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To cite this article: Thomas Solgård Svendsen, Lillian Bruland Selseng & Sarah Galvani (2018): Developing education on problematic substance use in Norwegian social work bachelor's degree, *Social Work Education*, DOI: [10.1080/02615479.2018.1556630](https://doi.org/10.1080/02615479.2018.1556630)

To link to this article: <https://doi.org/10.1080/02615479.2018.1556630>



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Published online: 17 Dec 2018.



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## Developing education on problematic substance use in Norwegian social work bachelor's degree

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### ABSTRACT

This commentary article is based on a mapping of education on problematic substance use (PSU) in the Norwegian social work bachelor's degree (SWBD). The results show that national discussions are necessary to ensure that Norwegian SWBD students are provided with consistent and adequate education in preparation for work with PSU issues in social work practice. A practical starting point for development is presented. A discussion concerning social work's role in future theoretical, practical, and research developments in the field of PSU is paramount.

### ARTICLE HISTORY

Received 11 June 2018

Accepted 30 November 2018

### KEYWORDS

Social work  
bachelor's degree; social  
work practice; social work  
research; problematic  
substance use

## Introduction

This commentary aims to provide a starting point for discussions about developments in social work education on problematic substance use (PSU) topics for Norwegian social work bachelor's degree (SWBD) students. It presents findings of a mapping exercise focusing on the nature and extent of education on PSU in the Norwegian SWBD. It reviews the Norwegian National Occupational Standards (NOS) for SWBD (2005), describes the content and extent of PSU topics in Norwegian SWBD, and discusses the implications of these findings. It begins with a brief summary of the nature and extent of substance use in Norway and its policy context.

## Nature and extent of substance use in Norway

As with most European countries, cannabis is the most commonly used illicit drug in Norway. In 2016, 1 in 10 of young adults reported cannabis use in the last 12 months (EMCDDA, 2018). High-risk drug use in Norway is mainly linked to injecting amphetamines and opioids, primarily heroin. Injecting is the main reason why the prevalence of hepatitis C infections remains high in Norway (2018). However, reportedly, alcohol is the most commonly used substance 6 months prior to people accessing treatment, followed by the illicit substances, cannabis, amphetamine, heroin, and other opiates (Indergård, Solbakken, & Urfjell, 2017, p. 22). Social intervention approaches to individuals with PSU

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have in the latest years especially been focused on flexible outreach help efforts, and homelessness projects such as Housing First (SIRUS, 2014, pp. 58–59).

## Government policy

Norway's health and care policy is delivered through universal welfare schemes. Therefore, its drug and alcohol policy is integrated in, and implemented through, such health and welfare schemes. The municipalities bear the responsibility for providing general health and care services, low-threshold mental health and substance use services, and follow-up after treatment (Prop. 15S, 2015–2016, pp. 14–15). An annually updated register that provides detailed information on people receiving health and social services has been developed in Norway. In 2017, the register showed that 23,000 people with PSU received social services across 267 Norwegian municipalities, connected to mental distress, housing, economical challenges, lack of education and satisfying daytime activities, and poor family and network relationships (Bjørge, Lie, Håland, Stevenson, & Nesvåg, 2018, p. 5).

The Norwegian government's conception of PSU has undergone a major revision in recent years, with medical perspectives on PSU been given more focus, while social aspects of PSU have received less attention (Selseng, 2017, pp. 14–15; Skretting, 2014, p. 579). Until 2004, treatment for PSU was the responsibility of county authorities, with emphasis on complex social consequences of PSU. In 2004, the Substance Treatment Reform ('the Rusreform') was implemented in Norway (Nesvåg & Lie, 2010, p. 655). Responsibility for PSU specialist treatment was transferred from county level to four state-owned, regional, specialized health-care authorities. The aim was to integrate the PSU treatment services into the already established legal, economic, and organizational structures of specialized health-care services in Norway to provide a better continuity of care (Nesvåg & Lie, 2010, pp. 656–659). In the research report from 2010, Nesvåg and Lie (p. 664) conclude that contradictions exist between the structures of the reform, based on organizational principles from the private market and existing requirements for a high quality of care, such as flexibility in how services are provided, and higher degree of coherence between the specialized health-care system and the general health, care, and welfare system (Prop. 15S, 2015–2016, p. 22). The major changes in treatment provision following the reform have led to the social worker's role being moderated and becoming less clear (Selseng, 2017, pp. 14–15). While policy documents indicate that social work remains important in this service provision (Prop. 15S, 2015–2016, pp. 25–26), there is little explanation in to who will respond to the harmful social aspects of PSU and how that should be done.

While numbers for individuals receiving treatment have steadily risen in the last decade (Indergård et al., 2017, pp. 16–17), a recent Norwegian national escalation plan to fight violence and abuse (Prop. 15S, 2015–2016, pp. 20–21) stated that although efforts have been made to meet the needs of individuals with PSU, several weaknesses in services responding to PSU have been detected. These include late detection of PSU, latency in treatment services, incoherent and uncoordinated services, and a lack of knowledge on PSU in national health, care, and welfare services (Prop. 15S, 2015–2016, pp. 20–26). Further, the number of drug-related deaths is still very high, and improvements are needed with regard to housing, meaningful activities and employment, and treatment

capacity, as well as the possibility of follow-up inpatient treatment (SIRUS, 2015, p. 11). Although individuals with PSU challenges often need long-term, continuous, follow-up services as an integrated part of help efforts, the focus continued to stay on short-term, specialized treatment efforts that, most often, were not sufficient for long-term changes in PSU (Godley et al., 2007, pp. 81–93; McKay, 2009, p. 4; Moos & Moos, 2007, pp. 46–54; Morgenstern, Hogue, Dauber, Dasaro, & McKay, 2009, pp. 257–259).

Thus, while Norwegian policy changes show promise in terms of rights for people with PSU to access services, there remain a number of challenges in the coordination of them. This has resulted in people with PSU accessing multiple health-care and social care services which, in turn, have been criticized for their lack of knowledge of PSU and the late detection of it (Prop. 15S, 2015–2016, pp. 20–21). To date, there is a lack of research that examines the consequences the drug reform has had on the social harms of PSU. Nor has there been any research conducted in Norway to evidence whether health and social care workers are being prepared appropriately to respond to those social harms in terms of training and education related to PSU.

This has been done in other countries including England and the USA. Research into PSU in the British SWBD has spun from the reported lack of PSU curricula in the UK (Galvani & Hughes, 2010, pp. 950–957; Galvani & Allnock, 2014, pp. 576–583; Galvani & Forrester, 2011a, pp. 16–57; Russett & Williams, 2015, pp. 54–55). This has led to calls for a triangulation of research, practice, and education on PSU topics in SWBD (Teater, 2014, pp. 620–624), the use of evidence-based knowledge to inform educational strategies (Hutchinson & Allnock, 2014, pp. 598–602), and suggestions for concrete curriculum tools (Galvani & Forrester, 2009, pp. 1–26; Galvani, 2012, pp. 1–3). Several studies have shown that SWBD graduates often experience insecurity and ambivalence when encountering PSU issues (Dance, Galvani, & Hutchinson, 2014, pp. 563–568; Galvani & Forrester, 2011b, pp. 426–434; Galvani, Dance, & Hutchinson, 2013, pp. 893–901) and therefore need to be adequately prepared. The British research has highlighted several PSU topic areas that require attention in order to better prepare SWBD students for practice. These include establishing clarity about the roles and remit of social workers when working with people with PSU (Galvani, 2015, pp. 1–21) and ensuring that national policy frameworks recognize that social workers, not just health professionals, are on the front line of responding to people with substance problems (Galvani, 2017, pp. 473–475).

### **Extent and content of PSU in Norwegian SWBD**

To begin the discussion on PSU in Norwegian SWBD, a preliminary desk-based mapping exercise was conducted in order to outline the scope and content of current SWBD curricula in relation to substance use. All Norwegian SWBD programs ( $n = 14$ ) were reviewed using (1) the Norwegian NOS for SWBD (2005), (2) annually updated online curriculum overviews from these 14 programs, and (3) information provided by course coordinators or other relevant staff where online information was not clear or available.

## National Occupational Standards

The NOS were established by the Norwegian Ministry in 2005. The NOS provide a framework, aims, and standards for Norwegian social work education. Each social work program comprises 180 credits of teaching and learning. The NOS are intended to be normative and guide program development while still allowing each university to build their own SWBD program. The local SWBD curricula must be sent to the ministry for information, but does not require the ministry's approval. In 2017, the authorities started a process of revision of the NOS.

The Norwegian NOS (2005) comprises 14 modules, 2 of which mention PSU. All 14 social work education programs across Norway are, therefore, formally obligated to have education on PSU in their SWBD program to some extent. However, there is no systematic monitoring of these standards in Norway. This leads to local variations in how the standards are put in to practice.

The two modules named 'social medicine' and 'clinical psychology and mental health work' are both small six credit modules. All 14 programs must formally adopt these modules as part of the NOS. The content of the 'social medicine' module includes how understandings of political, socioeconomic, and cultural conditions impact the structures and functions of health and welfare services, as well as covering health conditions and development of diseases. Knowledge of the effects of substance use and PSU are two of the topics covered in the broader 'social medicine' module. This sits alongside knowledge of somatic and physical health, social and material conditions from a life course perspective, diseases and disabilities, geriatrics, sexuality, domestic abuse, violence, suicide, inter-occupational interactions, and preventive and health-promoting work.

The six credit 'clinical psychology and mental health work' modules contain descriptions of knowledge of life challenges, crisis and stress coping, child abuse, sexual abuse, and child neglect. Substance use issues and mental health challenges are part of the topic with perspectives on the identification, prevention, and treatment of substance use issues.

Given the number and range of topics in these small six credit modules, it suggests that substance use education is likely to be an inadequate part of the curriculum, particularly in light of the breadth and reach of PSU in the social and health harms social workers will encounter in practice. This minimal attention in the curriculum has resulted in gaps in their knowledge and skills and, ultimately, in their failure to meet the needs of many of the people with PSU they attempt to support.

## Mapping exercise

The mapping exercise collated course content information from the online curriculum and further information from personal contact with course coordinators. It found that the extent of education on PSU varied hugely from institution to institution, underlining the fact that the NOS (2005) only provide formal guidelines and lack content monitoring and reviewing. This results in huge variation in how social work programs apply the required NOS to their individual curricula.

All 14 programs reported that there was teaching on substance use in their programs, but it was not possible to quantify the time spent on it because of the integration of the

topic with a myriad of topics in addition to PSU. The input ranged from PSU education integrated in a variety of modules to schools that provided specialized substance use modules attracting 15 credits, as part of the 180 credit SWBD. There was also a variety of learning outcomes, semester number(s), credits provided, types of assessment, a range of written curricula, and topic areas covered. The mode of educational delivery was similar across all 14 degrees, using a mix of plenary sessions, group work, seminars, and individual study.

The focus of education on PSU within the degree programs showed that the modules ranged from those with a focus on the individual substance user to a social work system focus. They covered a wide spectrum of topic areas, from next of kin challenges following PSU and prevention work with young people to social work practice methods, law and social policies linked to substance use.

## Discussion and implications

What this exercise has shown is a lack of consistency in the amount and content of PSU education across Norwegian SWBD. This was a desk-based mapping exercise. Nevertheless, it shows the variation in PSU education Norwegian social workers are receiving, leading to a social workforce that may not be equipped adequately to support people with PSU.

It could be argued that (1) the SWBD in Norway is a 3-year education program and the program is limited with what it can achieve in that time, (2) PSU education deserves no greater emphasis than other topics within the program, (3) PSU education should not be offered in specialized modules. However, PSU is a cross-cutting topic that affects all people, at all ages, of all classes and is highly correlated with trauma, violence, abuse, homelessness, safeguarding, and mental ill health—all social harms that social workers respond to on a regular basis. As such, PSU directly and indirectly affects large groups in the population. In Norway, the biggest challenges for people with PSU who need extensive help are (1) getting sufficient care for somatic and mental illness, (2) a lack of suitable housing, (3) coping with their daily life, (4) a lack of social networks, and (5) participation in meaningful activities (SIRUS, 2015 p. 36). Since most of these areas are at the core of social work practice, it is important that social workers are competent and confident to respond appropriately. Currently this is not known.

Research is needed with SWBD programs and students in Norway to establish (1) the nature and extent of PSU education in the SWBD, (2) their suggestions for a starting point for basic, adequate PSU education, and (3) the impact (or lack thereof) of PSU education on their role concerning PSU practice.

Further, the current lack of national discussion about the content and extent of PSU education in Norwegian SWBD makes social work education more vulnerable to changes at a political level. An increased focus on PSU as a medical condition could have been used to emphasize social workers' distinctive skills to work with the social harms of PSU. Instead, our mapping demonstrates that the problem of PSU seems to be primarily treated as a medical and a psychological problem. Currently, the Norwegian PSU education in SWBD is placed within the topics 'social medicine' and 'clinical psychology and mental health' which comprise the theoretical, organizing framework of PSU education in Norwegian SWBD. Discussions should consider whether these frameworks are adequate, given the

extent and complexity of PSU in Norway and the myriad of other topics that sit within this framework (Bjørge et al., 2018, pp. 20–21; Prop. 15S, 2015–2016, p. 5).

## Practical suggestions to develop PSU education in SWBD

Given the importance of this topic to the realities of social work practice, conversations about how to improve this situation are needed. Such conversations have been started in the UK, regarding what basic knowledge is necessary in education to respond efficiently and adequately to PSU challenges (Dance et al., 2014, pp. 563–568; Galvani & Forrester, 2011a, pp. 16–57; Galvani et al., 2013, pp. 893–901), but this has not been done in a Norwegian context.

The authors suggest that Norwegian SWBD educators use the suggestions in the teaching guide by Galvani (2012, pp. 1–3) as a starting point in search of a basic, adequate integration of substance use teaching into the Norwegian social work curriculum. The teaching guide presents suggestions for a variety of modules, ranging from 5 to 25 h. Examples include the impact on family and children, substance use and mental ill health, substance use and domestic violence, as well as fundamental knowledge about how to talk about substance use, and values and attitudes toward PSU.

The question in Norway, then, should be what the basic, adequate starting point should be to learn about PSU topics, allowing for varying local contexts and culture? As a starting point, the Norwegian national register (Bjørge et al., 2018, p. 5) shows which PSU areas are in need of special attention, challenges that usually require attention over time to progress in, such as mental distress, housing and economic challenges, lack of education, a lack of satisfying daytime activities, and poor family and network relationships. The use of the national register, linked with long-term research on PSU, and the teaching guide (Galvani, 2012, pp. 1–3), could provide a practical starting point for decisions on which PSU areas to focus on in SWBD education, within the current context of social work priorities in Norway. PSU is often regarded as a private matter and hard to talk about to others. Communication and relational skills are highly important when working with people with PSU; people who are often marginalized, stigmatized, and vulnerable. Such skills are vital to include when discussing PSU education content. Skills work needs to sit alongside education on the reasons for substance use, a knowledge of substances, PSU assessment and risks, what specialized PSU help is available, how to support families affected by PSU, and an understanding that long-term efforts by practitioners will often be needed when helping individuals with PSU challenges (Galvani, 2012, pp. 1–3, McKay, 2009, p. 4).

## Conclusion

In addition to the need for research to establish social work perspectives on supporting people with PSU in Norway, policy development is needed to underpin and clarify the Norwegian social worker's role. Given the prevalence of PSU in modern social work practice, there is an urgent need to update Norwegian SWBD to ensure PSU education is sufficient and thoroughly considered in relation to all service user groups. The challenges have been clearly underpinned in the Norwegian national escalation plan to fight violence and abuse (Prop. 15S, 2015–2016, pp. 20–21). The way forward should therefore include embedding solutions in the frameworks

that determine the Norwegian social work education curricula, and through monitoring and evaluating its effectiveness.

Future research projects should focus on how social work as profession can work in a long-term effort to support individuals with PSU and their families, networks, and communities. The goal should be to develop a continuity of services that would increase the quality of life for people with PSU, with a specific focus on developing the knowledge of PSU among social work students and professionals. In the meantime, we need to inform social work students of the practice guidance available for working with people with PSU, and we need to convey clearly and repeatedly that SWBD practitioners have key roles to play in supporting people with PSU, and that there is a need for adequate, basic education to arm SWBD students with the knowledge and skills needed to do so.

## Disclosure statement

No potential conflict of interest was reported by the authors.

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