management and care management approaches, this review concludes that care management appears to be an appropriate approach for coordinating services for people with substance use problems. Specialist social work services in substance use, operating a care management approach, are currently believed to be in place in approximately half the local authorities in Scotland. The evidence from this review would support this being extended to ensure that service users have access to ongoing care and support regardless of geographical location.

However, given the strong link between *limited caseloads* and the effectiveness of care management it may be appropriate for worker caseloads to be monitored or maximum numbers of service users per worker to be recommended. Further, effective care management approaches tended to *use skilful communication* approaches originating within the substance use treatment field. In particular, motivational interviewing was used in a large proportion of successful examples of case management. This research suggests that the evidence supports the widespread development of training and supervision to ensure that care managers are skilled in motivational interviewing or related approaches.

7.1.2. Develop and evaluate effective interventions

There is an urgent need to develop and evaluate new social work approaches among older people, people with disabilities, people experiencing domestic violence and children in care. The most obvious place to start such a process is by identifying and adapting approaches that have been found to work elsewhere. There are several promising interventions aimed at parents with problem drug and/or alcohol use, individuals with dual diagnosis or other groups – such as older people - that have been identified in this study.

7.1.3. Improve education and training on substance use for social workers and social care workers

The evidence suggests that where people feel substance use is part of their role they are more likely to benefit from training and improve their knowledge, skills, values and practice with people for whom alcohol and/or other drug use is a problem. Previous attempts at guidance for educators have failed to get substance use on to the social work curriculum in a consistent way. Consideration should be given to mandating substance use education within the qualifying and post-qualifying social work curricula. Attention also needs to be paid to the education of social care staff that fall outside social work education frameworks.

7.1.4. Ensure organisational support and responsibility

A crucial problem is that workers often practice in organisations that do not treat drug and alcohol problems as something they are responsible for. This creates situational constraints in developing confidence and skills in working with substance use. It is therefore important that all organisations providing social care have a clear

responsibility to ensure its workforce have the skills and support to help individuals with drug or alcohol problems.

7.1.5. Develop and monitor relationship skills

The importance of positive relationships when working with service users with alcohol and drug problems is a clear message from the research evidence and other literature. Good communication skills cannot be assumed, nor can skilled and empathic assessments or positive attitudes towards working with this service user group. These are vital to effective engagement and need to be at the core of professional development.

7.1.6. Ensure effective and informed supervision

Training alone is not enough to create skilled workers. Effective professional supervision is also necessary. It is therefore particularly important for those who supervise practitioners to have received appropriate training to support workers to work confidently and sensitively with drug and alcohol issues, and to monitor and support the further development of social workers' interpersonal and relationship building skills.

7.2. Research

7.2.1. Evaluating the effectiveness of existing services in Scotland

The lack of Scottish studies highlights a lack of research on social work and social care interventions with people who use substances problematically. In particular, care management as an approach in Scotland would benefit from evaluation. Such research should be aimed at identifying not only the impact of care management but also comparing care management in different Scottish contexts.

7.2.2. Determining key effective elements

Research exploring the effective elements of interventions is also needed. While this review identified some key elements that appeared to be consistent across the more successful interventions, more work is needed to clarify if it is the intervention, particular aspects of it, or the therapist skills that are key to its success.

7.2.3. Establish the effectiveness of training

Rigorous research is needed on the effectiveness of substance use training on social workers' knowledge and practice. Studies should be experimental in design, following-up at intervals to measure actual behaviour change.

Appendices

Appendix 1 - Search terms, databases and additional resources

The following key terms have been used in the respective strands of the review:

Intervention search	Social work*; social care*; care manager; case manager; care work*; care officer	intervention*; treatment; assess*; practi* (for practice/ practise); involvement; support* help*; recovery; rehabilitation	alcohol*; drink*; drug* substance; addict*

Workforce development search	Social work*; social care*; care manager; case manager; care work*; care officer	train*; educat*; qualify*; skills; develop*; teach* instruct*; guidance preparation; knowledge	alcohol*; drink*; drug* substance; addict*

Roles and function search	Social work*; social care*; care manager; case manager; care work*; care officer	role* or function* or position or responsibility or job or task	alcohol*; drink*; drug* substance; addict*

The following sources were searched for all searches:

- SocIndex
- Assia (only searches 2&3)
- Medline
- PsycInfo
- Social Care Online
- OpenSigle

In addition the following resources were accessed for background and contextual literature:

- Scottish Social Services Council
- Scottish Advisory Committee on Drug Misuse
- National Treatment Agency for Substance Misuse (England)
- Scottish Government website
- Alcohol Concern website
- IRISS website
- Adfam website
- Drugs Library at Stirling University website
- Drug Misuse Information Scotland website
- Social Research Association website
- ADSW
- Social Work Scotland
- EMCDDA (European Monitoring Centre for Drugs & Drug Addiction)
- Changing Lives microsite
- scottishrecovery.net
- Alcohol Focus Scotland
- Alcohol Information Scotland
- AERC
- SCIE
- STRADA
- BASW
- ICAP (International Centre for Alcohol Policies)
- Joseph Rowntree Foundation
- drinkanddrugs.net

Appendix 2 - Exclusion/inclusion criteria

For the initial screening the following broad criteria were applied:

Code	Criteria
A	Is not related to social work
B	Is not related to substance use
C	Is not related to social work nor substance misuse
D	Not empirical*
E	Does not meet the above, but is of interest (set aside).

* This exclusion criteria was not applied in search 3 (roles and functions) as a result of (a) the small amount of literature found and (b) the exploratory nature of this search, ie. not intervention or effectiveness focused.

The PICOS model was subsequently used to guide criteria for inclusion and exclusion for search 1 relating (interventions). PICOS was also applied more flexibly to search 2 (workforce development). Following mapping of the literature and discussion with the steering group, empirical research remained the focus of search 2 with the option of including policy analysis and literature reviews where rigorous methodology was transparent.

Exclusion

P - Participants	People not receiving a social work or social care service;
I - Interventions	Not social work specific nor appropriate for social work practice, eg. substitute prescribing; lacking rigorous evaluation
C - Comparison	No control group or comparison group**
O - Outcomes	Lack of clear outcomes or outcomes based on practice measures
S – Study type	Descriptions of models or methods**
Miscell.	Opinion pieces; editorial, media reports

Inclusion

P - Participants	People attending the range of social work and social care services; services users who use alcohol or other drugs; families of service users with alcohol or other drug problems
I - Interventions	Full or partial interventions, formal interventions, clear focus on care, support, rehabilitation and recovery
C - Comparison	Control or comparison group**
O - Outcomes	Measures clearly defined and appropriate to aims and objectives
S – Study type	Empirical research (qualitative or quantitative); evaluative research
Miscell.	England, Wales, Australia, New Zealand and appropriate European literature

** Some exceptions were made for interventions that had some evaluation, were clearly described and could demonstrate applicability to social work approaches. Similarly if there are models or methods that showed potential applicability these were set aside for discussion.

Appendix 3 - Rapid evidence maps

Search 1 – Effective Interventions

Year (n = 57)

- 1995-1998 (n = 7) 12.3%
- 1999-2002 (n = 8) 14%
- 2003-2006 (n = 23) 40.4%
- 2007-2010 (n = 19) 33.3%

Country (n = 57)

- UK (n = 6) 10.5%
- USA (n = 49) 85.9%
- Australia (n = 1) 1.8%
- Canada (n = 1) 1.8%

Service user Group (n = 57)

- Homeless (n = 13) 22.8%
- Older People (n = 1) 1.8%
- Families (n = 18) 31.5%
- Mental Illness (n = 14) 24.6%
- Substance Misuse (n = 11) 19.3%

Intervention (n = 69*)

Case Management – All Forms (n = 25)

- Aftercare Intensive Case Management (n = 1) 1.4%
- Case Management (n = 7) 10.1%
- Case Management with Peer Consumer Advocacy (n = 1) 1.4%
- Case Managers Training in Substance Misuse (n = 1) 1.4%
- Clinical Case Management (n = 2) 2.9%
- Intensive Case Management (n = 5) 7.2%
- Intensive Case Management with Peer Support (n = 1) 1.4%
- Intensive Case Management with Recovery Coach (n = 3) 4.3%
- Iowa Case Management (n = 1) 1.4%
- Peer Case Management (n = 1) 1.4%
- Time Limited Case Management (n = 1) 1.4%
- Enhanced Case Management (n = 1) 1.4%

Community Treatment- All Forms (n = 5)

- Assertive Community Treatment (n = 2) 2.9%
- Community-based Treatment (n = 1) 1.4%
- Immediate housing with assertive community treatment (n = 1) 1.4%
- Integrated Assertive Community Treatment (n = 1) 1.4%

Family Interventions- All Forms (n = 13)

- Adapting Parent-Child Assistance Program (PCAP) (n = 1) 1.4%
- CASAWORKS for Families (CWF) (n = 2) 2.9%
- Family Strengths and Empowerment 'Wrap-around' model (n = 1) 1.4%
- Family Treatment Drug Courts (FDTC) (n = 2) 2.9%
- Modified Family Nurturing Program (n = 1) 1.4%
- Option 2 (n = 1) 1.4%
- Ecologically based family therapy (n = 1) 1.4%
- SafePort (n = 1) 1.4%
- Parent training with behavioural couples therapy (n = 1) 1.4%
- Dependency Drug Courts (n = 1) 1.4%
- New Choices (n = 1) 1.4%

Methods of intervention – All Forms (n= 8)

- CBT (n = 2) 2.9%
- Cognitive Behavioural Integrated Treatment (n = 1) 1.4%
- Motivational Intervention (n = 1) 1.4%
- Motivational Enhancement Therapy (n = 1) 1.4%
- Methadone Maintenance (n = 1) 1.4%
- Multi-Dimensional Motivational (n = 1) 1.4%
- Behavioural couples therapy (n = 1) 1.4%

Miscellaneous approaches or programmes (n= 18)

- Hospital-based Acute Residential Treatment (n = 1) 1.4%
- Comprehensive Continuous Integrated System of Care (n = 2) 2.9%
- Comprehensive Service-Delivery Program (n = 1) 1.4%
- Contingent Management (n = 1) 1.4%
- Emergency Services Outreach Program (n = 1) 1.4%
- Health Evaluation and Linkage to Primary Care (HELP) (n = 1) 1.4%
- Individual Counselling, Vocational Counselling, Discharge Planning, Help post-discharge (n = 1) 1.4%
- Integrated Treatment Model (n = 2) 2.9%
- Recovery Management Checkups (n = 1) 1.4%
- Soup kitchen outreach with ME group counselling (n = 1) 1.4%
- Substance Abuse Treatment (n = 1) 1.4%
- Substance Abuse Treatment with Psychiatric Focus (n = 1) 1.4%
- Therapeutic Alliance (n = 1) 1.4%
- Engagement Group (n = 1) 1.4%
- Individual based treatment (n = 1) 1.4%
- Substance Misuse Intervention (n = 1) 1.4%

Quality of Study (n = 57)

MARYLAND RATING

- 2 (n = 24) 42.1%
- 3 (n = 7) 12.3%
- 4 (n = 4) 7%
- 5 (n = 22) 38.6%

* More than one intervention was mentioned in a number of studies.

Search 2- Workforce Development

Date (n = 48)

- Pre 1995 (n = 5) 10.4%
- 1995-1998 (n = 5) 10.4%
- 1999-2002 (n = 13) 27.1%
- 2003-2006 (n = 10) 20.8%
- 2007-2010 (n = 15) 31.3%

Country (n = 48)

- UK (n = 18) 37.5%
- USA (n = 26) 54.2%
- Other English speaking (Canada, New Zealand, Australia) (n = 2) 4.2%
- Other (n = 2) 4.2%

Content (n = 70*)

Training (n = 24)

- Professional training (n = 8) 11.4%
- Training needs a) knowledge (n = 5) 7.1%
- Training needs b) skills (n = 8) 11.4%
- Impact of training on practice (n = 3) 4.3%

Practice (n = 8)

- Practice a) good (n = 1) 1.4%
- Practice b) current (n = 2) 2.9%
- Practice c) challenges for (n = 5) 7.1%

- Professional programmes (n = 4) 5.7%
- Roles (n = 2) 2.9%
- Social work curricula (n = 4) 5.7%
- Social work education (n = 9) 12.9%
- Values and attitudes (n = 19) 27.1%

Empirical/ Unempirical (n =48)

- Empirical (n = 43) 89.6%
- Unempirical (n = 5) 10.4%

Qualitative/ Quantitative/ Mixed Methods (n = 43)

- Qualitative (n = 7) 16.3%
- Quantitative (n = 34) 79.1%
- Mixed (n = 2) 4.7%

Type of Study (n = 48)

EMPIRICAL

- Case control (n =4) 8.3%
- Cross sectional (n = 28) 58.3%
- Focus groups (n = 1) 2.1%
- Interview (n = 4) 8.3%
- Measurement validation (n = 4) 8.3%
- Observation (n = 1) 2.1%

UNEMPIRICAL

- Case study (n = 1) 2.1%
- Description of practice (n = 1) 2.1%
- Description of training (n = 1) 2.1%
- Literature review (n = 1) 2.1%
- Model analysis (n = 1) 2.1%
- Policy analysis (n = 2) 4.2%

Social Work Field (n = 48)

- Adults (n = 2) 4.2%
- Children's (n = 8) 16.7%
- General (n = 38) 79.1%

* More than one issue was mentioned in a number of studies.

Search 3 – Roles and functions

Date (n = 25)
- Pre 1995 (n = 9) 36%
- 1995-1998 (n = 3) 12%
- 1999-2002 (n = 6) 24%
- 2003-2006 (n = 6) 24%
- 2007-2010 (n = 1) 4%

Country (n = 25)
- UK (n = 2) 8%
- USA (n = 19) 76%
- Other English speaking (Canada, New Zealand, Australia) (n = 1) 4%
- Other (n = 3) 12%

Content (n = 33*)
- Challenges of social work role (n = 3) 9.1%
- Changing role of social workers (n = 5) 15.2%
- Functions social workers could perform (n = 4) 12.1%
- Impact of social workers values and attitudes on practice (n = 1) 3%
- Role of social workers in interventions (n = 7) 21.2%
- Role of social workers in treatment (n = 3) 9.1%
- The social work role (n = 9) 27.3%
- Required knowledge for role (n = 1) 3%

Empirical/ Unempirical (n = 25)
- Empirical (n = 4) 16%
- Unempirical (n = 21) 84%

Qualitative/ Quantitative (n = 4)
- Qualitative (n = 2) 50%
- Quantitative (n = 2) 50%

Type of Study (n = 25)

EMPIRICAL
- Cross sectional (n = 1) 4%
- Focus groups (n = 1) 4%
- Interview (n = 1) 4%
- Meta analysis (n = 1) 4%

UNEMPIRICAL
- Guidance for practice (n = 1) 4%
- Historical analysis (n = 2) 8%
- Literature review (n = 2) 8%
- Opinion piece (n = 3) 12%
- Policy analysis (n = 1) 4%
- Practice description (n = 12) 48%

Social Work Field (n = 25)
- Adults (n = 5) 20%
- Children's (n = 5) 20%
- General (n = 15) 60%

* More than one issue was mentioned in a number of studies.

Appendix 4 - Data extraction headings

* Author
* Year
* Type of study
* Country
* Topic/study focus
* Aims
* Data collection method and tools used
* Sample size and type
* Control group?
* Representative sample?
* Data analysis method
* Key Findings/ Results
* Implications for practice
* Implications for policy
* Gaps in research
* Comments

Appendix 5 - Summary of Primary Outcome Studies identified in Rapid Evidence Assessment

MS = Maryland Score

Study (N)	Follow-up	Intervention(s) & service user groups	Results
Substance misuse and social care interventions for homeless service users			
Bradford et al. 2005 N=102 MS 5	2m	Service users referred to psychiatric clinic at homeless shelter. CM (including psychiatric social worker) vs Treatment as usual	Significantly better attendance for CM group.
Braucht et al. 1995 N=282 MS 2	0-10m (6m post treatment)	Intensive CM vs normal care Homeless Substance misusing service users	Significant reduction in alcohol use. Significant reduction in legal measure. Significant improvement in housing stability. Significant improvement in employment measure.
Dunn et al. 2006 N=30 MS 2	4m	Methadone maintenance pilot	Significant reductions in heroin use (p<.001) and cocaine (p<.01).
Harrison et al. 2008 MS 2	6m	See Moore et al. below	
Kasprow et al. 1999 MS 2	Varied. Min 6m	SA: Substance abuse programmes DDX: SA and psychiatric focus for DD service users	Overview paper, summarising results from other studies
Kayman et al. 2005 MS 2		See Rosenblum et al.	
Meisler et al. 1997 N=114 / 67 DD MS 2	12-48m	Assertive Community Treatment Homeless serious mental disorder cases (67 dual diagnosis, DD)	59% DD had persistent subs problems post-treatment.
Moore et al. 2009 MS 2	6m, 12m	Comprehensive Continuous Integrated System of Care. Residential programme for homeless DD service users.	Significant improvements in housing, employment, mental health & substance use.
Morse et al. 2006 N=149 MS 5	12m, 24m	Dually diagnosed 1) Integrated Assertive Community Treatment 2) Assertive Community Treatment (ACT) 3) Standard care control	Significant reduction in problem alcohol use. Significant improvement in housing stability Small difference between group 3 and ACT no differences between groups 1 and 2.
Nwakeze et al. 2000 N 110 MS 3	3m	Case Management (CM) v CM plus Peer Consumer Advocacy (PCM) Soup kitchen guests	Peer Consumer Advocacy (PCA) + CM slightly better than CM alone in reducing crack use (p=.09).
Padgett 2006 N= 173 MS 5	48m	Dually diagnosed 1. immediate housing plus assertive community treatment 2. usual care – treatment first	No significant reduction in alcohol use. Significant improvement in housing stability. No difference across groups.
Rosenblum et al. 2005	Baseline – 5m	Soup kitchen based outreach plus ME group counselling	Alcohol use days/m 12.7 – 6.6. Significant reduction in alcohol use.

N=2006 MS 2		Control: info and referral Various measures and ratings	
Witbeck et al. 2000 N=18 MS 2	12m	Emergency Services Outreach program – ICM (Intensive Case Management) for substance abusing, or chronically mentally ill homeless	58% reduction in emergency service use for ICM group.
Substance misuse and child and family social work			
Boles et al. 2007 N=684 (parents) MS 3		Dependency drug courts (DDC) for parents with drug or alcohol misuse	Higher rates of treatment participation than comparison. 42% DDC children reunified vs 27.2% comparison children. No differences in outcomes by parent's primary drug problem
Brook & McDonald 2007 N=60 MS 4		A comprehensive service-delivery program designed to assist families in dealing with alcohol and other drug problems	Participants move more slowly to reunification. Re-entry rates significantly higher among those children whose parents participate in this service. More intensive interventions may not automatically produce better permanency of outcomes.
Comfort et al.(2000) N=70 MS 5	Pre and post	Evaluation of practical engagement services for mothers prior to and during drug treatment. Comprehensive package including transport, dedicated worker and child care.	No impact, in part because child care not substantially used.
Coughey 1998 N=202 MS 5	Pre and post	Two types of aftercare services for formerly homeless recovering women (mothers); intensive case management (ICM) services and ICM plus a peer support group.	Comparison compromised by including referred who did not attend in comparison group. Women who completed a year of aftercare had at the time of admission significantly longer periods of sobriety. Quant findings indicate that retention in case management aftercare is related to women's sobriety.
Forrester et al. 2008 N=279 MS 3	3.5 years	Option 2 - an intensive family preservation service using MI (Motivational Interviewing) and solution focussed approaches within a crisis intervention framework	40% of children in both groups entered care but option 2 children took longer to enter, spent less time in care and were more likely to be at home on follow up - so more cost effective.
Grant et al. 2004 N=19 MS 2	12m	Adapting Parent–Child Assistance Program (PCAP) for women with Foetal Alcohol Spectrum Disorders: (1) by specific modifications; (2) by educating community service providers	Decreased alcohol and drug use (14 not using). Increased housing and use of contraceptives (15 using contraceptives). Improved medical and mental health care services.
Green et al. 2007 N=250 MS 3		Family treatment drug courts (FTDCs) designed to improve treatment and child welfare outcomes for families with substance abuse problems. FTDC vs controls	FTDC parents entered treatment more quickly, stayed in treatment longer and completed more treatment episodes. FTDC children no reunified achieved permanent placements more quickly but were also more likely to be reunified with parents.
Jansson et al. 2005 N=56 MS 5	4m	Pregnant women additionally received bi-weekly case management (CM) services by telephone or in person to facilitate establishment of rapport, provide more frequent contact and more timely linkages to services	Intensified CM showed better treatment retention, women accessed a greater variety of services, were more likely to be abstinent at 4 months and felt their children benefitted.
Lam 2009 N=30 MS 5	6m, 12m	Random assignment to 1) (PSBCT) Parent Training with Behavioural Couples' Therapy , 2) (BCT) Behavioural Couples' Therapy, 3) (IBT) Individual	PSBCT comparable to BCT re substance abuse, dyadic adjustment and partner violence. . Both groups showed clinically meaningful effects over IBT. Compared to BCT, PSBCT resulted in larger effect

		Based Treatment. All male participants received cognitive behavioural therapy sessions. Urine tests for all participants.	sizes on parenting and CPS involvement throughout follow up.
Marsh et al. 2006 N=724 MS 2		See Ryan et al. (2008)	Progress in resolving co-occurring problem areas increases the likelihood of achieving family reunification.
Metsch et al. 2001 N=40 MS 2	6m	SafePort, a residential substance abuse treatment programme for women with children	Positive overall outcomes. Entering with children linked to better outcomes. Very small sample and high attrition
Niccols & Sword 2005 N=13 MS 2	3m, 6m	New Choices is a 'One stop shop'. Coordination and collaboration with multiple community based services for women with drug problems with children	Overall reductions in use reported; v small sample and high attrition.
Paluscui et al. 2008 Multiple groups of N=5-30 MS 2	Pre and post	Modification of the Family Nurturing Program among inmates, parents in substance abuse recovery and other at risk populations	Significant improvements in parenting attitudes. No significant differences in changes based on group. Males showed greater improvement in scores in all groups.
Ray 1998 N=22 MS 2		Family strengths & empowerment “wrap- around” model. 1 empowerment focus 2 responsive to individual need 3 family teams 4 family coordinator 5 intensive services	High levels of satisfaction. Some indications of improvements in family functioning and reduced substance misuse.
Ryan et al. 2006 N=738 MS 5	Every month for 1 year.	Intensive case management using recovery coaches. Coaches engage in a range of activities, including assessment, advocacy, and service planning, outreach and case management. They are always on call, evenings, weekends and holidays to address emergencies. Coaches also have access to outreach or “tracker” staff that specialise in identifying and engaging hard to reach or locate parents.	Recovery coaches increase access to substance abuse services (84% vs. 74%) and increase likelihood of family reunification (12% vs. 7%
Ryan et al. 2008 N=931 MS 5	Every 6 months for 3 years	See above Ryan et al. 2006	Recovery coaches significantly decrease risk of substance exposed births. 21% of Mothers in control group and 15% of Mothers in the experimental group were associated with a subsequent substantiated allegation indicating substance exposure at birth.
Slesnick & Prestopnick 2005 N= 124 MS 5		To compare (EBFT) ecologically based family therapy to services as usual for runaway adolescents who misuse substances.	EBFT reported greater reductions in overall substance use, other problem areas improved in both conditions.
Worcel et al. 2008 N=1220 MS 4	2 years	Family Treatment Drug Courts (FTDC) compared to a matched sample of substance misusing families receiving traditional child welfare services only	FTDC mothers more likely to enter substance misuse treatment; enter treatment sooner; stay in treatment twice as long; twice as likely to complete treatment. FTDC children more likely to be reunified with mothers than non-FTDC children (69% to 39%). FTDC took longer to permanent placement.

Substance misuse, mental illness and social work/social care			
Bouis et al. 2007 N=141 MS 2	3, 6, 9, 12m	Integrated treatment model based on trans-theoretical model of behaviour change for dually diagnosed people with HIV	Significant reductions in illicit drug use, alcohol use, and psychiatric symptoms. Significant increases in anti retroviral use and appropriate psychotropic medication use. Decreases in emergency room visits and inpatient hospital stays.
Craig et al. 2008 N=127 MS 5	18m	Training and supervision for case managers dealing with dually diagnosed people	Significant improvements in psychosis/psychopathology. Fewer needs for care at follow-up. No significant differences in substance use.
Cuffel et al. 2002 N=391 MS 3	30, 60, 180 days	Usual, enhanced and intensive care management vs control for dually diagnosed	Intensification did not increase outpatient follow up or decrease hospitalisation rates. Prediction models showed that clinical and demographic characteristics were significantly associated with risk of rehospitalisation.
Graham et al. 2006 N=58 MS 3	36m	Training and supervision for teams to deliver Cognitive Behavioural Integrated Treatment to dually diagnosed people	Reduction in alcohol intake and positive alcohol-related beliefs seen regardless of team training.
Haddock et al. 2003 N=36 MS 5	18m	CBT and Motivational intervention for schizophrenic substance misusers and their carers	No significant differences in abstinence compared to controls.
Johnson et al. 2007 N=232 MS 5	18m	Training teams to deliver substance misuse interventions to dual diagnosis patients vs controls	No reduction in number of days spent in hospital.
Ries et al. 2004 N=41 MS 5	27 weeks	Benefits for dually diagnosed either contingently or non contingently managed through mental health centre	Significant reduction in alcohol and drug use. Better money management.
Rush et al. 2008 N=865 MS 5	2 years	Quarterly recovery management checkups for African American women with substance disorders by level of co-occurring mental disorders	Effective in linking participants to treatment, with equal or better outcomes among those with more mental disorders.
Sells et al. 2006 N=137 MS 5	6m, 12m	Peer case management for severe mental illness	Participants perceived higher positive regard, understanding, and acceptance from peer providers at six, but not 12, months. 6m positive regard and understanding positively predicted 12-month treatment motivation for psychiatric, alcohol, and drug use problems and attendance at meetings.
Smelson et al. 2005 N=26 MS 2	8 weeks	Time Limited Case Management (TLC): A community linkage intervention re the transition from hospitalisation to outpatient treatment for dually diagnosed	TLC improved transition to outpatient care. TLC had higher show rate at intake appointment, attended more days at treatment centre, had a greater pharmacy refill compliance and were less likely to be lost to follow up at 8 weeks.
Timko et al. 2006 N=230 MS 5	1 year	Community-based vs hospital-based acute residential treatment for dually diagnosed	Better substance use outcomes when they were initially assigned to community rather than hospital acute care.
Timko et al. 2008 N=230 MS 2	1 year	Recommended services (eg individual and vocational counselling, discharge planning and additional help post-discharge) in one of 14	More likely to improve even when intake risk was controlled. Additional outpatient treatment post discharge was associated with fewer psychiatric symptoms.

		residential substance abuse programmes for dually diagnosed people	
Vaughan-Sarrazin et al. 2000 N=287 MS 5	12m	3 levels of case management according to location of case manager and use of telecommunication system vs standard treatment on substance abusers	CM being located at the facility had a positive impact on service users' use of substance use treatment and medical services. CM not related to use of mental health services.
Whetten 2006 N= 141 MS 2	3, 6, 9, 12m	Integrated treatment model based on tran-stheoretical model of behaviour change for dually diagnosed people with HIV	Significant reductions in illicit drug use, alcohol use, and psychiatric symptoms. Significant increases in anti retroviral use and appropriate psychotropic medication use. Decreases in emergency room visits and inpatient hospital stays.
Substance misuse and social work			
Carroll et al. 1998 N=125 MS 2	Monitored over 36m	Aftercare ICM - 6 months Abstinent service users post TC treatment Intensity of input related to assessed need.	11.2% relapsed. 79% re-engaged within 8.5 days. None became homeless. 5% lost their jobs. 1 engaged in criminal activity. 34 reunited with children.
Hall et al. 2009 N=503 MS 5	3, 6, and 12m	Iowa Case Mgmt (ICM) v Normal Care Urban and rural service users in residential or outpatient substance misuse treatment. CM in-house, external or by phone throughout treatment. Heterogeneous sample. Cross reference to Vaughan-Sarrazin et al. 2000 in mental health section	Significant decrease in substance misuse in all 4 conditions including control. No evidence ICM improved outcomes. No evidence ICM increased service utilization. No evidence of improved outcomes for rural over urban service users.
McKay et al. 2003 N=529 MS 2	1, 3, 6 and 12m	CASAWORKS for Families (CWF) throughout treatment. Substance misusing mothers on welfare: parenting, domestic violence, health care, housing, basic needs, substance misuse, employment. See McLellan et al. 2003.	Suggests CWF retained women in services longer and delivered wide ranging services. Longer retention associated with better alcohol outcomes only.
McLellan et al. 1998 Wave 1 N=431 Wave 2 N=710 Wave 3 N=187 MS 4	6m	CCM (Clinical Case Management) v Normal Care throughout treatment. Substance misusers in abstinence or methadone maintenance programmes – effectiveness of adding social services to normal care. Pre-contracted services. 3 Waves: Wave 1) 0m, Wave 2) 12m, Wave 3) 26m after introduction of ICM	Significantly increase in social and medical services uptake in Wave 2 and especially Wave 3. Significantly decrease in substance misuse and health problems plus better social functioning. Systemic changes take time to implement.
McLellan et al. 1999 N=672 MS 4	6m	CCM v Normal Care throughout treatment. Substance misusers in abstinence or methadone maintenance programmes – effectiveness of CCM in service access and utilization, and substance outcomes. 2 Waves: Wave 1) 12m Wave 2) 26m after introduction of CCM	Significant improvement in alcohol, medical and legal status, employment and family relations. Professional training and pre-contracting of services essential prerequisite. More active CCMs showed better results.
McLellan et al. 2003 N=529 MS 2	6 and 12m	CWF – see Mckay et al. 2003	Significant improvements in substance use and family and social functioning by 6 months. Improvement in employment by 1 year. Modest improvements in medical and psychiatric status. Suggests

			CWF improves outcomes, but no control so cannot be certain that favourable results attributable to CWF.
Mejta et al. 1997 N=316 MS 3	Monthly for 3 years	CM focused on helping opiate misusers access treatment. Treatment and referral process only.	Significantly greater and faster accessing of treatment services. Remained in treatment nearly twice as long as control. Improved outcomes including substance use.
Morgenstern et al. 2008 N=302 MS 5	3, 9 and 15m	Intensive Case Management (ICM) pre-entry and throughout treatment: care coordination for substance misusing women on welfare. Incentive system. Weekly meetings. MI	More CM contacts and self help attendance plus better treatment engagement in CM condition. ICM strongest mediator of outcome. Particularly effective for service users with low level initial contacts. Suggests outcome linked to CM/service user relationship.
Okpaku et al. 2010 N=207 MS 2	6 and 12m	3 part programme: pretreatment; CM; treatment. CM bridged initial contact into treatment for African American women at risk of HIV/AIDS. Continued throughout treatment. Care coordination. MI	Significant decrease in substance misuse. Improvement in psychiatric symptoms and housing stability. High risk sex reduced to 0. Increase in employment/training. Decrease in illegal activity.
Rogers et al. 2008 N=100 MS 2	3/4m	Assessed impact of Therapeutic Alliance (TA) within CM relationship on service user outcomes. High risk young people in drug treatment.	Suggests TA impacts on symptom change. Suggests greater effect with depressive symptoms than substance misuse.
Samet et al. 2003 N=470 (HELP N= 235 MS 5	6 and 12m	Health Evaluation and Linkage to Primary Care (HELP): Multi-service intervention, CM one of 3 professionals. 30 minute interview with CM. Aim to link service users in in-patient detox unit to primary health care. MI	HELP effectively linked substance misusers in detoxification unit to primary health care. Equally effective for alcohol/drugs. No significant differences in secondary outcomes.
Substance misuse, older people and social work			
D'Agostino 2006 N=99 MS 5	Discharge data, after 4months of treatment	1) Traditional referral with an assessment and linkage model. 2) Multidimensional motivational intervention (GAP)	Better inpatient and outpatient substance abuse treatment completion rates for those in GAP. Inpatient treatment completion rate: 80% vs. 57%. Outpatient treatment completion rate; 40% vs. 10%.

Appendix 6 - Summary of studies – Search 2: workforce development

Study (N)	Focus of study	Aims	Key findings
Attitudes/knowledge of social work staff/managers/preparation for practice			
Adams et al. 1999 N=75	Social workers' attitude's to drug using parents	Not clear. Assess attitudes of social workers towards drug using parents?	Majority positive attitudes to helping drug using parents; positive re ability to change and 'good enough' parenting ability; majority feel parents shouldn't use drugs; negative attitude among minority
Bina et al. 2008 N=211	Substance use training and perceived preparedness for working with issues	Does substance use training at informal, formal CPD, formal academic, substance abuse specialisation levels plus other individual variables affected perceived preparedness to work with substance use	Very little to moderate knowledge of substance use models and concepts; specialisation NOT found to be significant predictor of preparedness (only 2.4% respondents had specialised so sample is small); formal academic training only significant predictor of improved preparedness; perceived knowledge significantly associated with perceived preparedness
Burke & Clapp 1997 N= 575	Social workers' ideologies in substance use settings & managers' beliefs	Beliefs of managers in substance use treatment; do managers with social work background differ in beliefs about substance use	28% were social work trained; ¼ of all supported disease model; most supported psychological/ecological models (no figures given); 1/3rd range of causes for substance use. Less support for harm reduction overall but social work managers favoured it more; social work managers more likely to think professional qualification needed; all support abstinence rather than controlled drinking.
Conley et al. 2008 N=294	Rural social workers and attitudes to substance use	Testing psychometric performance and factor structure of scale	More than half felt education not prepared for working with 'addicted populations'; scale showed good internal consistency
Foster & Richmond 2003 N=56	Attitudes of mental health professionals to people with mental health and substance use problems	Investigate mental health professionals attitudes to substance misusers and variables affecting attitudes	People educated to post graduate level were less moralistic and had greater treatment optimism; social workers had higher permissiveness scores than nurses; personal use of some substances was assoc with greater treatment intervention scores.
Galvani & Forrester 2009 N=248	Social work students perceived readiness to practice with alcohol and other drug issues	Explore views on whether their qualifying programme prepared them for practice with substance use issues; quality and quantity of quality input on alcohol and other drug; training needs; good practice	Half or more of NQSWs service users had issues relating to alcohol and other drug use; most social workers not prepared for working with issues; only area rated by most social workers as not adequately prepared; key skills lacking, e.g. how to talk to people about alcohol and drug use or assess it; one third had no training on qualifying course; half reported half day or less; 3 days input felt prepared.
Gassman, 1997 N=194	Social work students characteristics & attitudes to alcoholic service users	Explore attitudes and formative characteristics of new social work graduate students towards alcoholic service users to inform curriculum development	4 sub groupings: 16 = moralistic view, 13 optimistic about effective treatment, 135 believed it was a disease, 20 believed it was a habit. Moralists – also higher beliefs in disease model and high alcohol knowledge scores, high proportion were non-practice majors, e.g. policy and admin; Treatment optimists – lower alcohol knowledge, higher alcohol in family, lower levels of alcohol consumption; Habit – lower family alcohol, drank more actively, lack of experience with alcoholics;
Giannetti et al. 2002	Social work practitioners' attitudes	Identify professional and personal involvement with alcohol abuse;	Majority felt moderate a great deal of satisfaction working with alcoholics; disease model beliefs not habit; overall levels of alcohol knowledge low so satisfaction

N=105	and knowledge and curriculum implications	identify beliefs about etiology and treatment of alcohol, and attitudes to addicted persons; explore relationship between personal experience, beliefs and knowledge	independent of knowledge. No significant relationship between personal experiences and attitudes or knowledge. Those in receipt of previous alcohol or drug training rated higher on knowledge of alcohol
Jani et al. 2009 N=211	Advanced standing of Masters in Social Work students compared to non advanced MSW students & their knowledge & preparedness to work with substance users	To make clear the differences between advanced & non advanced standing students on their perceived preparedness to work with substance use issues & perceived knowledge of substance use concepts	Strong positive correlation between perceived knowledge of substance use & perceived preparedness to work with substance users. Both groups had relatively low perceived knowledge & preparedness.
Lemieux & Schroeder 2004 N=109	Lack of social work education in substance use & ways to alter this	Identify students prior substance use training, knowledge change from pre-post elective & basic substance use modules, attitudes towards substance users, perceptions of their skills (assess & intervention)in working with substance users , self reported assessment & intervention behaviours, changes in attitudes/ perceptions/behaviours from elective module after the basic module	62.2% foundation & 60.3% advanced students reported <10 hrs of prior substance use training. 89.1% found & 96.9% advanced students believed substance use was a relevant issue for service users they had worked with on placements. 52.2% found & 41.5% advanced students said they lacked confidence in intervention with substance users. 76% found & 89.2% advanced students reported they knew where to refer substance users for professional assess. For advanced students, since participating in basic module, students reported significantly fewer negative experiences with substance user.
Lightfoot & Orford 1986 N=48	Factors affecting attitudes of helping professionals towards substance users (alcohol only)	Identify how situational variable + Cartwright's scale affects measure of workers attitudes towards substance users. Compare attitudes of social workers & CPNs	Situational constraint hinders positive therapeutic attitudes towards substance users. Significant differences between CPNs & social workers on subscales of task specific self esteem, motivation to work w/ drinkers, role adequacy, role legitimacy, role support & education, with CPNs having higher average's on variables. Social workers demonstrated significantly higher situational constraints compared to CPNs.
Loughran et al. 2010 N=197	Role adequacy & role legitimacy of social workers & effect on supporting alcohol and other drug using individuals	Determine predictors of role adequacy & role legitimacy in social work practitioners & students working with alcohol and other drugs. Identify demographic & professional variables impact on role legitimacy & adequacy. Identify predictors of role adequacy & legitimacy	> ¼ had training in identifying, > 1/3 had training in intervention. Participants who felt more adequate in their role were significantly more likely to be male, more contact with substance users, more training in alcohol and other drug identification & intervention, with master's degree & alcohol and other drugs experience. More training received, with greater role support, led to greater perceived legitimacy.
McLaughlin et al. 2006 N=35	Attitudes of social & health care professionals towards illicit drug users	Identify attitudes & opinions of social & health care professionals.	Professionals didn't want to be involved with care & treatment of illicit drug users & many held negative views. Lack of education contributed towards difficulties professionals have. Lack of training & education opportunities to gain further knowledge & skills.

Richardson 2007 N=89	Alcohol content & placements in MSW courses	Identify potential gap in knowledge & skills in MSW education from what social workers know to what they need to know, in order to work with alcohol and other drugs	53.9% participants had not attended any alcohol related courses whilst on their MSW. 70.8% reported working with service users with alcohol problems. 67% reported treating 1-5 service users a month with alcohol problems. Average score for diagnosis was 2.8 = the sample's ability is "middling". Average alcohol knowledge score for participants was 6.7/15. Average score for willingness to work with alcohol service users was 4.24 = participants are 'somewhat willing'.
Ronzani et al. 2008 N=195	Screening & brief intervention (SBI) training& its effect on attitudes & knowledge of primary healthcare (PHC) workers	Describe implementation of SBIRT training programme, in PHC centres	All PHC professionals demonstrated significant increases in SBI knowledge after training. Training reduced participants' perceived difficulty of conducting screening & perceived obstacles to intervention. Frequency of asking screening questions was negatively correlated with participants' age & perceived obstacles to SBI & positively correlated with self-efficacy. Emerging themes were lack of time to carry out SBI, lack of motivation, resistance to work with alcohol, lack of support, lack of resources.
Smith et al. 2006 N=1624	Social workers & their involvement in substance use services	Identify social workers role in providing substance use services through the PRN project (Practice Research Network) & use this info to develop best practices, inform policy & improve service delivery	53% reported having no substance use training in previous 12 months. Average number of hrs spent in professional development was 35.4, but average numb of hrs on substance use was 4.4. 1% had completed a substance use course. 71% reported taking 1+ actions related to substance use diagnosis & treatment in previous 12 months. 43% screened, 26% diagnosed or assessed, 19% treated service users with primary diagnosis, 47% treated with a secondary diagnosis, 61% signposted to specialist service.
Williams 1999 N=127	Practitioners attitudes towards substance users	Identify attitudes of healthcare professionals towards substance users & views on substance use contribution to mental health issues	Significant difference between all professional groups across the core attitudinal groups. Social workers rate the role of substance use in the causation of mental health as less important than other professionals. Rated their role in management lower, & attached less importance to the need for drug screening in the assessment of psychosis. 91% of participants agreed to strongly agreed staff need specialist training in substance use & mental health.
Impact of training on practice/ behaviour			
Amodeo & Fassler 2000 N=23	Masters in Social Work (MSW) professionals practice pre & post intensive training	Identify influence of intensive substance use training on practice patterns of social workers	Trainees had higher caseloads of substance use alone and with one psychiatric diagnosis; comparisons higher on 2 or more diagnosis; no differences on self-rated competence in assessment; significant differences in relation to intervention
Amodeo et al. 2002 N=159	Impact of substance use training on social workers' professional behaviour	To explore self-reported behavioural outcomes of social workers following substance use training	Trained social workers provided significantly more in-house training, get external supervision, engage in substance use community service, present at conferences, engage in professional development other than training, supervision or consultancy, changed interventions with own substance using family members. Higher quantity and quality of substance use training received in their careers.
Forrester, et al. 2008 N=40	MI as a tool for improving social workers interaction with parental substance use	Evaluate impact of 2-day training on MI on social workers' skills; establish level of skill in MI post training; identify factors associated with level of skill in MI 3 months post training including additional input	Training - modest evidence of improved practice in some areas – less so in more complex MI skills; mostly less confrontational and more listening skills. Only 10 achieved competence in MI; significant improvements but lower skill starting point than anticipated. Increase in confidence in responding to alcohol use; additional input little difference and low take up

Gorman et al.1990 N=66	Evaluation of alcohol education for health care and social work professionals	Assess the influence of a 2 day experiential alcohol education package.	No significant differences at baseline across teams; knowledge scores at 1 and 6 month for education package increased – not so with comparison; therapeutic attitude improved for education group at 1 month with some fall off at 6 months – comparison group changed very little; significant attitude improvement among GP, social workers and MfE group in that order, not significant for A&E; effects of education package greater for attitudes than knowledge. social workers attitude improved for adequacy and legitimacy but only moved a little and fall off at 6 months when similar to comparisons
Johnson et al. 2002 N=152	Assess impact of training substance use treatment providers in therapeutic community (TC) techniques	Not clear	9 months, drug abuse treatment (DAT) only affected 3/6 job behaviours for groups A&B. DAT & managing organisational change (MOC) produced moderate effects at 9 months for Group A's job behaviours. Group B- DAT training influenced organisational decisions to implement TC methods with fidelity at 1 & 9 months. DAT training had no significant effects on staff turnover or retention rates of service users.
Jones et al. 2002 N=52	Training programme for inter-disciplinary professionals supporting families involving child maltreatment, domestic violence, mental health & substance use , & outcomes of this	Gain knowledge in child maltreatment & protection, the relationship between child maltreatment, domestic violence, substance use & mental health, & develop attitudes & communication skills effective for collaboration	Training significantly positively impacted upon participants' perception of collaboration. Other items that improved: perceptions of benefits of collaboration, understanding one's role in collaboration, knowing when to seek compromise & meeting with other agency staff to plan service activities. Overall scores for perceptions of acquisition of knowledge increase post test & follow up. Trainees reported increases in collaboration with mental health, substance use, domestic violence, & child protection workers post test, sustained at follow up.
Lowden & Hall 2006 N=74	Evaluation of an initiative to train children's workers about substance use	Provide training for a wide range of early years' staff to promote their awareness & abilities in policies & procedures to support children living with substance use. Identify what is needed by the staff with the problems they are likely to encounter. Understand whether training has impacted upon staff knowledge & abilities, & are they more capable of recognising substance use in families & implementing strategies to support such families.	80% participants had not attended any substance use training in previous 18 months. Of those that had, mostly at STRADA. 97% participants 'agreed' to 'strongly agreed' that training had helped them to identify their own substance use beliefs & attitudes. 100% participants agree to strongly agree training made them more aware of legal implications, understand health implications of substance use. 95% participants agree to strongly agree they knew more about impact of substance use on families & communities. 99% participants agree to strongly agree training had improved their abilities to deal with substance use issues & provided useful info on where to gain further support & guidance.
Mason 1996 N=50	Evaluate implementation of the BASIC training programme for school	Not clear	Participants' clinical skill development in identification, intervention & prevention increased as a result of BASIC training (44% strongly agreed). 49% agreed with the structure & format of training.

	social workers & counsellors		
Straussner & Vairo 2007 N=43	Education of social workers & other health care professionals in substance use, & the impact of a training course on practitioners attitudes & skills	Assess impact of a post master's substance use training on careers of grads. Assess the degree to which such training impacted grads self-perceived attitudes, skills & behaviours towards substance use service users	74% directly employed in clinical practice, of which 60% of their service users were substance users. 61% felt being a substance use specialist was part of their professional identity. 91% felt they benefited from the TADAC training. 51% interested in additional training. Increase in positive attitudes, knowledge & desirable behaviours towards substance users post TADAC training.
Extent of substance use on social work curriculum			
Decker et al. 2005 N=426	Whether Bachelor in Social Work (BSW) education includes substance use training	To investigate whether BSW programmes provide course work in substance use	27% (n=88) offered a course/s in substance use; 4 offered a major in substance use, one offered a minor, 5 offered certification. 63/88 offered only one course, 11 providers offered two courses, 2 offered three courses, 5 offered four courses, 1 offered six courses.
Harrison 1992 N=80	Lack of alcohol and other drugs education in social work education, gather info on course delivery	What alcohol and other drugs training social work students receive? Identify whether educators are pleased with the level of alcohol and other drugs training they delivered. Establish future changes to curricula	89% said they delivered some alcohol and other drugs education, of which 71% alcohol and other drugs was part of compulsory education. 48.5% students on compulsory education received <5 hrs on alcohol, 70% received <10 hrs on drugs & 54% received <10 hrs of substance use. Average hrs teaching 50% lower in ENG than SCO, N.I. & IRE, Southern ENG particularly reduced. 4.5% students had alcohol and other drug placements
Quinn 2010 N=216	Lack of adequate training in substance use for social workers	Not made clear. Around establishing the amount of training MSW courses deliver to social work students	98% of courses didn't have required substance use courses for students. 21.3% didn't have a substance use course at all. 1.9% of participants had a substance use course as a requirement for all students. 11.6% had a certificate that incorporated substance use coursework & a placement. Conclusion =Institutional denial/minimization.
Schlesinger, & Barg 1986 N=1742	Alcohol and other drug training for nursing, psychiatry and social work professional's	Identify the preparation received by graduates from nursing, psychiatry and social work education programmes in identifying & treating substance misusers.	Nursing and psychiatry spent more time in contact with patients. Training mostly looked at treatment over theory. Research not often discussed. Social workers more likely to have elective elements. Curricula looked at abstinence over moderation. Placements provided much more contact with alcohol and other drug issues. Nursing & psychiatry students more likely to be required to see alcohol and other drug individuals than social work students.
Approaches to social work education on substance use			
Amodeo & Litchfield 1999 N=511	Substance use content in social work courses	To what extent faculty members trained in substance use integrate it into their classes compared with faculty members who received no substance use training	Suggests the faculty with substance use training include significantly more input on substance use on their course; higher numbers of case studies used; perceived by students as significantly more useful.
Billingham 1999a	Substance use in social work education	Review of literature on substance use in social work education and	Stage 1 – most learning around service provision, intervention, MI, knowledge of substance use. Stage 2 –interventions and process of change, additional info, facts

N=32	and module development	evaluation of newly developed module at end of module, end of 2nd placement and 9 months after start practice	and info most useful components of module; info useful in identifying and intervening and referring on; transferable skills; Stage 3 – service provision, interventions, additional info, facts and info scored lot lower. More input on diversity suggested and with those who don't recognise problem
Caldwell 2007 N=450	Teaching social workers about substance use - experiential learning	Not clearly stated. To explore use of experiential learning in teaching social work students about substance use problems?	All found hard; things have greater importance when need to give them up; not realized extent of relationships with behaviours and anticipation; substituting other behaviours; resentment towards tutor for assignment and transferability of this to social work professional; new appreciation for challenges of giving up; see negative aspects of social contacts and systems. Better insight and understanding.
Carpenter & Hewstone 1996 N=85	Shared learning between medical and social work students	Not clearly stated. To describe experience of shared learning	More positive attitudes and perceptions towards each other; both recognised greater life experience of social workers; and rated each other more highly at end of programme than before on a number of measures; remained secure in individual identity 19% of cases their attitudes worsened.
Tool development: Practice and research			
Bernstein, et al. 2007 N= 289	Development of alcohol screening tool (SBIRT)	Extent to which implementation of SBIRT curriculum improves providers beliefs and practices re alcohol use	3 month follow up self reported confidence in ability, responsibility to intervene and use of SBRT skills all improved significantly over baseline. Decreased at 12 months but still above baseline
Hohman et al. 2006 N=219	Avoidance of alcohol and other drug issues by social workers, developing a measure to understand why	Develop and start validation of a measure (AODI – Alcohol and other drug identification scale) looking at worker discomfort with discussing alcohol and other drug use with service users	Internal consistency of the scale was 0.86. 50% participants had 'none' or 'a little' training in identify & intervention was similar. On average participants estimated 39% service users with alcohol and other drug issues. Items on AODI reduced to 14. 3 internally consistent factors found in the AODI. Found social workers don't want to discuss alcohol and other drugs use because they don't want to upset service user.
Hohman et al. 2008 N=197	Social workers reluctance to discuss alcohol and other drug use with service users and a scale to measure this	Replicate 1st study (above) with different sample. Determine the concurrent validity of the AODI & compare AODI with Drug and drug problems perceptions questionnaire.	38% respondents said 50+% of service users had alcohol and other drug issues. 24.1% had none – little training on identifying, 38.7% had none – little training on intervention. 11 item scale internal consistency of .84. Both scales total scores were significantly correlated & the 4 identified sub factors of the DDPPQ were significantly negatively correlated with the sub factors of the AODI (scales coded in different directions)
Kranz 2003 N=399	Developing a scale to measure social workers self-efficacy about substance use	Measure social workers perceived self-efficacy in their substance use knowledge & skills using the newly developed AODSES (Alcohol & Other Drug Self-Efficacy Scale)	From the principal component analysis (PCA), a meaningful result was provided by a 43-item, 6 factor solution, accounting for 76.3% of the variance. Revised AODSES contains 43 items. A reliability estimate for each factor showed internal reliability (.92 to .96).
Practice/ Skill development			
Barsky & Coleman 2001 N= 19	Develop competencies for use of MI	Isolate a set of substance use intervention competencies using MI that could be used to teach and evaluate students. Essential skills, dysfunctional behaviour, can they be agreed upon through inter-observer agreement	Students found codes helpful in determining positive and dysfunctional skills/behaviours; observers found more MI skills used following classes introducing MI intervention. Inter-observer agreement for functional only 51.27%; 75.03% for dysfunctional agreement.

Burke & Early 2003 N=26	Factors influencing development of best practice among social workers in youth alcohol and other drug services	How adolescent alcohol and other drug providers obtain info on which to base critical programme elements such as which interventions to use and which outcomes to monitor	To implement evidence based approach: knowledge, supportive attitudes and resources; struggled with evaluation component; range of targets for change including self report of peer relationship, improvement of personal skills. No evidence of looking at outcome studies – relied on preferences; little capacity to influence evidence based approach; no specific outcome measurement instruments used.
Forrester et al. 2008 N= 24	Communication skills of social workers	To what extent do social workers use counselling skills and other skills in discussing child welfare? What impact do such skills and behaviours have on the process of the interview?	Very few used reflections of any kind; few positives mentioned. Lot of use of closed questions, far fewer closed questions; clarity, concerns and what next were good in general; strong relationship between raising of concerns and resistance of the service user; empathy associated with significantly more disclosure and less resistance – only significant variable
Training needs			
Billingham, 1999b N= N/A	Drug using parents – policy guidelines review	Analysis of LGA guidelines for working with drug using parents	Social workers must have appropriate knowledge and values to make decisions in best interests of the children. Collaborative approaches needed to provide drug using parents and children with required services.
Collins et al. 1988 N=N/A	Social work education and problem drinking in Scotland	Review of situation in Scotland re social work education and policy relating to working with alcohol problems	Need for education of social workers and support with agencies in relation to alcohol interventions
Hall et al. 2000 N=303	Assess of substance use training needs of social workers in substance use treatment facilities	Substance use treatment training of social workers and future training needs	Clinical supervision re substance use treatment not available to significant % of respondents; social workers reported significantly higher levels of knowledge and skill than other substance use treatment providers in 10/12 areas investigated; still request more knowledge and training however
Vander Bilt et al.1997 N=1414	Screening instrument skills in practitioners working in substance use treatment	Identify training needs of practitioners. Provide guidance for the allocation of existing training resources	Participants reported the lowest level of skill in screening of all of the treatment areas examined. Adequate training is significantly correlated to increased skill in training. Social workers were found to have the highest training need.
Current Practice			
Hayden 2004 N= 50	Parental substance use and how a child care social work dept responds to concerns	Fill the gap in lit around parental substance use caseloads. Estimate the 'scale' of parental substance use that raised concerns for child welfare. Understand how the dept could respond to this issue.	74% of cases = parental substance use caused concerns for child welfare. 2.6 average cases per social worker containing parental substance use raising concern for child welfare. 74% cases with major concerns, alcohol was involved, 61% for drugs. Many social workers didn't know how to respond to parental substance use. Social workers said specialist knowledge would help them, as would access to someone with in depth knowledge. Some fear for their safety when they visit families, and concerned by unpredictability of substance use. Parents faced difficulties in getting help as feared lack of understanding and didn't trust Social Services.
Shaw & Palattiyil 2008 N=18	Social workers awareness of alcohol misuse in older people & their	Capture the practitioners experiences of working with older people who misuse alcohol and identify their attitudes towards service provided by	Average number of service users with alcohol issues was 1-5 for each practitioner. Difficulties in identifying alcohol misuse in older people. Older people seemed to use alcohol to cope with isolation & ill health. A high level of unmet need of older people. Lack of specific services for older people. Workers should be trained how to

	attitudes towards the current support services	the Substance misuse team	support the specific needs of older people. Outreach service needed in old people's homes. Home visits would quell the stigma & embarrassment older people feel at admitting an alcohol problem. Older people need a strong rel with their support worker. A specialist role is needed that provides counselling & support.
Taylor & Kroll 2004 N=40	Practice issues for workers encountering parental substance use. Tensions of child focused vs. parent focused practice	Add to knowledge of "practice dilemmas" for workers encountering parental substance use	"The problem of engagement: access denied. "Differences between agencies: adults' needs, children's needs". "Communicating across agencies and the issue of confidentiality". "Assessment of substance misuse or assessment of parenting?" Child practitioners felt they did not know enough about alcohol or other drug issues and all other practitioners felt they did not know enough about child protection issues. "Practice with children: significant needs, low visibility" Difficult to truly assess impact on children.

Appendix 7 - Summary of studies – Search 3: workforce development

Study	Focus of study	Aims	Key findings
Social work roles in practice			
Barnea & Teichman. 1994 Lit review	Older people & substance use related to social work	Not clear.	Few specific treatment programmes for older people. Social workers can combat elderly substance use by: 1. uncovering it, 2. assessing issues & referring, 3. educating service users & their families on substance use effects, 4. educating other profs & communicating well with them 5. evaluating intervention outcomes. Need to educate & train social workers in older people's substance misuse needed.
Cook. 1997 Lit review	Social workers' role in perinatal substance use	Not clear.	Perinatal social worker can assess the whole situation that the individual exists in, and can deliver recommendations to a multidisciplinary team. This is seen as both an 'opportunity and a responsibility' of the perinatal social worker.
Dumaine. 2003 Meta analysis, 15 studies	Effective intervention with dual diagnosis (DD), implications for social work	Identify effective intervention for DD.	"Age of client was positively correlated with effect size…Intensive case management was associated with the greatest effect size….a small positive effect size was found for standard aftercare with outpatient psycho-educational treatment groups." "…Eight key intervention areas: outreach; engagement; assessment; goal setting; leverage, structure & limit setting; linkage, coordination, & integration of treatment services; long-term continuity of care; & advocacy & resource development." Most are involved in case management.
Fewell. 1975	Role of social worker in alcohol treatment team	Not clear.	Social worker aids delivery of treatment programme, which involved: detox, involving family, move them forwards, consistent service, form treatment plans with service user, AA meetings, support family, understand from family motivational factors for service user to change, discharge planning.
Goldmeier. 1994 Lit review	Elderly alcohol misusers in workplace & social workers role in intervention & treatment	Not clear.	Social workers contribute to EAPs (Employee assistance programmes). Social workers delivering wellness strategies. 5 roles of social worker: broker (connects service user with community offering elderly substance misuse treatment), enabler (help service users with positive activities), teacher (education approach), mediator & advocate, case manager (coordinates & follows up services recommended to service user).
Jenson, Howard & Yaffe 1995 Lit review	Adolescent substance use intervention & treatment, & implications for social work practice.	Not clear.	A range of services needed in order to provide for the diversity of adolescents with substance use issues. Systems involved need to collaborate to provide a system of care that matches individuals to intervention's appropriately. Inadequate substance use education in social work will impact on the abilities of social workers to implement effective intervention & treatment.
Kagle 1987 N=59	Secondary prevention of substance use in social work practice	Not clear.	Social workers may be missing vital opportunities to prevent further substance use with service users who refer themselves for other problems. 30% of case files social workers recognized substance use but did not refer on or raise the issue, believing substance use was not the main issue in the case, & their justifications were adequate. Children's social workers particularly adept at identifying substance use as a problem, but unlikely to initiate referral. Professional & organisational reasons provided for not referring.
Millard & McAuley 2008 N=90	Service gaps for 65+ yrs with alcohol use	Identify how service users alcohol problems identified, whether home care providers role to	Home care workers felt more time needed to build trusting relationship and then could drop hints about alcohol use; worried about reporting alcohol problems for fear of damaging relationships; more likely if safety issues for home worker; referrals came late on; sense of invading privacy/none of my business; older people targeted to bulk buy; suggestion that

		raise alcohol issue with service user, whether home care providers sought help for service users, barriers to seeking help, gaps in services for this population	home help buy small quantities but concerns over litigation; some escorted service user to pub and could limit intake.
O'Hare 2003 Lit review	Social work practice with co-morbid substance use & mental health	Examine evidence based practice & relate this to treatment of co-occurring mental health & substance use.	Social workers need to: "…develop a good working alliance with each client; identify and monitor problematic thoughts, feelings and situations that put the client at risk to use drugs; help the client make connections between their psychosocial complaints and their substance use; gauge the client's level of engagement and self-confidence (self-efficacy) in dealing with risky situations; use motivational interviewing techniques to engage the client in constructive change; provide psycho-education to inform and challenge beliefs and expectancies regarding the use of substances; role play and practice new coping skills (e.g., communication skills, stress management, drink or drug refusal); provide constructive feedback; practice new skills in the community; enhance available social supports; and generalize efforts to reduce and prevent relapse."
Raffoul 1986 Review/ reflection	Substance use & older people, interdisciplinary treatment.	Not clear.	Social workers are in a unique position to support older substance users: including service users at risk, assessment and referrals to other specialists, educating service users, evaluating interventions and feeding back to other professionals.
Roberts, et al. 2002 Lit review	TCs, resiliency theory & role of social workers	Wants to demonstrate how TCs can explicitly implement protective factors from resiliency theory for their residents.	Social workers knowledge of resiliency theory can be utilised by TCs to enhance protective factors for residents. Social workers skills in assessment, treatment, service brokering & relapse prevention can benefit TCs. Further developments in TCs can be stimulated by the presence of a social worker.
Sun 2000 Lit review	Substance using mothers within the child welfare system & their needs.	Understand what's needed in order to support this service user group.	Social workers should be: 1. "Treating mothers and children as one unit for recovery" This includes specific treatment programmes for women & their children. 2. "Providing gender, mother role & culturally sensitive practice" 3. "Offering life skills training" 4. "Mobilising old and facilitating new non-using support systems" 5. "Devising safety plans for children" 6. "Organising an interdisciplinary team & assuming the leadership".
Sun 2004 Lit review	Pregnant substance using women & social work roles to support them in treatment.	Outline guidance for workers on how to support & improve services for women who misuse substances & are pregnant.	5 roles of social workers in intervention with pregnant subs using women: 1. "Teacher" social workers should provide the women with info about substance use & nutrition, medical conditions, contraception, STIs, drug-exposed children. 2. "Broker" Case management-gathering the services the woman needs to provide a healthy & stable life for her & her newborn child, coordination of services into a 'one-stop shop' 3. "Clinician" social workers combat shame & guilt, enhance self-efficacy & non-using social networks, & treat dual-diagnosis. 4. "Mediator" Enable the client to resolve conflicts by providing them with the positive, constructive skills to do so. 5. "Advocate" Women's de-criminalisation & for more pregnant-specific treatment programmes, also reduced stigma in helping professions.
Toseland & Hacker 1982 N=43	Social workers support for self-help groups.	Understand the extent of social workers influence in self-help groups & the	Social workers play roles of: "providing material support to maintain a self-help group" "connecting traditional services, clients & self-help groups" "consultant" "initiating & developing a self-help group." Leaders said they would support the involvement of social

		role they play.	workers.
Challenges faced by social workers			
Burman 2004 Review/ Reflection	Social control role of social workers in substance use field.	Review of challenges facing social workers who on the one hand are service user centred, on the other have a social control role particularly with court mandated treatment monitoring roles	Makes point that extended abstinence is about longer term goals and support in other areas of people's lives and social workers holistic approach adapts to this position. Since social work has many roles and functions, the limitations of helping service users must be determined when assigned dual roles and functions conflict. 1. In the courts, acknowledge the goals and focus of substance abuse treatment 2. In treatment, focus on counselling/ therapy roles, activities, and policies 3. Protection of privileged communication 4. Educating referral sources on substance abuse/treatment and effecting policy change 5. Adding a Code of Ethics section on social control priorities and working with court-mandated service users.
Garbin 1974 Opinion	Professional vs. personal substance use beliefs.	Review of professional vs. personal drug use beliefs.	Discussion of the challenge of personal beliefs about drug use in relation to professional values and systems/structures, e.g. codes of ethics.
Reflections on the social work role			
Ashenberg Straussner. 2001 Lit review	History of social work & addictions in USA.	Brief historical overview of role of social workers in addictions.	"The social work profession's unique biopsychosocial perspective, its flexibility in adapting to new streams of thought and incorporating them into practice, and its ability to integrate disparate programming into a systemic whole (e.g., dual diagnosis), make it a profession extremely well suited to the ever changing field of addictions."
Butler 2002 Lit review	Social workers role in management of alcohol and other drugs problems	Review Irish alcohol and other drug policy and practice, specifically looking at role of social workers.	Limited info on how to deliver substance use knowledge in education. Social work educators unsure of how to deal with substance use, and tend therefore to recommend referring to specialist services. Ireland tends to follow GB policy & practice.
DiNitto 2005 Lit review	Future of social workers in the addictions field.	Not clear.	Social workers in the substance use field is expected to grow for 6 reasons: 1. Expanding populations, especially elderly population 2. More behaviours classed as addictions 3. Knowledge of substance use improving, research is increasing & social workers are contributing towards this 4. Growing recognition that substance use co-occurs with other disorders, e.g. mental health 5. The sheer number of individuals seen in fields that social workers are employed in, e.g. child protection 6. Insurance plans (in USA) deal with substance use & so more social workers involved in private practice. Social work is the ideal role to intervene & treat substance use due to holistic, ecological outlook.
Morell 1996 Opinion	Role of social workers in the addiction-recovery industry.	What can social workers do in the addiction-recovery industry?	Focus on social work in addiction settings – suggests social workers should bring political education and action into their practice and seek change; through indiv and group interactions with service users, seek to ensure political context and future possibilities for doing things differently is highlighted
Peleg-Oren,	Role of social worker in	Not clear.	Substance use included in social work education as viewed as "integral part of their work". If

Rahav & Teichman 2002 Lit review	substance use practice.		social workers want to work in addictions they have to undertake a 1 yr course on substance use. Social workers involved in Detox, Therapeutic Communities & hostels. Social workers role to campaign for better substance use treatment.
Rankin & Regan 2004 Review/ Reflection	Supporting individuals with complex needs.	What services should be provided for individuals with complex needs.	User empowerment: users of social care services need to be recognised as co-producers of their own care. Connected care centres recommended, where individuals can go & access services they need, determined by the nature of their complex needs "facilitate access to mainstream services". "A 'service navigator' would have knowledge of all mainstream and specialist services and would work with the service user to develop a sustained pathway of care. This role would mean that every individual would have a lead professional to case-manage their care, ensuring a coherent package of services to meet individual needs."
Sapir 1953 Opinion	The therapeutic relationship with the 'alcoholic'.	Explain practice in an alcohol treatment centre, highlighting the importance the relationship the service user has with workers.	Social workers receive the substance user's referrals & are the initial contact for patients & family members. "These persons need the affirmation of the worker's interest- and the affirmation of his warmth- at once". "...developing a positive relationship is basic". Individual needs of the service user are to be prioritized.
Van Wormer 1987 Opinion	Alcoholism counselling & SWs relationship to it.	The dynamics of workers within the 'alcoholism counselling' field.	Advantage of having social workers in the addictions field: The holistic approach they take is suited to the widespread impacts of substance use. Families need to be worked with, social workers can do this. "Interdisciplinary cooperation is essential between the fields of social work and alcoholism treatment" Substance use should be taught in all social work courses & substance use experts should be employed by Universities.
Vogt 2002 Review/ Reflection	Substance use & the role of social workers in assessment, intervention & treatment.	Practice of social work in substance use field & future changes.	Social workers increasingly involved in addictions research. Social work training needs to update itself with the 'what works' research in prevention, intervention & treatment.

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